Health scrutiny and the new reconfiguration arrangements: a further guide for scrutiny practitioners

9 January 2024 (incorporating changes made on 17 January 2024)

info@cfgs.org.uk

The intention of this short guide is to give health scrutiny practitioners (especially members) a brief primer on the changes that are being made to health scrutiny in England, covered in more detail in a suite of guidance issued by the Department for Health and Social Care on 9 January 2024.

This guide has no official status and is intended purely to support practitioners' thinking and planning. It represents solely the views of the Centre for Governance and Scrutiny and has not been produced using Government funding. (For practitioners in committee system authorities, the detail of health scrutiny in that context is provided in the new iteration of the main health scrutiny guidance).

We may revise and reissue this guide in the coming weeks depending on practitioner and partner feedback. One such set of changes has been made since initial publication – the nature of these changes is listed in the appendix.

What do you need to know?

- From 31 January 2024, new rules are being put in place in respect of the aspect of health scrutiny that relates to reconfigurations of local health services;
- This means that from this date, local health overview and scrutiny committees (HOSCs) will no longer be able to formally refer matters to the Secretary of State where they relate to these reconfigurations;
- Instead, the Secretary of State themselves will have a broad power in intervene in local services – HOSCs will have the right to be formally consulted on how the Secretary of State uses their powers to "call in" proposals to make reconfigurations to local health services;
- NHS commissioners will have an obligation to notify the Secretary of State of planned reconfigurations that are "substantial", but these reconfigurations are not the only proposals that may be called in;
- The Secretary of State's powers to "call in" proposals will only be used as a last resort, and only when they consider that local methods for resolution have been exhausted;
- An NHS commissioning body must give effect to any decision made by the Secretary of State on a call-in;
- Other aspects of health scrutiny remain unchanged – the power to require representatives of NHS bodies to attend formal meetings, the power to get information from NHS bodies and the power to require NHS bodies to have regard to scrutiny's recommendations;
- HOSCs' status as statutory consultees on reconfigurations also remains in place, with health and care providers required to engage as they do currently.

Transitional arrangements

From 31 January 2024, referrals may no longer be made by HOSCs, or JOSCs, to the Secretary of State.

Where a referral is made to the Secretary of State, under the 2013 scrutiny referral power, prior to 31 January 2024, the process taken will reflect the 2013 rules for such referrals. Specific provision has been made in Regulations for these arrangements to be "saved".

What do you need to do?

Now

- Check with the ICB, and with the HOSCs of neighbouring authorities, about the "live" status of proposed notifiable reconfigurations (especially ones where the launch of a formal consultation is expected to be imminent);
- Check with the ICB, and with the HOSCs of neighbouring authorities, about the progress of ongoing consultations;
- Confirm with the ICB and DHSC that (for the avoidance of doubt) any live referrals (made recently, or proposed to be made on any date up to and including the 30 January 2024) will continue to be dealt with under the 2013 system;
- Open discussions with the ICB and the HOSCs of neighbouring authorities about the need to make local arrangements for the drafting or redrafting of a protocol or memorandum of understanding to cover the new arrangements;
- Make initial contact with Local Healthwatch to co-ordinate on the above matters.

In the coming weeks, and probably by the end of March

- Discuss with the ICB their forward plan for possible service reconfigurations, identify whether any are likely to come forward in the first half of 2024, and if so identify the scope and nature of the consultation exercise that may need to follow;
- Take steps to agree a revised protocol or memorandum of understanding on health scrutiny to cover the ICB area (see below);
- Take steps to work with Local Healthwatch to publicise the changes to campaigners and user groups, and to create mechanisms to support people in the use of the requesting system.

Background to health scrutiny in general

History of the referral power

Local health overview and scrutiny committees (HOSCs) gained the power to scrutinise local health services further to the Health and Social Care Act 2001, with powers commencing in 2003. Previously, powers to oversee local health services were held by Community Health Councils. These powers were subsequently split between Patient and Public Involvement Forums (PPI Forums) and HOSCs. The role originally performed by PPI Forums is now carried out by Local Healthwatch.

The operation of the referral power has stayed broadly the same since then. The relevant legislation can be found in the National Health Service Act 2006, which is the main repository for the statutory provisions relating to the governance and organisation of the NHS in England.

Ongoing arrangements for health scrutiny

It is important to note that existing arrangements for health scrutiny, in a broader sense, will

continue. This means that upper tier and unitary authorities in England have the power to:

- review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local health services;
- require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny;
- require employees including non-executive directors of certain NHS bodies to attend before them to answer questions;
- make reports and recommendations to certain NHS bodies and expect a response within 28 days;
- where practicable, set up joint health scrutiny committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority.

HOSCs will continue to be statutory consultees where proposals for certain reconfigurations take place, and the new arrangements will require that evidence of HOSCs' views be shared with DHSC when NHS commissioners notify DHSC that a notifiable reconfiguration is proposed.

The changes in more detail

There are several relevant documents for you to be aware of in thinking about your obligations under the new arrangements.

- The Health and Care Act 2022, which makes changes to the National Health Service Act 2006
- The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (as amended at https://www.legislation.gov.uk/uksi/2024/16/contents/made):
- The National Health Service (Notifiable Reconfigurations and Transitional Provision) Regulations 2024: https://www.legislation.gov.uk/uksi/2024/15/contents/made
- Guidance: "Local Authority Health Scrutiny: Guidance to support local authorities and their partners to deliver effective health scrutiny" (DHSC, 2024). This replaces/supersedes guidance of the same name published in June 2014: https://www.gov.uk/government/publications/advice-to-local-authorities-on-scrutinising-health-services/local-authority-health-scrutiny
- Statutory guidance: "Reconfiguring NHS services – ministerial intervention powers" (DHSC, 2024). This is new guidance: https://www.gov.uk/government/publications/reconfiguring-nhs-services-ministerial- intervention-powers/reconfiguring-nhs-services-ministerial-intervention-

powers

- Guidance: "Health overview and scrutiny committee principles" (DHSC, 2022). This is guidance issued following the passage of the 2022 Act, and which remains in force: https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles/health-overview-and-scrutiny-committee-principles
- Guidance: "Planning, assuring and delivering service change for patients" (NHS England, 2018 plus 2022 addendum): https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/

The importance of the health scrutiny principles

In 2022 Government published a document setting out some key principles to underpin the operation of health scrutiny arrangements. These act as the context for the operation of the new powers (and are referenced in the statutory guidance).

Of the principles, and the general role of health scrutiny, Government has said,

> "HOSCs, local authorities, ICBs, ICPs and other NHS bodies should [...] ensure that scrutiny and oversight are a core part of how ICBs and ICPs operate. Leaders from across health and social care should use these principles to understand the importance of oversight and scrutiny in creating better outcomes for patients and service users and ensure that they are accountable to local communities."

The principles, reflecting best practice for ways of working between HOSCs, ICBs, ICPs and other local system partners, are:

- **Outcome focused**. Outcome focused to scrutiny will look at cross-cutting issues – and the effectiveness of local measures to integrate health and care. HOSCs also have a role to evaluate place-based outcomes at local authority level, and to scrutinise place-based services as a result.

- **Balanced**. This is about a balance between being future focused, and response to current issues (including service performance and proposed reconfigurations). Of performance, the guidance says,

  > "ICBs should take a proactive approach to sharing at an early stage any proposals on reconfigurations, drawing a distinction between informal discussions and formal consultations. ICBs should also take a proactive approach to involving relevant bodies on any other matters which system partners expect to be contentious, to help navigate complex or politically challenging changes to local services".

- **Inclusive**. Health scrutiny is "a fundamental way for democratically elected local councillors to voice the views of their constituents, hold the whole system [...] to account and ensure that NHS priorities are focused on the greatest local health concerns and challenges".

- **Collaborative**. This is about clarity in the mutual roles of HOSCs, ICBs, ICPs, the

NHS, local authorities, HWBs and local Heathwatch. The guidance suggests joint working across ICB areas to ensure strategic issues of importance can be identified and acted on collaboratively – which may include the establishment of statutory, and non-statutory, JOSCs.

- **Evidence informed**. This involves proactively seeking out information about the performance of local services and challenging information provided by commissioners and providers – which brings with it an obligation for those organisations to provide information "positively and constructively".

We envisage that these principles will need to play a strong part in the drafting, and redrafting, of local memoranda of understanding between HOSCs and system partners.

<u>How the new system will operate</u>

In respect of proposals that are "substantial", and therefore notifiable

- An NHS provider, and commissioner, will need to consider if a proposed reconfiguration is **notifiable** (basically, this is whether it can be expected to trigger a local authority consultation). The notification should be made by the NHS commissioner to DHSC via a form created for this purpose. The notification given to DHSC **should consider the relevant HOSC's views on a proposal when deciding when to notify and should make it clear to the Secretary of State of the HOSC's view of whether this reconfiguration is notifiable.** (The statutory guidance does not cover those instances where a HOSC may be aware of a proposed change which it thinks is notifiable but where the relevant provider disagrees – this state of affairs should probably be covered in redrafted memoranda of understanding);
- Where a proposal is substantial, and therefore notifiable, it will be managed at the local level in the usual way - following the guidance's view that "**local organisations are best placed to manage challenges related to NHS reconfiguration**". This may involve the establishment of a statutory JOSC – it can also be expected to involve the usual liaison and dialogue between the relevant provider and the HOSC/JOSC, which should be covered in a relevant memorandum of understanding;
- If a HOSC considers that a proposal is substantial, but the NHS commissioner does not, it will still be open to the HOSC to make a request for call-in, as set out below.

In respect of any proposal for change in local services

- Anyone locally (including a HOSC) may make a request to the Secretary of State that a proposal be "called in" – whether that proposal is substantial or not. However, the guidance envisages that a proposal will be called in only under "exceptional" circumstances. There will be certain criteria used to determine this:
  - Attempts have been made to resolve concerns through the local NHS commissioning body, or through raising concerns with their local authority/ HOSC, and;
  - NHS commissioning bodies and local authorities/HOSCs have taken steps to resolve issues themselves, and;
  - There are concerns with the process that has been followed by the

commissioning body or the provider (eg, options appraisal, the consultation process), and/or;
    - A decision has been made (ie a Decision-Making Business Case has been approved) and there are concerns that a proposal is not in the best interests of the health service in the area.

  Ministers may also consider whether the proposal is considered to be “substantial”, and the regional or national significance of a reconfiguration, and the impact of service quality, safety and effectiveness. These criteria are similar to – but not identical to – the current criteria for a referral by a HOSC to the Secretary of State;
- When a call-in request is received that request will be considered – and evidence gathered to support the Secretary of State’s decision-making. This is a process that will be co-ordinated between DHSC and the Independent Reconfiguration Panel (IRP). A range of people may be contacted to provide further information in doing so (and we would expect that this will include the relevant HOSC). The guidance emphasises that this process of review will be entirely separate to the substantive review that will take place should a decision to call in be made;
- Should the Secretary of State decide to call in a proposal he or she will issue a Direction Letter to the NHS commissioning body, at which point the call-in becomes “live”. The Direction Letter will set out the steps that the NHS commissioner is permitted to take next (which may or may not include continuing with a consultation). The requester will be informed as well. Others – such as the HOSC – will be copied in “if it is considered helpful to the stakeholder to have sight of the information included”. It is difficult to envisage a situation where a HOSC would not find this helpful. It is worth noting that it is explicitly stated that the NHS commissioning body should themselves share information on the call-in with the HOSC at this stage;
- The Secretary of State may formally seek advice from the IRP at this point. Previous experience has been that the IRP has led on the detailed analysis of proposals at this stage (but that does not mean that will be the case in he future);
- The Secretary of State will also give interested parties the opportunity to make formal representations at this stage. The guidance states that it will “often be important” to involve the relevant HOSC. The guidance advises that where multiple HOSCs are involved without a joint arrangement, a single HOSC takes the lead on making representations);
- The Secretary of State will make a decision within six months. A number of decisions can be taken, up to and including that the proposal should not be taken forward. Decisions will be notified and published, and commissioners will have to act on them. Decisions are stated to be “final” although – like any administrative action – they will be subject to judicial review.

Summary of HOSCs’ duties and opportunities to feed in

We think the HOSCs can:

- **Engage early** with commissioners and providers to understand where notifiable reconfigurations are under development, discussing how they and the associated consultation processes might be designed;
- **Work with Local Healthwatch** to provide a first port of call for concerns about the proposal, to avoid the unilateral submission of requests for intervention by local campaigners which are likely to result in a negative response;
- Where appropriate, **co-ordinate / support an appropriate request for intervention** to ensure that – when made – it is backed by evidence to meet the criteria set out above.

Memoranda of understanding

Central to these arrangements working properly is a meeting of minds between commissioners, providers, and scrutineers in the form of both local Healthwatch and relevant HOSCs.

Many areas have established memoranda of understanding with local providers and commissioners to provide certainty both on activity around reconfiguration, and on wider health scrutiny.

While the presence of such memoranda is not a formal requirement, it is notable that the language of the guidance has shifted to form an expectation that they should be in place, in order to ensure that the system can operate effectively.

Inevitably, this means that practitioners will now need to begin the task of determining how such memoranda should be concluded. We think that the following issues will need to be resolved:

- The geography to be covered. With a shift in strategic commissioning activity to "system" level, it is likely that memoranda will need to cover the geography of multiple local authorities;
- The organisations to be covered;
- Clarity on appropriate arrangements for proactive information sharing by commissioners and providers;
- Accountability on who "owns" the memorandum, amongst the different system partners signed up to it;
- Arrangements for joint scrutiny (see below);
- Detailed arrangements for managing reconfigurations;
- Dispute resolution arrangements – in particular, for when there may be disagreement on whether a proposed reconfiguration is substantial and/or notifiable. We are particularly keen to gather evidence of dispute resolution arrangements so that this aspect of the guidance can be expanded when it is reviewed in January 2025.

We think that memoranda should start with the health scrutiny principles, and work up from there.

Over the coming months we hope to be able to work with councils and partners to support

the development and redevelopment of these memoranda. In doing so we should note that it is unlikely that a single "template" memorandum can be developed for everyone to adopt, because memoranda will have to reflect unique local circumstances. We are engaging with NHS England to ensure that the importance of this activity is shared with commissioners and providers, and with other system partners.

Joint working

One of our concerns about some of these changes has been the expectation that more commissioning will happen at system level, and that this will result in an expectation of more joint scrutiny activity.

We know that joint scrutiny activity can be resource-intensive, and difficult to facilitate when geography makes the convening of in-person meetings a challenge across large geographical areas.

Nothing in the guidance suggests that areas should set up standing joint committees for statutory and non-statutory work. In our view, most health scrutiny work should remain carried out, practically, at "place" level. But there is likely to be a need for more, and more regular, informal liaison between councils within ICBs' areas. Where an ICB is home to important tertiary provision (eg a hospital of national significance) this will be especially important to manage and clarify.

Councils will though need to think about how they can pre-empt the resource demands of joint working by having arrangements which can sit in shadow form, and be "stepped up" to a live, formal state as necessary. We know that some areas already operate in that manner.

HOSCs facilitating and support wider debate, and facilitating requests for the Secretary of State to intervene

HOSCs should not be seen as gatekeeping the requesting process. Although the obligation that local attempts at resolution be exhausted could be seen as presupposing that making a successful request will hinge on the view of the HOSC, this is not the case.

HOSCs can and should however be seen as a space for making local attempts at resolution, and we think that it is sensible that this public forum, led by elected councillors, be seen as the focus for campaigners and patient advocates.

There is likely to be a need for HOSCs, and local Healthwatch, to think about the way that the requesting process is communicated to campaigners – especially in advance of a reconfiguration that can be expected to be contentious. Healthwatch and HOSCs can act as system navigators for campaigners and patient advocates, providing support and advice.

Appendix: changes made to this guidance since 9 January

On 17 January a revised version of this guidance was produced. In brief, the changes were:

- An amendment to reflect the fact that only matters on which a formal referral has been made, prior to 31 January 2024, will continue to be dealt with under the 2013 rules. The original version erroneously stated that matters where a consultation had begun would be caught by these saving provisions;
- Removal of a reference to Local Healthwatch having the right to be consulted / make representations where the Secretary of State uses their powers;
- Clarification to explanation of the process to emphasise that not only substantial variations can be called in;
- An amendment to reflect the fact that the revised health scrutiny guidance is not statutory;
- A number of typographical amendments, including a spelling mistake, a duplicate sentence and a couple of changes to assist with legibility.