Health and Care Act: implementation

Discussion paper on health scrutiny Regulations and statutory guidance

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About Centre for Governance and Scrutiny

CfGS is a charity that provides advice, guidance and support to local authorities, and other bodies, on matters relating to decision-making, oversight and governance more generally.

This briefing is intended to support practitioners to better understand activity in the coming months on the implementation of the Health and Care Act, and in particular the changes to health scrutiny during that period.

It is particularly intended to support dialogue and conversation in advance of, and at, a seminar being organised for scrutiny practitioners in late November 2022. Details of the date, time and format of this seminar will be publicised closer to the time.

Background to the Act

You can find earlier briefing CfGS material on the Act here – https://www.cfgs.org.uk/wp-content/uploads/Health-and-Care-Act.pdf

The LGA has also published a briefing - https://www.local.gov.uk/publications/get-act-health-and-care-act-2022

You can find our thoughts on possible legislative changes to be brought forward in Regulations here – https://www.cfgs.org.uk/wp-content/uploads/2021-03-22-Proposed-health-scrutiny-sections-revised.pdf (this was drafted when the Bill was still proceeding through Parliament in 2021).

The Health and Care Act received Royal Assent in early 2022. It makes some substantial changes to the planning and operation of health and care services in England. Principal amongst these is the placing on a legislative footing of "integrated care systems", comprised of:

- Integrated Care Boards, which are statutory NHS bodies with responsibility for leading, directing and overseeing health and care in a given area, and
- Integrated Care Partnerships. Each ICB and their respective upper ier councils are required to establish an ICP whose key duty will be to develop an "integrated care strategy".

ICBs and ICPs went "live" on 1 July 2022.

The Act also introduces significant new powers for the Secretary of State to intervene in local health services. Describing these new powers, the Explanatory Notes produced in support of the Bill on introduction to the Commons said,

> *"Most service changes are delivered and implemented locally – planned reconfigurations are developed at local or regional levels by commissioners. The current system for reconfigurations works well for the majority of changes, and this will be left in place for many day-to-day transactions.*
>
> *"The aim of this policy is to address the minority of cases which are complex, a significant cause for public concern, or where Ministers can see a critical benefit to taking a particular course of action. Cases such as these can lead to difficult debate and lengthy processes.*
>
> *"The Secretary of State is currently only able to intervene in such cases upon receiving a local authority referral. [...] [R]eferrals can often come very late in the process meaning Ministers must account for service changes in Parliament without often having been meaningfully engaged on them themselves.*
>
> *"These provisions will add a new discretionary power to the NHS Act 2006 for the Secretary of State to give a direction to NHS bodies or providers requiring a reconfiguration to be referred to him instead of being dealt with locally. The Secretary of State will be able to use this call-in power at any stage of the reconfiguration process. To support this intervention power, the current Local Authority referral power, which is set out in regulations under the NHS Act 2006 will be amended to reflect the new process. This does not remove the local Health Oversight [sic] and Scrutiny Committee (HOSC) role or the requirement to involve them in reconfigurations."*

Following a last-minute Government amendment, the exercise of these powers will be subject to consultation with local authorities – which we understand to be a specific reference to health scrutiny, rather than consultation with the HWB or with Cabinet, both of whom will have a stake in local issues (and an opportunity to engage) through the ICP.

Key issues for strong local scrutiny

For CfGS there are four central issues that Regulations and guidance will need to address:

- Making it clear that health scrutiny is a distinct function independent and separate from councils' engagement in the health and care system through HWBs and ICPs;
- Scrutiny's ability to proactively bring matters of concern to the SoS's attention;
- Joint scrutiny arrangements covering ICS areas;
- Scrutiny's role in improvement.

For us the overarching need in all of these areas is that the audience for guidance should be seen as both local authority scrutineers, and NHS partners and others acting in the decision-making space in systems. Health scrutiny practitioners will, we know, make extensive use of the guidance – but experience from previous health reforms suggest that decision-makers' understanding on the role of scrutiny will require a refresh.

The effective management of a relationship between scrutiny and other system partners might require the presence of a protocol or similar document to set out mutual rights and expectations. CfGS recognises that ICS governance is evolving and it may be that such agreements can be systematised in a different way.

Health scrutiny as a distinct function

We think that there is a risk in the current and ongoing debate that the fact of local government's involvement in health and care planning and delivery in different ways – in particular, through Health and Wellbeing Boards (HWBs) and Integrated Care Partnerships (ICPs) – risks that local health scrutiny is seen as a duplication.

In fact, health scrutiny is a vital part of a balanced and robust framework for governance across the health and care system. Along with Local Healthwatch, it provides for:

- Scrutiny and oversight exercised by individuals with no role in decision-making;
- Oversight in public, carried out by democratically elected public representatives;
- Oversight as part of a framework that takes into account the interaction of health, care, and other areas of public policy. Health scrutiny has demonstrated its capability in looking, across the piece, at health inequalities, with significant positive results;
- Proper and meaningful representation of the public voice as a formal part of the system;
- A cross-cutting and holistic approach that makes use of scrutiny's general powers to look at any issue which affects the area or the area's inhabitants. This means that scrutiny can look across the piece at services and strategies of the council (and other partners) which have an impact on health, care and wellbeing.

Guidance needs to set out the unique, distinct and complementary roles of those involved in system activity overall – especially from the local government perspective. The clearer this is, the easier it will be for partners who are part of NHS bodies (in particular, the staff of ICBs) to understand the distinction between (for example) executive and scrutiny councillors.

We suggest that as well as guidance providing clarity on this issue, the profile of scrutiny and of local accountability in general should be raised through a description of the scrutiny function, and its role, in future iterations of the NHS Oversight Framework, as well as through more prominence being given to the scrutiny role in any future iteration of the NHS system-wide guidance on participation, consultation and public involvement.

It is important that the role and function of scrutiny be thrown into sharper relief for system partners.

Scrutiny's ability to proactively bring matters of concern to the Secretary of State's attention

We recognise that, for Government, providing the Secretary of State with powers to intervene proactively is an important part of asserting political accountability for actions undertaken within the system. National accountability is vital – but local accountability is also crucially important. It is only through the application of strong local accountability that the Secretary of State will be able to gather the intelligence necessary to exercise their powers confidently.

Government has accepted the need for the Secretary of State to consult with health scrutiny committees in advance of their powers of intervention being used. We believe that a further, proactive element is needed – a power for scrutiny to bring things to the attention of the Secretary of State in advance.

We believe that this should be accompanied by a restatement of the importance of scrutiny's formal role in reconfigurations, as the removal of the formal referral power could give the erroneous impression that scrutiny will have less importance in the system. Earlier, substantive engagement with scrutiny will reduce the risk of Secretary of State interventions, just as it reduced the likelihood of a formal scrutiny referral in the past.

The power to bring things formally to the notice of the Secretary of State, short of that notice being a "referral", might exist in respect of two issues:

- The proposal and design of new services (including planned reductions or withdrawals of services) – similar to what would currently be described as "substantial variations";
- Performance, or other, matters in respect of ongoing issues (which are in any case the subject of long-standing, and continuing, health scrutiny powers).

In practice, we think that a proportionate system may look like the following (we should stress that this is illustrative):

- Scrutiny, alongside Local Healthwatch, is understood to hold a watching brief over the design and delivery of health and care services across an ICS footprint;
- There is therefore an expectation that ICSs should notify local health scrutiny of major changes being planned, and that scrutiny will be actively involved in discussion around those major changes from an early stage, and an understanding that scrutiny will also have access to performance information and other data that gives insight into ongoing service delivery.
- There might also need to be closer co-ordination between scrutiny and Healthwatch, given the latter's important "enter and view" powers;
- When certain criteria are met (which could be set locally or nationally or through a combination of the two) a scrutiny committee could notify the Secretary of State of their concerns. This might be preceded by conversation with the ICS and other system partners about those concerns. We think that there is a conversation to be had over whether different approaches are needed depending on whether scrutiny has concerns over the process undertaken to reach a decision, or whether

scrutiny has substantive concerns about the decision itself (ie the decision is not in the interests of the health and care system locally and/or not in the interests of local people);

- Where scrutiny notifies the Secretary of State of those concerns, it does not trigger a formal intervention or similar process. However, he Secretary of State is held to an expectation that a response will be provided within a certain timeframe. This response may or may not be that she proposes to use her powers of intervention. This may form part of the statutory guidance to the Secretary of State on the subject of those intervention powers;
- Where relevant action might, as now, involve reference of issues to the Independent Reconfiguration Panel.

The role of Local Healthwatch, in working with local scrutiny to understand, inform and act on concerns with regard to local health and care issues, would need to be discussed and agreed as part of these measures.

Joint scrutiny arrangements

In some areas of England, joint scrutiny arrangements are a continuing feature of their formal role. In others, joint committees are only established when substantial variations are planned which affect more than one authority's area. Under these circumstances, where the NHS is obliged to consult all relevant local authorities, the relevant local authorities are obliged to establish a joint committee as the official consultee. This does not preclude the need for ongoing health scrutiny activity in individual authorities.

The nature of ICS decision-making leads to an expectation that more and more scrutiny may need to be joint in nature – to take this wider footprint into account.

ICSs will want to make decisions that rationalise or reorganise local health services to reflect this wider footprint, particularly relating to secondary and tertiary care. Increasingly, scrutiny committees can expect to work with neighbouring councils as a matter of routine, as these kinds of changes (affecting the areas of a number of local authorities) become more frequent. This may – either by design or evolution – lead to the establishment of more standing joint committees.

A framework for action

At the moment expectations here are unclear. We would not wish to impose an expectation of councils that they should establish standing joint committees and would not suggest to Government that they do so.

We think that health scrutiny focused on individual council areas should continue to be the default, proportionate, approach. We are though concerned that there is the risk that the establishment of joint arrangements might be seen as diluting the need for ongoing, strong local scrutiny of health services (which must continue, on a council by council basis).

We do, however, think that a framework or blueprint needs to be established for scrutiny, and other system partners, to follow to determine where it might be necessary, and then to put in place the necessary steps to set up joint arrangements. This would need to take account of the need to complement and align with health scrutiny activity being undertaken at local level – co-ordination across larger systems might prove challenging.

The development of a kind of blueprint would avoid the need to design systems from the ground up in every area. While such a system would not produce perfection, it would we think allow areas to overcome the first hurdle – establishment of these systems in the first place – making refinement based on local need possible further down the round.

Resourcing for joint scrutiny

A framework or blueprint would need to tackle the resourcing of these arrangements as a priority. We think that resourcing arrangements for effective health scrutiny in these geographies would need to be supported by ICBs or ICPs. Recognising the benefit of effective scrutiny and the time and resource saving to ICBs not having to engage with multiple local authority scrutiny committees invites a quid pro quo in which a measure of resourcing to support joint arrangements is provided to a "host" authority. If this does not happen, the burden placed on hosts to provide the administrative and policy support to such a body would, we think, be significant, and onerous.

Scrutiny's role in improvement

There are two important ongoing lines of work in respect of ICSs' setup and future sustainability in which health scrutiny committees have a potential stake. In highlighting these two areas we should stress that we consider scrutiny has a broader role in ICS improvement overall. Scrutiny can usefully bring support and challenge to ICBs and ICPs on the development and agreement of Integrated Care Strategies, forward plans, outcomes and other aspects of their work – and guidance might usefully spell out these wider opportunities for engagement and oversight.

The effectiveness of ICS constitutions

NHS England has recently undertaken significant work in bringing ICS constitutions into being. For each ICB, adherence to a set of design principles was required, and a formal review of readiness of operate was undertaken.

ICSs will need to keep the effectiveness and appropriateness of their constitutions, and wider governance arrangements, under continual review. We are aware that ICBs are being asked to take stock of their decision-making arrangements by means of self-assessment in early 2023.

The complex landscape within health and care systems makes it likely that governance arrangements will need to be refined, particularly in the first year. Health scrutiny can play a role in helping ICSs to understand challenges and opportunities during this period, keeping a watching brief over the development of relationships and system partners' ability to manage a smooth transition over the coming months, and beyond. Local government holds significant expertise in the governance and democratic services space which may be of use to NHS partners as they develop and refine their systems.

CQC

CQC continues to undertake assessments of ICBs, to provide external oversight and to provide assurance to the system. This process follows on from the provider collaboration reviews (PCRs) which CQC has carried out for some time for both non-statutory ICSs and their predecessors, STPs.

There is a role for scrutiny in understanding learning from these exercises and how they can contribute to continuous improvement. Periodic national inspection is important but

local scrutiny is best placed to understand the impact of action plans and to oversee health partners in their implementation.

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