Changes to scrutiny of health reconfigurations: frequently asked questions

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On 31 January 2024, new powers will come into force allowing the Secretary of State for Health and Social Care to intervene in proposals for changes to local NHS services (otherwise referred to as 'reconfigurations'). These reforms update a process, whereby powers previously held exclusively by Health Overview and Scrutiny Committees (HOSCs) to refer proposed reconfigurations to the Secretary of State are replaced with a call-in request process open to anyone. The changes also mean that the Secretary of State may act proactively without a HOSC referral or call-in request.

These FAQs have been produced to reflect questions asked and issues raised following Government's publication on 9 January 2024 of the guidance relating to these powers, and the laying on the same day of connected Regulations. CfGS and other national partners updated scrutiny practitioners on these changes at a webinar held on 16 January 2024, and some of these questions and issues raised in that webinar are also covered in these FAQs.

Other material which may be useful

- 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-servicesministerial-intervention-powers/reconfiguring-nhs-services-ministerial-intervention-powers

- CfGS guidance: "Health scrutiny and the reconfiguration arrangements: further guidance" (CfGS, 2024). This guide produced by CfGS is intended to provide further information to scrutiny practitioners: https://www.cfgs.org.uk/?publication=health-scrutiny-and-the-new-reconfiguration-arrangements
- 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/

What is the purpose and intent of the new powers?

The Explanatory Note to the Act states:

> "While [the pre-2024 referral power] was able to help with difficult cases, referrals often came very late in the process meaning Ministers had to account for service changes in Parliament without having been meaningfully engaged on them themselves.
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> The Act adds a new discretionary power to the NHS Act 2006 for the Secretary of State to call in and make a decision on a reconfiguration proposal. The Secretary of State will be able to use this call-in power at any stage of the reconfiguration process.
> This power is intended to be used in 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."

What do these changes mean for health overview and scrutiny arrangements overall?

Other than the removal of the power to refer, all other health scrutiny powers remain the same.

HOSCs hold powers in respect of "responsible persons" this will include NHS commissioners and providers in the area. Relevant powers can be found in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (SI 218/2013). These Regulations have been issued further to the National Health Service Act 2006 and amended by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny (Amendment and Saving Provision) Regulations 2024 (SI 16/2024).

- A local authority may review and scrutinise any matter relating to the planning, provision and operation of the health service in its area (Regulation 21(1));
- Where it does so, the authority *must* invite interested parties to comment on the matter and take account of relevant information provided to it by local Healthwatch (described as a "referrer" – this power of reference from Healthwatch to a HOSC is of course not being removed) (Regulation 21(2), with the rules around how Healthwatch references are to be managed covered in Regulation 21(3), (4) and (5));
- A local authority may make reports and recommendations to a "responsible person" on any matter scrutinised under Regulation 21 (Regulation 21(1) – (6)). There are requirements for

such reports and recommendations to meet certain criteria; if they do then where a local authority requires a response from the responsible person that response must be provided within 28 days;
- Responsible persons must consult local authorities on "substantial developments" or "substantial variations" in health services (Regulation 23);
- Responsible persons must provide local authorities with "such information about the planning, provision and operation of health services in the area of that authority as they authority may reasonably require in order to discharge relevant functions" (Regulation 26);
- Local authorities may require any member or employee of a responsible person to attend before the authority to answer questions (Regulation 27).

Most local authorities choose to use HOSCs to carry out their health scrutiny functions. However, since councils have been able to adopt the committee system form of governance – which does not require a council to appoint an overview and scrutiny committee – the powers in the Act and Regulations are conferred on local authorities. Regulation 28 states that local authorities "may" arrange for their relevant functions to be discharged by an OSC or under certain circumstances by the OSC of another council.

Regulation 30 deals with the appointment – on a statutory, and non-statutory, basis – of a joint overview and scrutiny committee, or JOSC – this is covered in more detail below.

Under the new arrangements, HOSCs will also be consulted where the Secretary of State has decided to "call in" a proposal for reconfiguration.

When does the referral process end and the new call-in request process begin?

A referral can be sent to the Secretary of State in line with the 2013 rules on a date up to, and including, 30 January 2024. After this date the new rules will apply and a referral will not be possible.

If a referral is made between now and 30 January 2024, the 2013 process will continue for that referral until the matter has been resolved. Saving provisions in the Regulations specifically allow for this.

Are there any exemptions to the duty on NHS commissioners to notify DHSC of substantial variations in the case of urgency?

If there is a proposal to make a substantial variation then it must be notified to DHSC; if there is a proposal that requires a statutory consultation then that consultation will need to be carried out. The NHS England guidance, "Planning, assuring and delivering service change for patients" (2018) contains more information on the timescales, legal requirements and suggested approaches.

Arrangements exist for commissioners to make urgent temporary reconfigurations of services – usually for reasons of patient safety. Under these circumstances, the rules require a commissioner to notify (but not consult) the HOSC of these changes. The commissioner will not need to notify DHSC of these changes. The expectation is that clear plans for reverting changes, or moving to permanent reconfiguration, will be made in due course – though there are no set timescales for "temporary" changes.

Other exemptions from NHS commissioning bodies' and NHS providers' duty to consult the HOSC are set out in Regulation 24 of the 2013 regulations. These exemptions also apply to NHS commissioning bodies' duty to notify the Secretary of State and include.

Is a "notifiable" change basically a "substantial" one, and what does "substantial" mean?

Yes, a notifiable change is one that is substantial. A reconfiguration is notifiable if it meets the requirement for a statutory consultation under Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. Statutory consultations with HOSCs are required where a proposal for change is substantial.

In line with the previous process, the exact meaning of "substantial" has not been defined in legislation or guidance. The amended health scrutiny guidance notes local protocols and memoranda between HOSCs and NHS commissioners can help to determine where a proposal may be substantial. For example, a substantial variation may be one that affects a large number of people in a locality – such as the closure or downgrading of a specialist or community services, or of a general service such as an Emergency Department. It may be one that affects a small number of people, but which is nevertheless substantial because of the impact on a specific group.

Are only notifiable (and therefore substantial) reconfigurations subject to call in by the Secretary of State?

No. Any proposal for change may be subject to call-in intervention by the Secretary of State.

Although commissioners do not have to notify the Secretary of State of proposals that are not notifiable / substantial, they hold a general obligation to provide information necessary for the Secretary of State to fulfil their new functions, which could support an intervention for a non-substantial proposal if thought necessary.

When is something considered a "proposal" that may be subject to call in?

There is no specific definition of "proposal" in legislation or guidance. The arrangements for determining when a "proposal" exists are unchanged. The 2018 NHS England guidance referred to above sets out (at section 6) an internal and external assurance process for proposals. Once a proposal has cleared these hurdles it is considered to have passed from being an "outline proposal" to a proposal ready to be formally presented (including presentation through consultation). At this point it can be assumed that a "proposal" will be classed as one subject to call-in under the Act and Regulations.

Such a proposal, as noted above, need not be "substantial" to be called in.

Must a request be made for a call in, in order for the Secretary of State to act?

No. The Secretary of State can intervene in a proposal at any point during the reconfiguration process. . However, the statutory guidance on the use of the powers states that the purpose of the power is to unblock local problems and disagreements, which suggests that use of the call-in power to intervene would in most cases be following a call-in request.

It is important to note that the Secretary of State's powers sit independently to the requesting framework – unlike the 2013 arrangements, where the Secretary of State's powers needed to be "triggered" by a HOSC referral.

What if a HOSC considers that a change is notifiable, and the NHS commissioner disagrees?

A call-in request can be made about any proposal, not just ones that relate to notifiable reconfigurations. A HOSC (or any other person) could make a request on the basis that they consider that a change is notifiable, and (for example) that the consultation planned for that proposal is inadequate. As on other matters, it will be important for the HOSC to demonstrate that local attempts at resolution have been exhausted.

This may prove to be a live issue in cases where patient flows lead to disagreement about where formal consultation needs to be carried out. For this and other matters, local protocols / memoranda of understanding are likely to provide part of the solution. Advice on this matter may also be sought from the Independent Reconfiguration Panel.

Are there timing requirements for when call-in requests should be sent in?

The Statutory guidance does not specify any timeframes. As long as a proposal for reconfiguration exists, a request may be made at any point in the reconfiguration process. However, local attempts to resolve the issue must have been exhausted before this happens. Government guidance expects that NHS commissioners will involve HOSCs early in the planning process for major changes.

What are the circumstances in which a joint health overview and scrutiny committee (JOSC) needs to be established?

JOSCs can established as a result of a statutory requirement. Where a commissioner proposes a reconfiguration that covers ones or more area, and so is obliged to consult with more than one HOSCs, a statutory JOSC must be established to transact this role. A JOSC may also be established on a non-statutory basis, where local authorities in the area determine that they wish to do so.

Are requirements for the establishment of JOSCs changing?

These changes do not affect the ongoing obligation for areas to establish statutory JOSCs, under the same provisions that currently exist (Regulation 30, SI 218/2013 as amended). It is possible / likely that ICSs will make proposals for change that cover a wider geographic footprint than has been the case in the past, given their size, and that this may involve an expectation for more, and more frequent, JOSCs. Some areas have considered the establishment of standing JOSCs to cover ICS areas. CfGS is, with its partners, considering what further guidance and advice can be given to local areas to ensure that joint working is proportionate, properly resourced, and adds value.

How should changes be communicated to residents?

As part of the development of new protocols / memoranda between local partners, partners might wish to consider if and how local awareness of these changes might be raised.

Some campaigning and advocacy groups may be familiar with the existing 2013 arrangements but may not be aware of these changes, and certainly may not be aware of the detail. Partners – particularly local Healthwatch – might want to consider how they can work together with HOSCs, with NHS commissioners and providers and with other stakeholders to highlight this.

Are there expected to be any new burdens imposed on local government as a result of these changes?

The updated process retains many of the previous arrangements for local health scrutiny of NHS reconfigurations. In some cases, councils' and commissioners' may need to revisit memoranda of understanding, or protocols, that underpin the HOSC-NHS relationship as part of an ongoing dialogue on NHS service changes. Substantively, with new arrangements in place, HOSCs will be expected to liaise with commissioners and providers much as they do at present. In exceptional circumstances where local resolution is not possible, HOSCs will also need to think about the way that they will need to engage with the Secretary of State (by way of DHSC and the IRP) via the call-in request process. DHSC do not consider these to be new burdens, as they reflect an ongoing conversations between scrutineers, commissioners and others that forms an integral part of the ongoing arrangements for health scrutiny.

Are there plans to keep the implementation of these arrangements under review?

DHSC have stated that they are actively monitoring these arrangements and will update statutory guidance a year after the new process comes into force.