Department of Health & Social Care

Guidance

Local authority health scrutiny

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Contents

This publication is available at https://www.gov.uk/government/publications/advice-to-local-authorities-on-scrutinising-health-services/local-authority-health-scrutiny

Summary

The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered an integral part of the commissioning and delivery of health services and that those services are effective and safe.

Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working - relevant to this might be how well health and wellbeing boards are carrying out their duty to promote integration - and in making recommendations about how it could be improved.

At the same time, health scrutiny has a legitimate role in proactively seeking information about the performance of local health services and institutions, in challenging the information provided to it by NHS commissioning bodies and providers of services for the health service ('relevant NHS bodies and relevant health service providers') and in testing this information by drawing on different sources of intelligence.

Health scrutiny is part of the accountability of the whole system and needs the involvement of all parts of the system. Engagement of relevant NHS bodies and relevant health service providers with health scrutiny is a continuous process. It should start early with a common understanding of local health needs and the shape of services across the whole health and care system.

Effective health scrutiny requires clarity at a local level about the respective roles of the health scrutiny function, NHS bodies, the local authority, health and wellbeing boards and local Healthwatch.

Local authorities should ensure that regardless of any arrangements adopted for carrying out health scrutiny functions, the functions are discharged in a transparent manner that will boost the confidence of local people in health scrutiny. Health scrutiny should be held in an open forum and local people should be allowed to attend and use any communication methods such as filming and sharing on social media to report the proceedings. This is in line with the transparency measures in the Local Audit and Accountability Act 2014 (https://www.legislation.gov.uk/ukpga/2014/2/contents/enacted) allowing local people, particularly those who are not present at scrutiny hearing meetings, to have the opportunity to see or hear the proceedings.

Definitions of terms

Throughout this guidance, the following definitions apply to the terms set out below.

Health service commissioners and providers

This refers to: a) certain NHS bodies (namely NHS England, integrated care boards (ICBs), NHS trusts and NHS foundation trusts) and b) providers of NHS and public health services commissioned by NHS England, ICBs and local authorities.

Each of these is 'a responsible person', as defined in The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (https://www.legislation.gov.uk/uksi/2013/218/contents/made) ('the 2013 regulations') , on whom the regulations impose certain duties for the purposes of supporting local authorities to discharge their health scrutiny functions.

NHS body

'NHS body' refers to NHS England, ICBs, NHS trusts and NHS foundation trusts.

Relevant health service provider

This refers to a body or person, other than an NHS trust or NHS foundation trust, which provides any relevant services to persons residing in the area of the local authority.

NHS commissioning body

'NHS commissioning body' means NHS England or an ICB.

NHS provider

'NHS provider' refers to both NHS trusts and NHS foundation trusts.

NHS services

'NHS services' means services provided as part of the health service in England.

Integrated care systems

Integrated care systems are non-statutory partnerships of organisations (including ICBs, local authorities and their system partners) that come together to plan and deliver joined-up health and care services.

Reconfiguration of NHS services

This means a change in the arrangements made by an NHS commissioning body for the provision of NHS services where that change has an impact on either of the following:

- the manner in which a service is delivered to individuals (at the point when the service is received by users)
- the range of health services available to individuals

Call-in power

This refers to the Secretary of State for Health and Social Care's statutory power to consider a proposed reconfiguration of NHS services developed by an NHS commissioning body and take a decision.

Call-in request

This refers to a non-statutory means for any group or individual to request that the Secretary of State consider use of their intervention powers for a proposed reconfiguration of NHS services.

Health overview and scrutiny committees

This refers to committees set up by local authorities to discharge their functions to provide overview and scrutiny of local health services as provided for by the 2013 regulations. While these committees are most likely to be exercising health scrutiny functions in local authorities, we are aware that there are a variety of such bodies with different names and remits, including joint health overview and scrutiny committees.

Updates to this guidance

This guidance has been updated to reflect amendments to the local authority scrutiny function following the introduction of the Health and Care Act 2022 (https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted) ('the 2022 Act'), which inserted schedule 10A into the National Health Service Act 2006 (https://www.legislation.gov.uk/ukpga/2006/41/contents) ('the NHS Act 2006').

Local authorities have an important role to play in integrated care systems and in the improvement of local population health outcomes through the planning and provision of services. The 2022 Act established local authorities as mandated members of the ICB, giving local authorities a greater voice than ever before in NHS decision-making. Local authorities are also mandated members of the integrated care partnership (ICP), tasked with developing an integrated care strategy to address the health, social care and public health needs of their system.

The NHS Act 2006 gives the Secretary of State a general power to direct a call-in for any reconfiguration proposal. This power allows the Secretary of State to call in and take any decision on a reconfiguration proposal that could have been

taken by the NHS commissioning body. The Secretary of State will be able to use this call-in power at any stage of the reconfiguration process and will enable the Secretary of State to determine a way forward for challenging reconfigurations.

The Department of Health and Social Care (DHSC) has published Reconfiguring NHS services - ministerial intervention powers (https://www.gov.uk/government/publications/reconfiguring-nhs-services-ministerial-intervention-powers) ('the 2024 statutory guidance') to provide NHS commissioning bodies (ICBs and NHS England) and NHS providers (NHS trusts and NHS foundation trusts) with practical guidance on the new process for ministerial intervention in reconfiguration of NHS services. This includes setting out the considerations the Secretary of State will take into account when deciding whether to use the call-in power.

Local authorities' powers of referral to the Secretary of State have been removed. Instead of the referral power, health overview scrutiny committees and other interested parties can write to request (via a call-in request form) that the Secretary of State consider calling in a proposal. DHSC expects requests only to be used in exceptional situations where local resolution has not been reached. Such a request will then be considered as set out in the statutory guidance.

Where there are concerns about proposals for substantial developments or variation in health services (also referred to as 'reconfiguration' for the purposes of this guidance) local authorities and the NHS commissioning body should work together to attempt to resolve these locally if at all possible. If external support is needed, informal advice is available from the Independent Reconfiguration Panel (https://www.gov.uk/government/organisations/independent-reconfiguration-panel) (IRP).

In considering substantial reconfiguration proposals local authorities need to recognise the resource envelope within which the NHS operates and should therefore take into account the effect of the proposals on the sustainability of services, as well as on their quality and safety.

Introduction

This guidance is intended to support local authorities, relevant NHS bodies and relevant health service providers in discharging their responsibilities under the relevant legislation, and thereby supporting effective scrutiny. The guidance should be conscientiously taken into account. However, the guidance is not intended to be a substitute for the legislation or to provide a definitive interpretation of the legislation. Only the courts can provide a definitive interpretation of legislation. Anyone in doubt should seek legal advice.

Background

The primary aim of health scrutiny is to act as a lever to improve the health of local people, ensuring their needs are considered as an integral part of the commissioning, delivery and development of health services. For some time, local authority overview and scrutiny of health has been an important part of the government's commitment to place patients at the centre of health services. Updated regulations for local authority public health, health and wellbeing board and health scrutiny can be viewed here.

Health scrutiny is a fundamental way by which democratically elected local councillors are able to voice the views of their constituents and hold relevant NHS bodies and relevant health service providers to account. To this end, it is essential that health scrutiny functions are also carried out in a transparent manner, so that local people have the opportunity to see and hear proceedings, in line with the transparency measure in the Local Audit and Accountability Act 2014.

As outlined in the Health overview and scrutiny committee principles (https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles), health and overview scrutiny committees continue to play a vital role as the body responsible for scrutinising health services for their local area. They retain legal duties to review and scrutinise matters relating to the planning, provision and operation of the health service in the area.

Under the health overview and scrutiny committee principles, there are 5 points of best practice for ways of working between health overview and scrutiny committees, ICBs, ICPs and other local system partners. The principles are that joint working should be outcome focused, balanced, inclusive, collaborative and evidence informed. To ensure the benefits of scrutiny are realised, these principles should form the basis of ongoing discussions between system partners about how they will work together.

Within NHS bodies, there has been increasing emphasis on the need to understand and respond to the views of patients and the public about health and health services: the NHS Constitution for England (https://www.gov.uk/government/publications/the-nhs-constitution-for-england) provides a strong set of principles underpinning NHS bodies' accountability to the people they serve. The government's mandate to NHS England set objectives that NHS England must seek to meet in discharging their functions. The NHS England operating framework (https://www.england.nhs.uk/publication/operating-framework/) sets out how accountabilities and responsibilities will be allocated to improve local health and care outcomes in a way that maximises taxpayer value for money. Responding positively to health scrutiny is another way for NHS bodies to be accountable to local communities.

Purpose of this guidance

This guidance includes an up-to-date explanation and guide to the updated 2013 regulations[footnote 1] (which came into force on 31 January 2024), and reflects amendments to the local authority scrutiny function following the introduction of the 2022 Act, which sets out a new process for ministerial intervention in reconfiguration of NHS services by inserting schedule 10A into the NHS Act 2006.

The 2013 regulations have implications for relevant NHS bodies and relevant health service providers, including local authorities carrying out the local authority health scrutiny function, health and wellbeing boards and those involved in patient and public engagement activities. The duties in the 2013 regulations are aimed at supporting local authorities to discharge their scrutiny functions effectively. Failure to comply with those duties would place the relevant NHS body or relevant health service provider in breach of its statutory duty and render it at risk of a legal challenge.

This guidance is, therefore, of relevance to:

- local authorities (both those which have the health scrutiny functions and district councils)
- ICBs
- NHS England
- providers of health services including those from the public, private and voluntary sectors
- those involved in delivering the work of local Healthwatch

The guidance should be read alongside other guidance issued by DHSC and NHS England, including:

- Health overview and scrutiny committee principles (DHSC)
- the 2024 statutory guidance, 'Reconfiguring NHS services - ministerial intervention powers' (DHSC)
- Working in partnership with people and communities: statutory guidance (https://www.england.nhs.uk/long-read/working-in-partnership-with-people-and-communities-statutory-guidance/) (NHS England)
- Planning, assuring and delivering service change for patients (https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/) (NHS England)

This guidance will be updated no later than January 2025.

Scope of the regulations

This guidance explains local scrutiny of matters relating to the health service, including services commissioned and/or provided by NHS bodies as well as public health services commissioned by local authorities. This includes services provided to NHS bodies by external, non-NHS providers, including local authorities (this is discussed in more detail in the 'Consultation' section below).

The NHS Constitution for England provides a set of guiding principles and values for NHS bodies which indicate that the NHS is not just a sickness service, but is there to improve health, wellbeing and to address health inequalities. Since the creation of the health scrutiny functions under the Health and Social Care Act 2001 (https://www.legislation.gov.uk/ukpga/2001/15), local authority scrutiny committees have prioritised issues of health improvement, prevention and tackling health inequalities as areas where they can add value through their work. In their reviews, local authorities have looked at the wider social determinants of health and health inequalities, not least because of local government's own contribution through the whole range of their services.

NHS bodies have a responsibility to support the triple aim of improving quality of care, reducing health inequalities across communities, and delivering the best value care. Reconfiguration should act as a window of opportunity to drive forward the delivery of fair and equitable care - for example, by improving access to services for the most deprived and least healthy communities.

Moreover, DHSC has always advised and local authorities have recognised that the best use of their health scrutiny powers will depend on scrutiny extending to health issues, the health system and health economy rather than being limited to services commissioned or managed by NHS bodies or local authorities.

The duties of health service commissioners and providers under the 2013 regulations apply to NHS commissioning bodies and to providers of health services as part of the health service, including NHS bodies and local authorities, as discussed below. However, local authority health scrutiny committees have often drawn on their wider powers to promote community wellbeing to carry out overview and scrutiny of a range of health issues which go beyond NHS services. Public health is a responsibility of local government, and health and wellbeing boards provide strategic leadership of the health system through partnership, with a specific duty to encourage integrated working across health and social care. This means that some services will be jointly commissioned between local authorities and NHS bodies. Any health scrutiny exercise may therefore include reviewing the local authority's own contribution to the health of local people and the provision of health services, as well as the role of the health and wellbeing board, and of other agencies involved in the health care of local people.

Requirements under the 2013 regulations

Powers and duties for local authorities

Under the regulations, local authorities in England (that is, 'upper tier' and unitary authorities such as county councils, district councils, the Common Council of the City of London and the Council of the Isles of Scilly, or lower tier or joint councils with delegated authority) 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 overview and scrutiny committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority

Executive members may not be members of local authority overview and scrutiny committees, their sub-committees, joint health overview and scrutiny committees and sub-committees. Overview and scrutiny committees may include co-opted members - that is, those who are not members of the relevant local authority (for example, co-opted members of overview and scrutiny committees of district councils or representatives of voluntary sector organisations). Co-opted members may not be given voting rights except where permitted by the relevant local authority in accordance with a scheme made by the local authority. For further information see section 9FA of and schedule A1 to the Local Government Act 2000 (https://www.legislation.gov.uk/ukpga/2000/22/contents), regulations 5 and 11 of The Local Authorities (Committee System) (England) Regulations 2012 (https://www.legislation.gov.uk/uksi/2012/1020/made) and regulation 30 of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

The position of councils that have returned to a committee system of governance is discussed in the 'Consultation' section below.

The legislation covers additional and new organisations and diverse local authority arrangements, as described in the 'Consultation' section below.

Councils as commissioners and providers of health services

As commissioners or providers of public health services and as providers of health services to the NHS, services commissioned or provided by local authorities are themselves within the scope of the health scrutiny legislation.

To that end local authorities may be bodies that are scrutinised, as well as bodies that carry out health scrutiny.

The duties which apply to scrutinised bodies such as the duty to provide information, to attend before health scrutiny and to consult on substantial reconfiguration proposals will apply to local authorities insofar as they may be 'relevant health service providers'. For further information see section 244 of the NHS Act 2006 and regulation 20 of the 2013 regulations for the meaning of 'relevant health service provider'.

It remains important, particularly in making arrangements for scrutiny of the council's own health role, that all possible steps are taken to identify conflicts of interest and to take steps to deal with them.

Councils as scrutineers of health services

The Local Government Act 2000 (as amended by the Localism Act 2011 (https://www.legislation.gov.uk/ukpga/2011/20/contents/enacted)) makes provision for authorities:

- to retain executive governance arrangements (comprising a leader and cabinet or a mayor and cabinet)
- to adopt a committee system of governance
- to adopt any other form of governance prescribed by the Secretary of State

Health scrutiny arrangements will differ in some respects depending on the system that the council chooses to operate. Most importantly:

- councils operating executive governance arrangements are required to have at least one overview and scrutiny committee. In this case, the scrutiny is independent of the executive
- if a council adopts a committee system, they can operate overview and scrutiny committees if they choose, but are not required to do so

At present, most local authorities are retaining executive governance arrangements. For those councils moving to a committee system, a further discussion of the differences and implications for health scrutiny is included in 'Councils operating a committee system' below.

Generally, health scrutiny functions are in the form of powers. However, there are certain requirements under the 2013 regulations as follows. Local authorities on whom health scrutiny functions have been conferred should:

- have a mechanism in place to deal with referrals made by local Healthwatch organisations or contractors - for further information see regulation 21 of the 2013 regulations
- have a mechanism in place to respond to consultations by relevant NHS commissioning bodies and relevant health service providers on substantial reconfiguration proposals. Such responses could be made through the full council, an overview and scrutiny committee with delegated powers from the full council, a joint health overview and scrutiny committee or a committee appointed under section 101 of the Local Government Act 2000
- consider in advance how the members of a joint health overview and scrutiny committee would be appointed from their council where the council was required to participate in a joint health overview and scrutiny committee with other councils to respond to substantial reconfiguration proposals covering more than one council area

Conferral of health scrutiny function on full council

Regulations made under section 244 (2ZD) of the National Health Service Act 2006 ('the NHS Act 2006'), as amended, confer health scrutiny functions on the local authority, as distinct from any overview and scrutiny committee or panel within the local authority. This provision is designed to give local authorities greater flexibility and freedom over the way they discharge health scrutiny functions. The full council of each local authority does determine which arrangement is adopted. For example:

- they may choose to continue to operate their existing health overview and scrutiny committee, delegating their health scrutiny functions to the committee
- they may choose other arrangements such as appointing a committee involving members of the public and delegating their health scrutiny functions to that committee
- they may operate their health scrutiny functions through a joint health overview and scrutiny committee with one or more other councils

As indicated above, local authorities may delegate their health scrutiny functions under section 101 of the Local Government Act 1972 (https://www.legislation.gov.uk/ukpga/1972/70/contents) (as updated in 2000) but are not permitted to delegate the functions to an officer (regulation 29 of the 2013 regulations).

Executive members of councils operating executive governance arrangements (that is, a leader and cabinet or a mayor and cabinet) may not be members of local authority overview and scrutiny committees or of their sub-committees or of joint health overview and scrutiny committees and sub-committees.

Overview and scrutiny committees are a proven model offering a number of benefits that other structures may not, including having a clear identity within the local authority, political balance and, in many cases, an established reputation within the local community for independence and accessibility.

Delegation of health scrutiny function by full council

The legislation enables health scrutiny functions to be delegated to:

- an overview and scrutiny committee of a local authority or of another local authority (regulation 28 of the 2013 regulations)
- a sub-committee of an overview or scrutiny committee (Local Government Act 2000)
- a joint health overview and scrutiny committee appointed by 2 or more local authorities or a sub-committee of such a joint committee
- a committee or sub-committee of the authority appointed under section 102 of the Local Government Act 1972 (section 101 of the Local Government Act 1972)
- another local authority (section 101 of Local Government Act 1972)

Local authorities may not delegate the health scrutiny functions to an officer - this option under the Local Government Act 1972 (as updated in 2000) is disapplied (disallowed) by regulation 29 of the 2013 regulations.

If a council decides to delegate to a health scrutiny committee, they need not delegate all of their health scrutiny functions to that committee - they could retain some functions themselves. Equally, they might choose to delegate that power to the scrutiny committee.

Joint health scrutiny arrangements

Local authorities may choose to appoint a discretionary joint health overview and scrutiny committee (regulation 30) to carry out all or specified health scrutiny functions - for example, health scrutiny in relation to health issues where local authority and ICB boundaries do not align. Establishing a joint committee of this kind does not prevent the appointing local authorities from separately scrutinising health issues. However, there are likely to be occasions

on which a discretionary joint committee is the best way of considering how the needs of a local population, which happens to cross council boundaries, are being met. Local authorities can develop arrangements for informal joint working across ICS boundaries which can be stepped up into formal arrangements as required.

Regulation 30 requires local authorities to appoint joint committees where relevant NHS body or health service providers consult more than one local authority's health scrutiny function about substantial reconfiguration proposals (referred to below as a mandatory joint health scrutiny committee). In such circumstances, regulation 30 sets out the following requirements (see the 'Consultation' section below for more detail):

- only the joint committee may respond to the consultation (rather than each individual local authority responding separately). Best practice would be for all affected scrutiny committees to be consulted before a joint committee response
- only the joint committee may exercise the power to require the provision of information by the relevant NHS body or health service provider about the proposal
- only the joint committee may exercise the power to require members or employees of the relevant NHS body or health service provider to attend before them to answer questions in connection with the consultation

Reporting and making recommendations

Regulation 22 of the 2013 regulations enables local authorities and committees (including joint committees, sub-committees and other local authorities to which health scrutiny functions have been delegated) to make reports and recommendations to relevant NHS bodies and health service providers. The following information must be included in a report or recommendation:

- an explanation of the matter reviewed or scrutinised
- a summary of the evidence considered
- a list of the participants involved in the review or scrutiny
- an explanation of any recommendations on the matter reviewed or scrutinised

A council can choose to delegate to an overview and scrutiny committee (including joint committee, sub-committee or another local authority) the function of making scrutiny reports and recommendations to relevant NHS bodies and health service commissioners. Alternatively, a council can choose to delegate only the function of preparing such reports and recommendations and retain for themselves the function of actually making that report or

recommendation. The latter approach would give the full council the opportunity to endorse the report or recommendation before it was sent to NHS bodies.

Where a local authority requests a response from the relevant NHS body or health service provider to which they have made a report or recommendation, there is a statutory requirement (regulation 22 of the 2013 regulations) for the body or provider to provide a response in writing within 28 days of the request.

Conflicts of interest

Councils should take steps to avoid any conflict of interest arising from councillors' involvement in the bodies or decisions that they are scrutinising. A conflict might arise where, for example, a councillor who was a full voting member of a health and wellbeing board was also a member of the same council's health scrutiny committee or of a joint health overview and scrutiny committee that might be scrutinising matters pertaining to the work of the health and wellbeing board.

Conflicts of interest may also arise if councillors carrying out health scrutiny are, for example:

- an employee of an NHS body
- a member or non-executive director of an NHS body
- an executive member of another local authority
- an employee or board member of an organisation commissioned by an NHS body or local authority to provide services

These councillors are not excluded from membership of overview and scrutiny committees, and, clearly, where the full council has retained the health scrutiny function, they will be involved in health scrutiny. However, they will need to follow the rules and requirements governing the existence of interests in matters considered at meetings. Where such a risk is identified, they should consult their monitoring officer for advice on their involvement.

Councils operating a committee system

Councils that have returned to a committee system under the Local Government Act 2000 may or may not have retained a council-wide overview and scrutiny function. If they have retained such functions, they will be able to delegate their health scrutiny functions to overview and scrutiny committees in the same way as those councils operating executive arrangements that have executive and scrutiny functions.

Councils with a committee system that have not retained a council-wide scrutiny function will need to decide what to do about their health scrutiny functions. The health scrutiny function is conferred on the full council but delegation to a committee, joint committee, sub-committee or another local authority is permitted. Therefore such a council might retain health scrutiny functions or delegate these to a committee, joint committee or sub-committee (or indeed to another council or its overview and scrutiny committee).

In deciding how to operate a health scrutiny function, councils operating a committee system will need to consider issues of potential conflicts of interest. Like upper tier and unitary councils, they will need to have a health and wellbeing board whose work will be within the scope of health scrutiny insofar as it relates to the planning, provision and operation of the health service. They may also have a health and social care committee or a stand-alone health committee which makes decisions about the commissioning of public health services. A conflict might arise where, for example, under a committee system, the members of any committee of the council which is taking commissioning decisions on public health services are also members of the council's health scrutiny committee, or where a health and social care committee of a council operating a committee system is also acting as a health overview and scrutiny committee. The solution might be to have a separate health overview and scrutiny committee, with different members.

Regardless of the governance arrangements being operated by a council, the health scrutiny function may not be delegated to an officer (regulation 29).

The role of district councils

Under the 2013 regulations (regulation 31), district councillors in 2-tier areas who are members of district overview and scrutiny committees may be co-opted by the upper tier county council onto the health overview and scrutiny committees of those councils or other local authorities. Such co-option may be on a long term (that is, for the life of the overview and scrutiny committee or until the county council decides) or ad hoc basis (that is, for the review and scrutiny of a particular matter) (regulation 31).

District councillors in 2-tier areas may also (regulation 30 and regulation 31 read in conjunction with the Local Government Act 2000) be co-opted onto joint health overview and scrutiny committees between the upper tier county councils and other local authorities.

District councillors in 2-tier areas may also be on joint health overview and scrutiny committees of the relevant district council and the upper tier county council (regulation 30).

Many county councils have taken the opportunity to co-opt district councillors onto their scrutiny committees, as district councillors bring very local knowledge of their communities' needs and may also provide a useful link to enhance the health impact of district council services. Health and wellbeing strategies in 2-tier areas are likely to include references to the role of district councils in improving health and reducing inequalities - for example, through their housing and leisure functions. As health and wellbeing boards' functions including their strategies (insofar as related to the planning, provision and operation of the health service) will be within the scope of health scrutiny, this provides an additional reason for considering the co-option of district councillors.

Powers and duties for NHS bodies

These duties apply to:

- ICBs
- NHS England
- local authorities as providers of NHS or public health services
- providers of NHS and public health services commissioned by ICBs, NHS England and local authorities

Additional responsibilities are described in the 'Consultation' section below.

These duties require NHS bodies to:

- provide information about the planning, provision and operation of health services as reasonably required by local authorities to enable them to carry out health scrutiny (the 'Consultation' section, below, lists all those covered by this requirement)
- attend before local authorities to answer questions necessary for local authorities to carry out health scrutiny
- consult on any proposed substantial developments or variations in the provision of the health service subject to exceptions as set out in the 2013 regulations
- respond to health scrutiny reports and recommendations: NHS commissioning bodies and providers have a duty to respond in writing to a report or recommendation where health scrutiny requests this, within 28 days of the request (this may be paused if there is a Secretary of State call-in). This applies to requests from individual health scrutiny committees or sub-committees, from local authorities and from joint health overview and scrutiny committees or sub-committees

Scope of health scrutiny

The 2013 regulations cover providers of health services (commissioned by NHS England, ICBs or local authorities) who are not themselves NHS bodies. Together with relevant NHS bodies these are known as 'responsible persons' in the legislation and include:

- ICBs
- NHS England
- local authorities (insofar as they may be providing health services to ICBs, NHS England or other local authorities)
- NHS trusts and NHS foundation trusts
- GP practices and other providers of primary care services (previously not subject to specific duties under health scrutiny regulations as independent contractors, they are now subject to duties under the 2013 regulations as they are providers of NHS services)
- other providers of primary care services to the NHS, such as pharmacists, opticians and dentists
- private and voluntary sector bodies commissioned to provide NHS or public health services by NHS England, ICBs or local authorities

Under the 2013 regulations, 'responsible persons' are required to comply with a number of duties to assist the health scrutiny function. These duties are underpinned by the duty of co-operation that applies between NHS bodies and local authorities under section 82 of the NHS Act 2006 which requires them, in exercising their respective functions, to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

Required provision of information to health scrutiny

Regulation 26 imposes duties on 'responsible persons' to provide a local authority with such information about the planning, provision and operation of health services in the area of the authority as it may reasonably require to discharge its health scrutiny functions. All relevant NHS bodies and health service providers (including GP practices and other primary care providers and any private, independent or third sector providers delivering services under arrangements made by ICBs, NHS England or the local authority) have a duty to provide such information.

In addition, the duty of candour under the NHS Standard Contract is also relevant in relation to the provision of information to patients generally.

The type of information requested and provided will depend on the subject under scrutiny. It may include:

- financial information about the operation of a trust or ICB - for example, budget allocations for the care of certain groups of patients or certain conditions, or capital allocations for infrastructure projects, such as community facilities
- management information such as commissioning plans for a particular type of service
- operational information such as information about performance against targets or quality standards and waiting times
- patient information such as patient flows, patient satisfaction surveys, numbers and types of complaints and action taken to address them
- any other information relating to the topic of a health scrutiny review which can reasonably be requested

Confidential information that relates to or identifies a particular living individual or individuals cannot be provided unless the individual or individuals concerned agree to its disclosure. However, the information can be disclosed in a form from which identification is not possible. In such a situation, health scrutiny bodies (that is, councils or council health overview and scrutiny committees or sub-committees carrying out delegated health scrutiny functions) can require that the information be put in a form from which the individual cannot be identified in order that it may be disclosed.

In some cases, information, such as financial information, may be commercially sensitive. In such cases, it may be possible for health scrutiny to receive this information in confidence to inform, but not be directly referred to in, their reports and recommendations.

Required attendance before health scrutiny

Members and employees of a relevant NHS body or relevant health service provider have a duty to attend before a local authority when required by them (provided reasonable notice has been given) to answer questions the local authority believes are necessary to carry out their health scrutiny functions. This duty applies to all those listed at the beginning of this section. So, for example, if a local authority were to require the attendance of a member of an ICB, or of a private company commissioned to provide particular NHS services, they could do so under regulation 27 of the 2013 regulations. Bodies, the employees or members of which are required to attend by local authority health scrutiny, are expected to take the appropriate steps to ensure the relevant member or employee complies with this requirement.

The meaning of 'member' is given in section 244 of the NHS Act 2006 and includes people who are members of committees or sub-committees of ICBs who are not members of the ICB, directors of NHS trusts and directors and governors of NHS foundation trusts. They also include directors of bodies that provide health services commissioned by NHS England, ICBs and local authorities.

As regards the attendance of particular individuals, identification of the appropriate member or employee to attend will depend on the type of scrutiny review being undertaken and its aims. By way of example, where the local authority has required the attendance of a particular individual, say the accountable officer of an ICB, and it is not practicable for that individual to attend or if that individual is not the most suitable person to attend, the ICB would be expected to suggest another, relevant individual. Thus, in such situations, both the local authority and the NHS commissioning body or provider (as the case may be) would be expected to co-operate with each other to agree on a suitable person for attendance and, in doing so, to act reasonably at all times.

Responding to scrutiny reports and recommendations

Depending on the topic being reviewed, reports and recommendations by local authority health scrutiny bodies may be made to any of the relevant NHS bodies or health service providers covered by the legislation (and, in the case of health scrutiny by a body to which the function has been delegated, to the delegating authority - for example, the relevant local authority, or in the case of a sub-committee appointed by a committee, that committee or their local authority).

Under regulation 22 of the 2013 regulations, relevant NHS bodies and health service providers to which a health scrutiny report or recommendation has been made must by law, if a response is requested, respond within 28 days of the request. Reports and recommendations are expected to be based on evidence. Respondents should take the evidence presented seriously, giving a considered and meaningful response about how they intend to take forward reports or recommendations. Meaningful engagement is likely to lead to improvements in quality and access to services.

Many local authorities, as part of their work plan, return to completed scrutiny reviews after a certain period - usually 6 months or a year - to find out whether and how their recommendations have been implemented and how they have influenced improvements. Relevant NHS bodies and health service providers to whom scrutiny reports have been presented should be prepared for this kind of follow-up and be able to report on progress and improvements resulting from scrutiny reviews.

Powers and duties - referral by local Healthwatch

Local Healthwatch organisations and contractors have specific roles which complement those of health scrutiny bodies. For example, they can 'enter and view' certain premises at which health and social care services are provided. This can enable local Healthwatch to act as the 'eyes and ears' of patients and the public, to be a means for health scrutiny to supplement and triangulate information provided by service providers, and to gain an additional impression of the quality of services, safety and issues of concern around specific services and provider institutions. Health scrutiny bodies and local Healthwatch are likely each to benefit from regular contact and exchange of information about their work programmes. It may also be helpful in planning work programmes, to try to ensure that certain aspects are aligned. For example, if a health scrutiny body is planning a review of a certain service, it might be useful if local Healthwatch plans to visit the service in a timely way to inform the review.

Local Healthwatch organisations and their contractors carry out certain statutory activities including that of making reports and recommendations concerning service improvements to scrutiny bodies. This would cover the provision of information and the referral of matters relating to the planning, provision and operation of health services in their area (which could potentially include concerns about local health services or commissioners and providers) to local authority health scrutiny bodies.

Regulation 21 sets out duties that apply where a matter is referred to a local authority by local Healthwatch organisations or contractors. The local authority must:

- acknowledge receipt of referrals within 20 working days
- keep the local Healthwatch organisations (or contractors as the case may be) informed of any action they take in relation to the matter referred

For patient and public involvement

Legislation (including the NHS Act 2006 and the 2013 regulations) has created a number of requirements for different types of NHS bodies to involve and consult service users and prospective users in planning services. These requirements apply to the development and consideration of proposals for changes in the way services are provided and in decisions affecting the operation of those services.

For NHS trusts and NHS foundation trusts, the duty relating to involvement and consultation is set out in section 242 of the NHS Act 2006 (as amended). The public involvement duties of NHS England and of ICBs are set out in sections 13Q and 14Z45 of the NHS Act 2006. These are separate duties from those set

out in the 2013 regulations discussed here. Together these provide a framework for local accountability for health services.

Under paragraph 4(2) of schedule 10A to the NHS Act 2006, once a Secretary of State call-in has been made, the NHS commissioning body must not take any further steps in relation to a proposal except to such extent (if any) as may be permitted by the direction.

The direction letter may allow the NHS commissioning body to continue to involve the public and progress proposals in some cases, but not to do anything irreversible or commence a formal public consultation (if that stage has not yet been reached).

The Health and Social Care Act 2012 (https://www.legislation.gov.uk/ukpga/2012/7/contents) introduced local Healthwatch to represent the voice of patients, service users and the public, and health and wellbeing boards to promote partnerships across the health and social care sector. The 2013 regulations set up formal relationships between local Healthwatch and local authority health scrutiny, to ensure that the new system reflects the outcomes of involvement and engagement with patients and the public.

Consultation

The context of consultation

Where substantial changes are proposed to NHS services, there is a separate duty to consult the local authority under the 2013 regulations made under section 244 of the NHS Act 2006. This is additional to the duties on NHS commissioning bodies and providers for involvement in NHS reconfigurations. NHS bodies should ensure that there is meaningful and on-going engagement with service users in developing the case for change and in planning and developing proposals. There should be engagement with the local community from an early stage on the options that are developed.

Proposals for change should emerge from involving service users and the wider public in dialogue about needs and priorities and how services can be improved. Much of this dialogue may take place through the representation of service users and the public on health and wellbeing boards and through the boards' own public engagement strategies. With the increasing integration of health and care services, many proposals for change may be joint NHS-local authority proposals which may have been discussed at an early stage through

the health and wellbeing board. Health scrutiny bodies should be party to such discussions - local circumstances will determine the best way for this to happen. If informally involved and consulted at an early enough stage, health scrutiny bodies, in collaboration with local Healthwatch, may be able to advise on how patients and the public can be effectively engaged and listened to. If this has happened, health scrutiny bodies are less likely to raise objections when consulted.

NHS England has published good practice guidance ('Planning, assuring and delivering service change for patients') for NHS commissioning bodies on the planning and development of proposals for major service changes and reconfigurations. The guidance is designed to support NHS commissioning bodies and NHS providers, working with local authorities and providers, to carry out effective service reconfiguration in a way that puts quality of care first, is clinically evidence-based and which involves patients and the public throughout. It is intended to be used as a reference guide to help develop and implement plans in a clear and consistent way.

When to consult

Regulation 23 requires relevant NHS bodies and health service providers to consult a local authority about any proposal which they have 'under consideration' for a substantial development of or variation in the provision of health services in the local authority's area. The term 'under consideration' is not defined and will depend on the facts, but a development or variation is unlikely to be held to be 'under consideration' until a proposal has been developed. The consultation duty applies to any 'responsible person' under the legislation - that is, relevant NHS bodies and health service commissioners which now come under the scope of health scrutiny as described above.

As previously, 'substantial development' and 'substantial variation' are not defined in the legislation. Many local authority scrutiny bodies and their NHS counterparts have developed joint protocols or memoranda of understanding about how the parties will reach a view as to whether or not a proposal constitutes a 'substantial development' or 'substantial variation'. Although there is no requirement to develop such protocols it may be helpful for both parties to do so with named accountable owners for keeping the definitions and dispute resolution mechanisms up to date to reflect the new processes for notification and ministerial interventions. The local authority may find a systematic checklist, of the kind often contained in such protocols, useful in reaching a view about whether a proposed development or variation is substantial and, for example, NHS commissioning bodies may find it helpful in explaining to providers what is likely to be regarded as substantial. Where one or more local authority chooses to work together as a joint health overview and scrutiny committee, protocols can be used to agree shared definitions of 'substantial' with an NHS commissioning body, as well as joint working arrangements for

administering scrutiny and making representations during consultation. Where agreement cannot be reached on a shared definition of 'substantial', advice may be sought from the Independent Reconfiguration Panel.

Who consults health overview scrutiny committees

In the case of substantial developments or variation to services which are the commissioning responsibility of ICBs or NHS England, health overview scrutiny committee consultation is to be done by NHS commissioners - that is, by the relevant ICB or NHS England. In some circumstances an NHS provider may be leading the reconfiguration proposal including involvement and consultation activities. When these providers are in a collaborative setting, a lead provider should be appointed to consult where appropriate. Where a provider has a development or variation 'under consideration' they will need to inform the NHS commissioning body at a very early stage so that the NHS commissioning body can comply with the requirement to consult as soon as proposals are under consideration.

Timescales for consultation

The 2013 regulations require timescales to be provided to health scrutiny bodies and to be published by the proposer of substantial developments or variations, (regulation 23(1)(b) to (d)). When consulting health scrutiny bodies on substantial developments or variations, a relevant NHS body or health service provider is required by the 2013 regulations (subject to use of the Secretary of State call-in power) to notify the health scrutiny body of the date by which they require the health scrutiny body to provide comments in response to the consultation and the date by which they intend to make a decision as to whether to proceed with the proposal. These dates must also be published. This is so that local patients and communities are aware of the timescales that are being followed. Any changes to these dates must be notified to the relevant health scrutiny body and published. Constructive dialogue between relevant NHS bodies and health service providers on the one hand and health scrutiny bodies on the other, when communicating on timescales for comments or decisions in relation to substantial developments or variations, should help ensure that timescales are realistic and achievable.

It is sensible for health scrutiny to be able to receive details about the outcome of public consultation before it makes its response so that the response can be informed by patient and public opinion.

When consultation is not required

The 2013 regulations set out certain proposals on which consultation with health scrutiny is not required. These are:

- where the relevant NHS body believes that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff (this might, for example, cover the situation where a ward needs to close immediately because of a viral outbreak) - in such cases the NHS body must notify the local authority that consultation will not take place and the reason for this
- where there is a proposal to establish or dissolve an NHS trust or ICB or vary the constitution of the ICB, unless the proposal involves a substantial development or variation
- where proposals are part of a trust's special administrator's report or draft report (that is, when a trust has financial difficulties and is being run by an administration put in place by the Secretary of State) - these are required to be the subject of a separate 30-day community-wide consultation
- where proposals are contained in recommendations by a health special administrator on the action which should be taken in relation to a company subject to a health special administration order under section 128 of the 2012 Act (health special administration orders)

A consultation may need to be paused if the Secretary of State uses their call-in power in respect of the particular proposal. When exercising the call-in power, the Secretary of State will issue a direction letter which will set out what, if any, steps the NHS commissioning body is permitted to take which will include the expectations around consulting the health overview scrutiny committee during a live call-in.

Responses to consultation

Where a health scrutiny body has been consulted by a relevant NHS body on substantial developments or variations, the health scrutiny body has the power to make comments on the proposals by the date (or changed date) notified by the body or provider undertaking the consultation. Having considered the proposals and local evidence, health scrutiny bodies should normally respond in writing to the body undertaking the consultation and when commenting they would need to keep within the timescale specified by them. In the majority of cases the consulting body will be the local ICB. Some consultations with the local authority will be led by NHS England or delegated from the ICB to an NHS provider - that is, an NHS trust or NHS foundation trust - with prior agreement from the ICB.

Where a health scrutiny body's comments include a recommendation and the consulting organisation disagrees with that recommendation, that organisation must notify the health scrutiny body of the disagreement. Both the consulting organisation and the health scrutiny body must take such steps as are reasonably practicable to try to reach agreement. Where NHS England or an ICB is acting on behalf of a provider, in accordance with the regulations, as mentioned above, the health scrutiny body and NHS England or the ICB (as the case may be) must involve the provider in the steps they are taking to try to reach an agreement.

Secretary of State intervention powers

Schedule 10A to the NHS Act 2006 provides new call-in powers to allow the Secretary of State to intervene in NHS service reconfigurations at any stage. Under paragraph 3(1) of that schedule the Secretary of State may issue an NHS commissioning body a direction to call in any proposal. Paragraph 3(3) sets out detail of how the powers can be used. This includes:

- deciding whether a proposal should, or should not, proceed, or should proceed in a modified form
- whether particular results should be achieved by the NHS commissioning body in taking decisions in relation to the proposal
- whether procedural or other steps should, or should not, be taken in relation to the proposal
- whether to retake any decision previously taken by the NHS commissioning body

For further background information please see the 2024 statutory guidance.

Previously, the Secretary of State was only able to intervene in reconfigurations upon receiving a local authority referral relating to the adequacy of consultation, or whether the proposal was in the interest of the health service in their area. Following a referral, the Secretary of State had a discretionary power to take certain decisions based on the grounds of the referral.

The call-in power allows for Secretary of State interventions to help unblock issues at any stage in the reconfiguration process. The aim of a ministerial intervention is to support local partners to find a way forward, to enable improvement to happen faster and produce sustainable solutions to NHS services facing challenges.

Local authorities' powers of referral to the Secretary of State have been removed. Instead of the referral power, health overview and scrutiny committees and other interested parties can write to request (via a call-in request form) that the Secretary of State consider calling in a proposal. DHSC

expects requests only to be used in exceptional situations where local resolution has not been reached. Such a request will then be considered as set out in the statutory guidance.

Local organisations are best placed to manage challenges related to NHS reconfiguration. A call-in request is highly unlikely to be considered by the Secretary of State before:

- NHS commissioning bodies and local authorities have taken all reasonable steps to try and resolve any issues
- those making a request or others have tried to resolve any concerns through their local NHS commissioning body or have raised concerns with their local health overview and scrutiny committee

A call-in intervention only becomes live at the point when the Secretary of State issues a direction letter to the NHS commissioning body which communicates that a ministerial decision to call in the proposal has been made.

The direction letter will set out, among other matters, the steps the NHS commissioning body is permitted to take which will include the expectations around consulting the health overview and scrutiny committee and meeting their duties to involve the public during a live call-in. Typically, the NHS commissioning body's consultation with a local authority will be paused (unless specified otherwise in the direction letter). However, it will often be important, in order to assist the Secretary of State in carrying out their call-in functions, for the NHS commissioning body to share information on the call-in with the health overview and scrutiny committee during a live call-in to support local authorities to make representations to the Secretary of State.

The direction letter may allow the NHS commissioning body to continue to involve the public and progress proposals in some cases, but not to do anything irreversible or commence a formal public consultation (if that stage has not yet been reached)

Before making a decision on a called in reconfiguration proposal, the Secretary of State must provide the NHS commissioning body, NHS England (if the NHS commissioning body is an ICB), the local authority whose area the proposed reconfiguration relates to and any other person that the Secretary of State considers appropriate, with the opportunity to make representations in relation to the proposal.

Where multiple organisations or scrutiny committees are involved in making representations, it is strongly encouraged that a collaborative approach is taken and a lead organisation is appointed for the purposes of representation.

During the call-in process, the Secretary of State or department may also seek further information from the NHS commissioning body and NHS providers, NHS England, or local authorities in advance of their decision.

Most reconfigurations will continue to be managed at a local level and will not require ministerial intervention. NHS commissioning bodies and local authorities are expected to take all reasonable steps to try and resolve any issues without a Secretary of State intervention.

Useful links

Relevant legislation and policy

See:

- NHS Constitution for England (https://www.gov.uk/government/publications/the-nhs-constitution-for-england)
- NHS mandate (https://www.gov.uk/government/publications/nhs-mandate-2023)
- Health overview and scrutiny committee principles (https://www.gov.uk/government/publications/health-overview-and-scrutiny-committee-principles)
- Health and wellbeing boards: guidance (https://www.gov.uk/government/publications/health-and-wellbeing-boards-guidance)
- Consultation principles: guidance (https://www.gov.uk/government/publications/consultation-principles-guidance)
- Health and Care Act 2022, schedule 6 (https://www.legislation.gov.uk/ukpga/2022/31/schedule/6#:~:text=Duties%20to%20provide%20information%20and,any%20functions%20under%20this%20Schedule)
- Health and Social Care Act 2012 (http://www.legislation.gov.uk/ukpga/2012/7/contents) sections 190 to 192
- Local Government Act 2000 (http://www.legislation.gov.uk/ukpga/2000/22/contents)
- Localism Act 2011 (http://www.legislation.gov.uk/ukpga/2011/20/contents/enacted)
- National Health Service Act 2006 (http://www.legislation.gov.uk/ukpga/2006/41/contents), sections 46, 244 to 245 and schedule 10A

Useful reading

See:

- Independent Reconfiguration Panel webpage (https://www.gov.uk/government/organisations/independent-reconfiguration-panel)
- Planning, assuring and delivering service change for patients (https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/) - NHS England
- Working in partnership with people and communities: statutory guidance (https://www.england.nhs.uk/long-read/working-in-partnership-with-people-and-communities-statutory-guidance/) NHS England

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1. Amended by The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment and Saving Provision) Regulations 2024 (https://www.legislation.gov.uk/uksi/2024/16/contents/made).

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