Social Care and Health Overview and Scrutiny Committee

Thursday 19 February 2024 at 6.00PM

Meeting Venue: Council Chamber at the Council House, Lichfield Street, Walsall

Livestream Link

Membership:

Councillor K. Hussain	(Chair)
Councillor V. Waters	(Vice-Chair)
Councillor P. Gill	
Councillor I. Hussain	
Councillor S.B. Hussain	
Councillor R. Martin	
Councillor R.K. Mehmi	
Councillor N. Nawaz	
Councillor A. Parkes	
Councillor W. Rasab	
Councillor L. Rattigan	

Quorum:

Four Members

Democratic Services, The Council House, Walsall, WS1 1TW
Contact name: Jack Thompson Telephone: 01922 654196
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Walsall Council Website

If you are disabled and require help to and from the meeting room, please contact the person above

The Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012
Specified pecuniary interests

The pecuniary interests which are specified for the purposes of Chapter 7 of Part 1 of the Localism Act 2011 are the interests specified in the second column of the following:

Subject	Prescribed description
Employment, office, trade, profession or vocation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by a member in carrying out duties as a member, or towards the election expenses of a member. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Regulations (Consolidation) Act 1992.
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority: (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to a member's knowledge): (a) the landlord is the relevant authority; (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where: (a) that body (to a member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either: (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one

	hundredth of the total issued share capital of that class.

Schedule 12A to the Local Government Act, 1972 (as amended)

Access to information: Exempt information

Part 1

Descriptions of exempt information: England

1. Information relating to any individual.

2. Information which is likely to reveal the identity of an individual.

3. Information relating to the financial or business affairs of any particular person (including the authority holding that information).

4. Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising between the authority or a Minister of the Crown and employees of, or office holders under, the authority.

5. Information in respect of which a claim to legal professional privilege could be maintained in legal proceedings.

6. Information which reveals that the authority proposes:

   (a) to give any enactment a notice under or by virtue of which requirements are imposed on a person; or

   (b) to make an order or direction under any enactment.

7. Information relating to any action taken or to be taken in connection with the prevention, investigation or prosecution of crime.

8. Information being disclosed during a meeting of a Scrutiny and Performance Panel when considering flood risk management functions which:

   (a) Constitutes a trades secret;

   (b) Its disclosure would, or would be likely to, prejudice the commercial interests of any person (including the risk management authority);

   (c) It was obtained by a risk management authority from any other person and its disclosure to the public by the risk management authority would constitute a breach of confidence actionable by that other person.

Part 1 – Public Session

1. Apologies

2. Substitutions
To receive notice of any substitutions for a Member of the Committee for the duration of the meeting.

3. Declarations of Interest

4. Local Government (Access to Information) Act, 1985 (as amended):
To agree that the public be excluded from the private session during consideration of the agenda items indicated for the reasons shown on the agenda.

5. Minutes
To approve and sign the minutes of the meeting held on 18 January 2024.
(Enclosed – Pages 1-5)

6. NHS Commissioned Dentistry Services
To receive an update on commissioning arrangements for dentistry services in Walsall and the progress made to resolve issues since the last update report.
(Enclosed – Pages 6-9)

7. Preparing for the Care Quality Commission Assurance Process of Adult Social Care
To receive a report on the Care Quality Commission (CQC) Assurance process for Adult Social Care and the readiness preparations being made by the service.
(Enclosed – Pages 10-13)

8. Adult Social Care Continues Improvement & CQC ratings of Service Providers
(To Follow)

9. Changes to Health Scrutiny Powers and Guidance
To provide an overview of the changes to the statutory regulation in relation to health scrutiny powers and accompanying guidance from the Department of Health and Social Care.
(Enclosed – Pages 14-53)

10. Recommendation Tracker
To review progress with recommendations from previous meetings.
(Enclosed – Pages 54-56)

11. Areas of focus for 2023/24

To review the Committee Work Programme and the Forward Plans for Walsall Council and the Black Country Executive Committee.

(Enclosed – Pages 57-68)

12. Date of next meeting

The date of the next meeting will take place on the 4 April 2024.

Minutes of the Social Care and Health Overview and Scrutiny Committee held in the Council Chamber, Walsall Council House

Thursday, 18 January 2024 at 6PM

Committee Members present:
Councillor K. Hussain (Chair)
Councillor V. Waters (Vice Chair)
Councillor P. Gill
Councillor S.B. Hussain
Councillor R. Martin
Councillor R.K. Mehmi
Councillor A. Nawaz
Councillor A. Parkes
Councillor L. Rattigan

Portfolio Holder:
Councillor G. Flint – Wellbeing, Leisure and Public Spaces
Councillor K. Pedley – Adult Social Care

Officers Present:
Dr Nadia Inglis – Interim Director of Public Health (Walsall Council)
Jack Thompson – Democratic Services Officer (Walsall Council)
Marsha Foster – Chief Executive of Black Country Healthcare NHS Foundation Trust
Laura Brooks – Head of Health Transformations and Integrations (Black Country Healthcare NHS Foundation Trust)
Prof. David Loughton – Chief Executive of Walsall Healthcare NHS Trust

44 **Apologies**

Apologies were received from Councillors I. Hussain and W. Rasab.

45 **Substitutions**

No substitutions were received.

46 **Declarations of Interest and Party Whip**

There were no declarations of interest or party whip for the duration of the meeting.

47 **Local Government (Access to Information) Act 1985 (as amended)**

There were no agenda items requiring the exclusion of the public.

48 **Minutes**

A copy of the Minutes of the meeting held on the 7 December 2023 were submitted [annexed].

Resolved

That the minutes of the meeting held on the 7 December 2023, a copy previously having been circulated, be approved and signed by the Chair as a true and accurate record.

49 **Mental Health Services Update**

At the invitation of the Chair, Marsha Foster and Laura Brooks took the Committee through the provided presentation [annexed].

At the end of the presentation the Chair invited Members of the Committee to ask questions, the responses to those questions included:

- The Trust had undertaken work to improve access to its mental health services, but more work was needed to make sure that the correct information on services was available to residents at the right time.
- There were a range of services available to patients experiencing a mental health crisis and the Trust had implemented a Black Country area telephone number to help residents, even those who were not under care already.
- When producing communications for the public the Trust took into account how the information would be interpreted and the accessibility of the communication to those who were in crisis.

- Times for initial assessments of children for mental health services was relatively quick however there were longer waiting times for specific treatments.
- The Trust had made available at home treatment and crisis treatment for children.
- The Trust had undertaken work to improve its documentation so that when patients were transferred between clinicians, patients did not have to reexplain their issues to new staff.
- In relation to deprivation levels the Black Country was the second worst for deprivation levels in England.
- The trust was working with organisations within deprived areas to help with mental health support and the Trust was spending £400,000 in Walsall to support this.
- Investing in deprived areas would help the Trust reach those who are harder to reach and the organisations already operating in these areas could help with making referrals to mental health services.
- The Trust was undertaking work to improve digital inclusion for mental wellbeing and improving services for those with accessibility needs such as interpreters.
- The Trust was planning on improving services to offer a more family centred approach to mental health.
- NHS 111 now had an option within its automated directory to access mental health support, users could call 111 and select 2 to access this support.
- It had been recognised that people's lives since the Covid-19 Pandemic had become more complex and that those experiencing loneliness did not always need specific mental health support but needed support from the community.
- The Trust was trying to improve the understanding of the different levels of services available within the voluntary sectors and then joining that up to make the knowledge available to clinicians.
- The Early Intervention Team for psychosis offered intense intervention for young people experiencing psychosis for the first time, for both them and their families. The young person would be monitored by a case worker and after the three-year intervention the individual would be transferred to a community mental health team through a six-month transition period.
- The Trust had developed a digital platform for talking therapy services and evidence suggested that digital talking therapy was good for patients.
- There had been significant investment in perinatal mental health support and there had been a focus on certain ethnic groups which data showed had poorer outcomes.
- The Trust was preparing to undertake work to help reach communities in relation to perinatal mental health.
- The Trust recognised that there was a fracture between some medical staff and the board of the Trust. To help rectify this fracture the Trust had started to collaborate more with medical staff and better communication on the transformation plan was needed.

- The interim medical director could attend a meeting of the Committee to present an item on the medical leadership at the Trust.
- There were no current plans to cut bed numbers at the Trust.
- There was increased demand on acute mental health services, and this meant that the trust must use its beds more efficiently, however, these beds were fragmented over serval facilities and there were not enough beds in the right places.
- The overall CQC inspection of the Trust was good, however, on a responsive visit to Acute wards for adults of working age and psychiatric intensive care units, concerns were raised in relation to staffing levels and safety. In response the Trust's board had agreed a large investment to improve staffing levels within these services.
- The CQC inspection result was also a reflection of the fractured estate which was of variable quality. The Trust was implementing a programme to refurbish or in some cases rebuild facilities to improve the estate, however the budget for this was limited and was not a quick fix.
- There was a link between physical and mental health, which could include dietary effects on mental health. The Director for Public Health added, it was there for important that an environment was provide that enabled residents to make good choices easily.

The Portfolio Holder for Wellbeing, Leisure and Public Spaces added that the Council had commissioned a bereavement service and a men's mental health service. Additionally, that Walsall had a good social prescribing joint service and was working with GPs to help promote social prescribing. Moreover, the Council was working with the Foundation Trust on a joint alcohol and drugs strategy.

Prof. David Loughton added that Walsall Healthcare NHS Trust worked closely with the Foundation Trust with patients with complex mental health needs. In addition, that more community support and less institutionalisation of patients was positive, however, hospitals had seen an increase in older residents with complex mental health needs.

Resolved

- **That the Committee note the presentation.**
- **That the Committee receive a report on the work being undertaken by the Trust to improve its Acute wards for adults of working age and psychiatric intensive care units, and its programme to improve its estate.**

50 **Adult Social Care – CQC Inspection Readiness**

The Chair informed the Committee that due to illness officers were unavailable to attend to present the item on CQC Inspection Readiness.

Resolved

That the item, Adult Social Care – CQC Inspection Readiness be deferred to the next meeting of the Committee.

51 **Recommendation Tracker**

The Democratic Services Officer outlined the outstanding actions of the Recommendation Tracker and informed Members that information on the Black Country Integrated Care Board's Time 2 Talk service in relation to GP complaints would be sent to Members via email.

Resolved

That the Committee note the Recommendation Tracker.

52 **Areas of focus for 2023/24**

The Democratic Services Officer informed the Committee of the upcoming items for the next meeting of the Committee.

Additionally, the Democratic Services Officer informed the Committee that new guidance had been released by the Department for Health and Social Care for health scrutiny and that the statutory powers of the Committee were also changing.

Resolved

- **That the Committee note the Areas of focus for 2023/24.**
- **That a report be presented to the Committee on the new guidance from the Department of Health and Social Care and the changes to the Committee powers at the next meeting of the Committee.**

53 **Date of next meeting**

The date of the next meeting would be 19 February 2024.

There being no further business, the meeting terminated at 19:11.

Signed:

Date:

Social Care and Health Overview and Scrutiny Committee **Agenda Item No 6**

19 February 2024

NHS Commissioned Dentistry Services

Ward(s): All

Portfolios: Councillor G. Flint (Wellbeing, Leisure and Public Spaces)

1. Aim

This report aims to provide members of the Social Care and Health Overview and Scrutiny Committee with an update on the commissioning arrangements for dentistry services within the Walsall Borough.

This report builds upon information provided to the Social Care and Health Overview and Scrutiny Committee by NHSE dentistry commissioners in April 2023.

This report aims to provide an update on issues and progress since that point and to secure feedback from HOSC members around areas of specific interest for future enquiry.

2. Recommendations

Scrutiny Members are asked to note the contents of this report and highlight any issues for onward consideration by Dentistry Commissioners working within the Office of the West Midlands.

3. Report detail

3.1 Overview of NHS commissioned dental provision in Walsall

Since the April 2023 report to Committee dentistry services in Walsall have been stable.

There continue to be 38 dental contracts (in 26 practices) of varying sizes which offer a range of routine dental services. Most of these practices are taking on new patients, however waiting times differ for each practice.

Walsall residents also have access to the following NHS dental services,

- Secondary care is provided by Walsall Health care NHS Trust e.g. oral surgery and other Black Country acute hospital services.

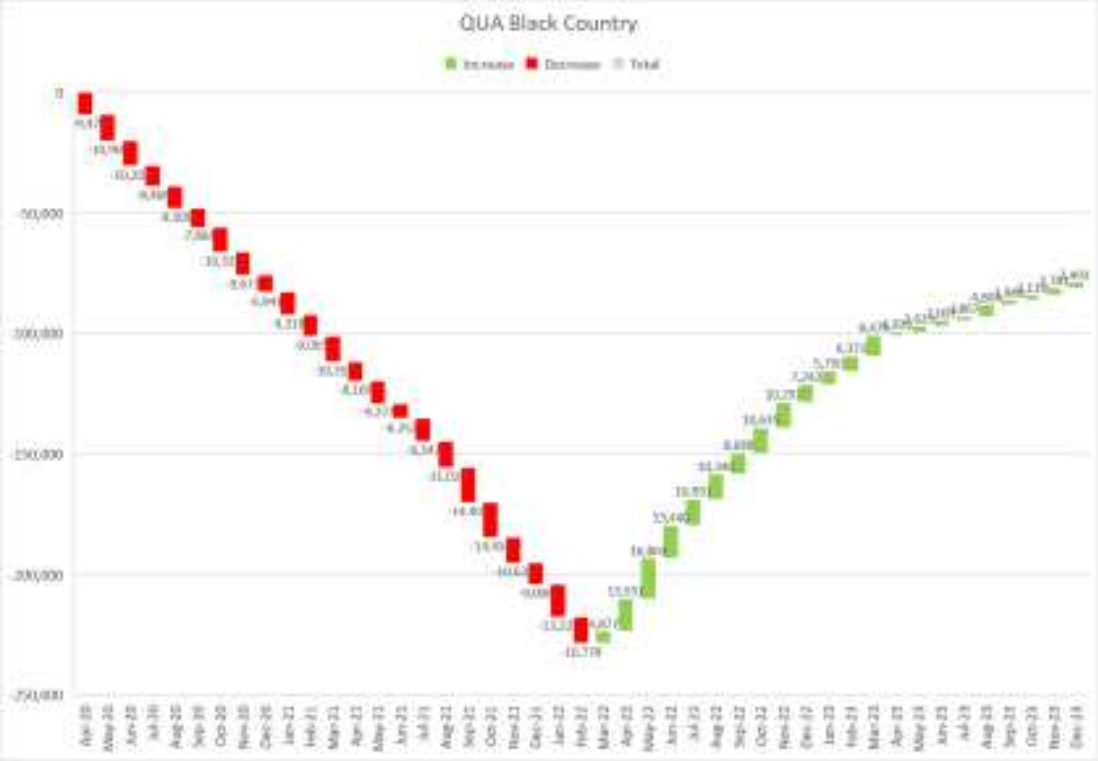
- Community Dental Services for special care adults and children being delivered by Birmingham Community Health Care Trust (BCHC) (from a number of clinics across the Walsall area).
- Residents may have to travel to the Dental Hospital in Birmingham for more specialist services such as complex Restorative dentistry, Oral Medicine or to the Children's Hospital should a child have complex medical issues.

  All other dental services are private and therefore outside the scope of control of dental commissioners.

3.2 Improving Access

The focus of work for the past 12 months has continued to be on the recovery of dentistry services post COVID.

Data on dentistry activity is recorded and reported at a Black Country level. The latest available data set from December 2023, shows that the situation continues to steadily improve however the a gap still exists with fewer patients being seen in the 2 preceding 2 year period compared to pre-pandemic.



Access to Urgent Care

To ensure that Walsall residents have access to urgent dental care for on the day treatment three practices have been commissioned to provide this service. Access to these appointments is via NHS 111 who can make direct referrals.

Access to Orthodontics

In the last report to Committee a problem in relation to access to orthodontic services was highlighted as the consequence of 2 providers handing back their contracts. Orthodontic services provide treatment to children to straighten misaligned teeth, give a healthy bite and prevent disease.

It has proved difficult to identify new providers via procurement however additional capacity has been secured to ensure children waiting to start treatment do not experience further delays.

Waiting times for orthodontics have been restored to pre-pandemic levels.

Access for residents in receipt of Domiciliary Care

Work has continued since the last update Committee to ensure that care home and housebound residents can access dental care. It has not been possible to date to establish a domiciliary dental provider in Walsall and services are currently provided through a Wolverhampton based service.

The commissioners for dental services have confirmed that Walsall remains a priority area for the development of domiciliary dental services with further work being undertaken to address the gap.

3.3 Changing Commissioning Arrangements

In April 2023, the commissioning responsibility for dentistry services transferred from NHSE to ICBs. This delegation was undertaken to bring services closer the local populations and support integration.

Following an options appraisal conducted by ICBs across the West Midlands the decision was taken to establish the Office of the West Midlands to receive the delegation on behalf of all ICBs within the region. This decision was taken to provide stability to the sector in the post delegation period. Representatives from each of the ICBs to include the Black Country come together to steer the work of commissioners located in the Office of the West Midlands, which is hosted by Birmingham and Solihull ICB.

4. Financial information

No specific financial implications identified.

5. Reducing Inequalities

In the work undertaken to date to recover access to dentistry services specific consideration has been given to ensuring that recovery is equitable across protected characteristic groups to include children requiring orthodontics, older people living in care homes and the housebound.

6. Decide

The Committee are asked to request any additional information or an update on dentistry services in the future.

7. Respond

Any recommendations from the Committee will be responded to by the Black Country ICB jointly with the Dentistry Commissioners located in the Office of the West Midlands.

8. Review

Progress in relation to the recovery of dentistry services will continue to be monitored through Dentistry Commissioners located within the Office of the West Midlands. The Black Country ICB will work alongside the commissioners to ensure that the needs of the Walsall population are taken into account and remaining access issues addressed. The Committee can receive an update on the improvement work in future as part of an update report on NHS Dentistry.

Background papers

None

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Social Care and Health Overview and Scrutiny Committee **Agenda Item No 7.**

19 February 2024

Preparing for the Care Quality Commission Assurance Process of Adult Social Care

Ward(s): All

Portfolios: Councillor Keir Pedley (Adult Social Care)

1. Aim

1.1 The aim is to outline the Care Quality Commission (CQC) Assurance process and in turn Adult Social Care's readiness preparations.

2. Recommendations

2.1 That the Committee acknowledge the planning undertaken to prepare for the CQC Assurance process and consider any further recommendations as required.

3. Report detail – know

Context - CQC Assurance Process

3.1 The Health and Care Act – April 2022, gave new powers to the CQC, which allow CQC to undertake a meaningful and independent assessment of care at local authorities in England, specifically assessing delivery of their duties under the Care Act (2014). The overarching aim of gaining an understanding on the quality of care in a local area or system and provide independent assurance to the public of the quality of care in their area.

3.2 CQC have developed a single assessment framework, in order to provide standardisation in approach. The single assessment framework uses quality statements, which have been developed in collaboration with people who use services and they are based on people's experiences and the standards of care they expect. The quality statements attempt to show what is needed to deliver high-quality, person-centred care and are commitments that providers, commissioners and system leaders should live up to.

3.3 The approach CQC have taken and the associated timelines are as follows: April 2022 – December 2023 CQC have spent time; designing and refining their approach, developing their infrastructure and piloting the approach across 5 local authorities – who were assessed as part the pilot. December 2023, following government approval, CQC published updated guidance for local authorities. This guidance is to support local authorities to understand how CQC will assess them. It includes the framework CQC will use to assess how well local authorities are

performing against their duties under Part 1 of the Care Act 2014. CQC have committed to further refining of guidance at key intervals going forward.

3.4 For local authorities CQC assessments will use a subset of the quality statements from the published framework which will apply to providers, local authorities and integrated care systems. This is because local authorities are being assessed against a different set of statutory duties to registered health and care providers.

West Midlands Association of Adult Social Directors Association Response

3.5 The West Midlands Association of Directors Adult Social Services (WMADASS) have prioritised their focus and efforts during 2023 in supporting the West Midlands region in preparing for the introduction of CQC Assurance. This has included a programme of site based local authority readiness reviews. During September 2023 Walsall Adult Social participated in its readiness review, where a team from WMADASS spent a number of days on site reviewing themed areas which will form part of CQC Assurance process. Walsall have fully participated and supported the efforts being led by WMADASS.

3.6 Following the WMADASS readiness review receipt of feedback, Adult Social Care refined its approach to preparation for CQC Assurance, by fully integrating this into our Continuous Improvement Programme refresh and developing an action plan, which considers all areas of Care Act Duty (part 1), along with developments across our wider improvement programme – specifically linked to people; process and practice.

3.7 Key recognised areas of improvement identified our **co-production** – collaborating with people who use services; partners and stakeholders on the review and development of strategies and commissioned services; **supporting carers** to continue to undertake the crucial of supporting people who use services; optimising all opportunities to work across the whole of the health and care systems to improve outcomes for the people of Walsall; **contract and market management across commissioned services** – all of which feature as part of our improvement plan.

Adult Social Care – Our Approach

3.8 Our ongoing internal assessment of compliant discharge of our Care Act duties, contained with the aforementioned action plan, are first overseen by the statutory role of Director of Adult Social Services (DASS) (a role which all local authorities with adult social care responsibilities is required to appoint). The statutory role of role of DASS is in summary in place to act as accountable officer for the delivery of local authority social care functions as detailed within the Care Act (part 1). From a deployment perspective, operational leadership for the delivery on the ground is being led by the Director of Adult Social Care and the Director of Commissioning – who will provide ongoing assurance to the DASS on Walsall's readiness for CQC assessment. We recognise that our internal assurance against Care Act duties is part of our business as usual in terms of the statutory services discharged by Adult Social Care, with conjunction with the wider council.

3.9 Our refreshed Continuous Improvement Programme, seeks to underpin the delivery and embedding of ongoing positive change, aligned to both national reforms and regional developments, tailored to our Walsall local demography. The programme is also the driver to deliver efficiencies as well improvements for customer and staff aligned to our wider council commitments.

3.10 Our Adult Social Care Continuous Improvement Programme operates within a governance framework and we continue to work with WMADASS to ensure we take ongoing learning from across region and support one another in CQC assurance preparations.

3.11 The CQC commenced formal local authority assessments in December 2023, with the announcement of the first wave, for the first assessments the focus has been largely in the South East area, with site based visits commencing in February 2024. Below the graphic provides an overview of the timetable CQC are operating within. At this point Walsall Adult Social Care continue preparations and improvements, whilst absorbing all guidance material and information published by CQC.

CQC Timeline Overview

When	What
April 2022	CQC awarded new powers as part of Health and Care Act 2022 to assess local authorities
April 2022-November 2023	CQC designing and refining their approach, developing their infrastructure; publishing iterative guidance CQC confirm 153 Local authorities with responsibility for delivering Adult Social Care will be assessed over a 2 year window commencing by end of 2023 3+2 pilot site Local authorities named who will work with CQC to go through and refine the assessment process
December 2023	Outcomes of 5 pilot site assessments are published alongside indicative outcomes and corresponding reports Central Government Approve CQC Local Authority Guidance Guidance and Information Return is published CQC confirm the roll out of assessments will be iterative with the first 3 authorities within the South East Region confirmed
January 2024	A further 2 London authorities are advised by CQC of assessment
February 2024	Onsite inspections commence Timetable of published reports to be confirmed with outcome rating

3.12 Our theme leads have commenced a programme of communication across internal staff; wider council and key partners and stakeholders, which will be rolled out in earnest over the coming weeks, as one strand to ensure we our supporting all colleagues; partners and stakeholders to understand the CQC assurance process and the Adult Social Care journey, including how integral their contribution is.

4. Financial information

4.1 There are no financial implications associated with this report.

5. Reducing Inequalities

5.1 Care Act Duty (2014) places a requirement on Adult Social Care to demonstrate how equality in approach is embedded across all areas including practice; commissioned service; accessibility; workforce and alignment to the wider council priorities across equality, diversity and inclusion. Assurance is being sort ensure equality in approach underpins all we do and forms part of our improvement programme.

6. Decide

6.1 Our Continuous Improvement Programme continues to demonstrate progression and embed positive change and so strengthens our ability to discharge Care Duties compliantly and in a way that continues to support the people who live in Walsall. Whilst there is no decision for scrutiny to be made around the programmes, scrutiny are asked to support the direction of travel and consider a future agenda item linked to an update on progress.

7. Respond

Report is presented for feedback from scrutiny.

8. Review

Not applicable

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Social Care and Health Overview and Scrutiny Committee **Agenda Item No 9.**

19 February 2024

Changes to Health Scrutiny Guidance and Powers

Ward(s): All wards

Portfolio: Councillor G. Flint (Wellbeing, Leisure and Public Spaces)

1. Aim

To provide an overview of the changes in statutory regulations contained within The Local Authority *(Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment and Saving Provision) Regulations 2024* and the accompanying guidance from the Department of Health and Social Care published on the 9 January 2024.

2. Recommendations

1. That the Committee note the removal of the referral powers under The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment and Saving Provision) Regulations 2024 and the subsequent creation of the 'call-in' mechanism in relation to local significant service changes/reconfigurations.
2. That the Committee note that the new guidance and the NHS reorganisation under the Health and Care Act 2022 has created a more regional approach to health service delivery meaning that more joint scrutiny between local authorities on significant service changes could be needed in future.
3. That the Committee be requested Democratic Services to explore options to facilitate potential future joint scrutiny on significant service changes with health partners and including the possibility of a joint memorandum of understanding be explored between Black Country Local Authorities and regional health partners.

3. Report detail – know

3.1 On the 9 January 2023, the Department of Health and Social Care (DHSC) released new guidance and new *regulations (The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) (Amendment and Saving Provision) Regulations 2024)* to reflect changes that were made under *the Health and Care Act 2022*. The main changes outlined in the new regulations are the removal of the health scrutiny's powers of referral to the Secretary of State for Health and Social Care in relation to NHS significant service reconfigurations (sometimes called Substantial Service Change) to health care services locally.

The power of referral to the Secretary of State was removed on the 31 January 2024.

Changes to Secretary of State intervention powers

3.2 Previously the Secretary of State could only intervene in health service reconfigurations upon receiving a referral from a local authority scrutiny function. In addition, the Secretary of State could only intervene in relation to the adequacy of the consultation for service reconfigurations or whether the proposed reconfiguration was in the interest of the health services in the area.

3.3 The removal of the referral powers on the 31 January 2024 has been replaced by a 'call-in' mechanism in which scrutiny committees or any other interested party can write to the Secretary of State to call in a reconfiguration proposal.

3.4 Whilst the new 'call-in' mechanism is open to anyone effected by proposed health service reconfigurations, the guidance stresses that all steps be taken to reach a resolution at a local level before making a 'call-in' request to the Secretary of State.

3.5 The new call-in mechanism grants additional powers to the Secretary of State to intervene over that of the referral system. The Secretary of State can now intervene at any stage of the reconfiguration process and when used this will prevent the NHS service provider from starting any irreversible changes until a decision has been made. In addition, the guidance states that the Secretary of State will provide the NHS commissioning body, the local authority which is affected by the proposed reconfiguration and any other person the Secretary of State considers appropriate the opportunity to make representations before a decision on a 'call-in' is made.

3.6 The guidance makes clear that the most reconfigurations should be delt with at a local level and should not require ministerial intervention. If a call-in is required to resolve local disagreements, then local parties should take reasonable steps to try and resolves issues before Secretary of State intervention.

3.7 In practice NHS partners will still be expected to engage the Committee with consultations in relation to significant service reconfigurations. Whilst the removal of the referral powers under *s244 National Health Service Act 2006* and the creation of the new 'call in' powers under *s68A: Schedule 10A* may seem like reducing the role of health scrutiny committees. In practice the referral powers were rarely used.

Unchanged powers of the Committee

3.8 Under the new guidance the Committee retains the following powers under the *(Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013* as delegated by full Council:

- 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.

3.9 As the Council is also responsible for the commissioning of its own and joint health services through its public health functions. It too is also subject to the above powers.

3.10 The Committees functions as an overview and scrutiny committee of the Council are unaffected by these changes and the committee retains the responsibility to scrutinise decisions of the Council's executive and the running of the Council within its remit as set out in the Council's constitution.

3.11 It is also important to note that under regulations the local Healthwatch can make referrals to the Committee for scrutiny.

Effects of new guidance and increased joint working

3.12 The changes to current health scrutiny guidance for both local authorities and health partners coupled with the restructuring of NHS commissioning within England will make it increasingly likely that joint scrutiny between local authorities could need to take place.

3.13 Section 30 of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 makes clear that joint scrutiny must take place when more than one local authority is consulted on a significant reconfiguration.

3.14 The current Black Country Integrated Care System, under which the BCICB (Black Country Integrated Care Board) and the BCICP (Black Country Integrated Care Partnership) sits, the Black Country Foundation Trust and the various hospital trusts all provide or commission healthcare services in areas which overlap local authority boundaries. The creation of the Integrated Care Systems indicates that in future more regional and joined up healthcare systems will develop which could affect services in more than one local authority and thus require joint scrutiny.

3.15 The Committee will need to consider what kind of approach to joint scrutiny it wishes to take and how it will interact with both health partners and other local authorities in relation to significant health service reconfigurations. A possible method of facilitating this is through the agreement of a joint memorandum of understanding between Black Country Local Authorities and health partners.

3.16 A joint memorandum of understanding could help facilitate how Black Country Local Authorities manage significant service reconfigurations which affect

services across one of more of their boroughs. The memorandum could set out how joint consultations with health partners are handled and how a joint response to a consultation would be coordinated. In addition, the memorandum would need to outline the steps that local authorities and health partners should take to resolve disagreements in relation to significant services changes before requesting intervention from the Secretary of State through the 'call in' mechanism. The risk of not agreeing a joint memorandum of understanding would be that local authorities would not be prepared to respond to a proposed service reconfiguration in a timely manner and affect the ability of scrutiny to alter proposals before they are implemented.

3.17 More detailed information on the effect of the changes can be found in guidance from the Centre for Governance and Scrutiny in **Appendix 1 - Changes to scrutiny of health reconfigurations: frequently asked questions.**

3.18 The new guidance from the Department of Health and Social Care on health scrutiny can be found in **Appendix 2 – Guidance: Local authority health scrutiny (Updated 9 January 2024).**

4. Financial information

4.1 There are no financial considerations associated with this report.

5. Reducing Inequalities

5.1 The Council has a duty to reduce inequalities under the Public Sector Equality Duty (Equality Act 2010). Any decisions taken by the Committee should take into account this legislation.

6. Decide

6.1 The changes in health scrutiny guidance and the recent reorganisation of NHS commissioning make it increasingly likely that joint scrutiny may need to take place between local authorities in relation to significant health service reconfigurations.

6.2 While there are no decisions for the Committee to take at this stage, the Committee is asked for its opinions on how they would like potential joint scrutiny arrangements to work in future.

7. Respond

7.1 The report will be presented for scrutiny for feedback.

7.2 If the Committee requests for work to carried out to explore the options for future joint scrutiny, then a further report will be provided outlining those options.

7.3 Additionally, any joint scrutiny in relation to health will need to be either decided by full Council or full Council will need to delegate power to the Committee to set up joint scrutiny arrangements.

8. Review

Not applicable.

Background papers

None

Appendices

Appendix 1 - Changes to scrutiny of health reconfigurations: frequently asked questions

Appendix 2 – Guidance: Local authority health scrutiny (Updated 9 January 2024)

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Appendix 1

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.
>
> 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.

Department of Health & Social Care

Guidance

Local authority health scrutiny

Updated 9 January 2024

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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Committee Meeting Date	Agenda Item	Action/Recommendation	Officer responsible	Status	Target Completion Date	Notes
13 July 2023	Areas of Focus	A work programme for the municipal year be produced containing agreed areas of focus.	Jack Thompson	Complete	6 September 2023	Sent with agenda papers.
		Information on Social Worker referrals for Adult Social Care be shared with Members of the Committee.	Jack Thompson/ Kerrie Allward	In progress		
		The Committee be provided with the cumulative impact of the Fair Cost of Care exercise.	Jack Thompson/ Kerrie Allward	In progress		
		That the Committee be provided with the amount and percentage of the Council's Council Tax spent on Adult Social Care.	Jack Thompson/ Kerrie Allward	In progress		
14 September 2023	Access to GP Services – Update on telephone systems	That the Committee be supplied with figures of the money allocated through National General Practice Improvement Programme to Walsall.	Jack Thompson/ Black Country ICB	In progress		
		That information on how to raise complaints to the ICB be shared with Members of the Committee.	Jack Thompson/ Black Country ICB	Complete		Information was relayed to Members of the Committee via email on the 23 January 2024.

26 October 2023	Update on Opening of Walsall Healthcare NHS Trust's Urgent and Emergency Care Centre	That the Committee request a future update on the Trust's Urgent and Emergency Treatment Centre.	Jack Thompson/ Walsall Healthcare NHS Trust	In progress		This recommendation will be relayed to the Committee when setting its areas of focus for 2024/25.
7 December 2023	Update on the midwifery led unit and maternity services.	That the Committee receive a future update on the Midwifery Led Unit, once it had been moved to the Manor Hospital.	Jack Thompson/ Walsall Healthcare NHS Trust	In progress		This recommendation will be relayed to the Committee when setting its areas of focus for 2024/25.
	Draft Revenue Budget and Draft Capital Programme 2024/25 – 2027/28	That a further report on the Draft Revenue Budget 2024/25 be presented to the Committee if any changes were made to the draft budget outlined in relation to the Committees remit.	Jack Thompson/ Kerrie Allward/ Suzanne Letts	Complete		This recommendation was not actioned as it was not possible to relay changes to the Committee. However, the Scrutiny Overview Committee received an updated version of the proposed budget on the 6 February 2024.

18 January 2024	Mental Health Services Update	That the Committee receive a report on the work being undertaken by the Black Country NHS Foundation Trust to improve its Acute wards for adults of working age and psychiatric intensive care units, and its programme improve its estate.	Jack Thompson/ Marsha Foster	In progress		
	Areas of Focus	That a report be presented to the Committee on the new guidance from the Department of Health and Social Care and the changes to the Committee powers at the next meeting of the Committee.	Jack Thompson/ Craig Goodall	Complete		Report provided to at the meeting on the 19 February 2024.

Social Care and Health Overview and Scrutiny Committee: Work programme 2023/24[1]

Main agenda items	14/09/23	26/10/23	07/12/23	18/01/24	19/02/24	04/04/24
Theme: Primary Care Access						
Access to GP Services - Update on telephone system						
Social Prescribing (Walsall Healthcare Trust – Walsall Together)						
Mental Health Services						
Dentistry						
Theme: Emergency and Hospital Care						
Update on the new Urgent Treatment Centre						
Update on the midwifery led unit & maternity services (neonatal birthweights) ICB/Walsall Healthcare Trust						
Manor Hospital CQC inspection report feedback						
West Midlands Ambulance Services Update						
Theme: Waiting times						
Elective care waiting times (inc. Surgery)						
Adult Social Care						
Adult Social Care Continues Improvement Programme & CQC ratings of service providers						
Adult Social Care – CQC Inspection Readiness						
Adult Social Care Debt						
Reablement Services						
Budget Scrutiny						
Quarter 2 Financial Monitoring						
Budget Setting 2024/25						

[1] **Please note that the work plan can be edited, and items can be added and removed at the discretion of the chair.**

Walsall Council

FORWARD PLAN OF KEY DECISIONS

Council House,
Lichfield Street,
Walsall, WS1 1TW
www.walsall.gov.uk

5 FEBRUARY 2024

FORWARD PLAN

The forward plan sets out decisions that are termed as "key decisions" at least 28 calendar days before they are due to be taken by the Executive (Cabinet). Also included on the plan are other decisions to be taken by the Cabinet ("non-key decisions"). Preparation of the forward plan helps the Council to programme its work. The purpose of the forward plan is to give plenty of notice and an opportunity for consultation on the issues to be discussed. The plan is updated each month with the period of the plan being rolled forward by one month and republished. Copies of the plan can be obtained from Democratic Services, Walsall MBC, Council House, Walsall, WS1 1TW craig.goodall@walsall.gov.uk and can also be accessed from the Council's website at www.walsall.gov.uk. The Cabinet is allowed to make urgent decisions which do not appear in the forward plan, however, a notice will be included on the agenda for the relevant Cabinet meeting which explains the reasons why.

Please note that the decision dates are indicative and are subject to change. Please contact the above addressee if you wish to check the date for a particular item.

The Cabinet agenda and reports are available for inspection by the public 7 days prior to the meeting of the Cabinet on the Council's website. Background papers are listed on each report submitted to the Cabinet and members of the public are entitled to see these documents unless they are confidential. The report also contains the name and telephone number of a contact officer. These details can also be found in the forward plan.

Meetings of the Cabinet are open to the public. Occasionally there are items included on the agenda which are confidential and for those items the public will be asked to leave the meeting. The forward plan will show where this is intended and the reason why the reports are confidential. Enquiries regarding these reasons should be directed to Democratic Services (craig.goodall@walsall.gov.uk).

"Key decisions" are those decisions which have a significant effect within the community or which involve considerable expenditure or savings. With regard to key decisions the Council's Constitution states:

(1) A key decision is:

(i) any decision in relation to an executive function which results in the Council incurring expenditure which is, or the making of savings which are, significant, having regard to the Council's budget for the service or function to which the decision relates or

(ii) any decision that is likely to have significant impact on two or more wards within the borough.

(2) The threshold for "significant" expenditure/savings is £500,000.

(3) A decision taker may only make a key decision in accordance with the requirements of the Executive Procedure Rules set out in Part 4 of this Constitution.

FORWARD PLAN OF KEY DECISIONS
MARCH 2024 TO JUNE 2024 (05.02.2024)

1	2	3	4	5	6	7
Reference No./ Date first entered in Plan	**Decision to be considered** (to provide adequate details for those both in and outside the Council)	**Decision maker**	**Background papers (if any) and Contact Officer**	**Main consultees**	**Contact Member** (All Members can be written to at Civic Centre, Walsall)	**Date item to be considered**
50/23 (2.10.23)	**Corporate Financial Performance 2023/24:** To report the financial position based on 9 months to December 2023.	Cabinet Non-key Decision	Vicky Buckley Vicky.Buckley@walsall.gov.uk	Internal Services	Cllr Bird	7 February 2024
51/23 (2.10.23)	**Corporate Budget Plan 2024/25 – 2027/28, incorporating the Capital Strategy and the Treasury Management and investment Strategy 2024/25:** To recommend the final budget and council tax for approval by Council.	Cabinet Council Key Decision	Vicky Buckley Vicky.Buckley@walsall.gov.uk	Council taxpayers, business rate payers, voluntary and community organisations. Internal Services	Cllr Bird	7 February 2024 (Council: 22 February 2024)
52/23 (2.10.23)	**Council Plan 2022/25 – Q2 23/24:** To note the Quarter 2 2023/24 (outturn) performance against the Markers of Success in the Council Plan 2022/25.	Cabinet Non-key Decision	Elizabeth Connolly Elizabeth.Connolly@walsall.gov.uk	Internal Services	Cllr Bird	7 February 2024
1/24 (8.1.24)	**Walsall's Regeneration Pipeline:** To award a contract for the strategic partner framework.	Cabinet Key Decision	Joel Maybury Joel.Maybury@walsall.gov.uk	Internal Services	Cllr Andrew	7 February 2024

3/24 (8.1.24)	**Investment and Leasing Proposals for Council Owned Community Buildings:** To support the continued delivery of services by the voluntary and community sector, through the signing of lease agreements and the underwriting of capital investment gaps for those occupying Council-owned properties. *This is an updated item previously included in the forward plan as entry 60/23.*	Cabinet Key Decision	Nick Ford Nick.Ford@walsall.gov.uk	Internal Services	Cllr Andrew	7 February 2024
4/24 (8.1.24)	**Walsall Balloon and Lantern Release Policy:** Decision to be made on adopting the policy which will treat any 'releases' as litter.	Cabinet Non-key Decision	Jaki Brunton-Douglas Jaki.Brunton-Douglas@walsall.gov.uk	Internal Services	Cllr Murphy	7 February 2024
5/24 (8.1.24)	**Fee Uplift Approach for Adult Social Care:** To outline a revised approach to fee setting, fee uplifts and the links to quality across Adult Social Care services. *This will be a private session report containing commercially sensitive information.*	Cabinet Key Decision	Andrew Osborn Andrew.Osborn@walsall.gov.uk	Internal Services	Cllr Pedley	7 February 2024

53/23 (2.10.23)	**Determination of the Scheme for coordinated admissions, and the Admission Arrangements for Community and Voluntary Controlled Primary Schools for the 2025/26 academic year:** To determine the scheme of admissions and admission arrangements for community and voluntary-controlled primary schools for 2025-26.	Cabinet Key Decision	Alex Groom Alex.Groom@walsall.gov.uk	Internal Services, Neighbouring Local Authorities, Schools, Faith Groups	Cllr M. Statham	7 February 2024
7/24 (5.2.24)	**Darlaston Long Term Plan for Towns:** To authorise the Executive Director for Resources and Transformation, in consultation with the Cabinet Member for Regeneration, to act as Accountable Body for the Darlaston Long Term Plan for Towns.	Cabinet Key Decision	Amelia Brachmanski Amelia.Brachmanski@walsall.gov.uk	Internal Services	Cllr Andrew	20 March 2024
8/24 (5.2.24)	**Fixed Penalty Notices:** Cabinet to consider law changes allowing the increase of penalties for litter, fly tipping and duty of care and approving the new penalty limits in Walsall.	Cabinet Key Decision	David Elrington David.Elrington@walsall.gov.uk	Internal Services	Cllr Perry	20 March 2024
9/24 (5.2.24)	**West Midlands Local Transport Plan Settlement and Transport Capital Programme 2024/25:**	Cabinet Key Decision	Matt Crowton Matt.Crowton@walsall.gov.uk	Internal Services	Cllr Andrew	20 March 2024

	To approve the West Midlands Local Transport Plan Settlement and Transport Capital Programme 2024/25.					
2/24 (8.1.24)	**Acquisition of a Strategic Town Centre Development Site:** To approve the acquisition of a strategic town centre development site. *This will be a private session report containing commercially sensitive information.*	Cabinet Key Decision	Nick Ford Nick.Ford@walsall.gov.uk	Internal Services	Cllr Andrew	20 March 2024
15/24 (5.2.24)	**Acquisition of a Town Centre Property for Strategic Regeneration:** To approve the acquisition of a town centre property for strategic development. *This will be a private session report containing commercially sensitive information.*	Cabinet Key Decision	Nick Ford Nick.Ford@walsall.gov.uk	Internal Services	Cllr Andrew	20 March 2024
11/24 (5.2.24)	**Town Deal & Future High Street Fund Updates:** To approve delegations to enable continued delivery of the external grant funded programmes/ projects in line with the agreed governance and assurance framework.	Cabinet Key Decision	Simon Tranter Simon.Tranter@walsall.gov.uk	Internal Services	Cllr Andrew	20 March 2024
14/24 (5.2.24)	**Healthy Levelling Up Partnership:** To agree to the Healthy LUP proposal and agree delegations to bring forward	Cabinet Key Decision	Simon Tranter Simon.Tranter@walsall.gov.uk	Internal Services	Cllr Andrew	20 March 2024

	proposals for funding under the scheme.					
65/23 (4.12.23)	**Materials Contract Awards:** To award off-take and processing contracts for multiple recyclable materials. *This will be a private session report containing commercially sensitive information.*	Cabinet Key Decision	Katie Moreton Kathryn.Moreton@walsall.gov.uk Alan Bowley Alan.Bowley@walsall.gov.uk	Internal Services	Cllr Murphy	20 March 2024
12/24 (5.2.24)	**Walsall Safer Streets – Palfrey Big Local and General Update:** To cover the work of Palfrey Big Local, their resident led approach and the outcomes they have achieved.	Cabinet Non-key Decision	Paul Gordon Paul.Gordon@walsall.gov.uk	Internal Services Palfrey Big Local	Cllr Perry	20 March 2024
6/24 (8.1.24)	**Alternative Provision Contract:** To approve the award contracts for the provision of Alternative Education.	Cabinet Key Decision	Laura Wood Laura.Wood@walsall.gov.uk	Internal Services	Cllr M. Statham	20 March 2024
58/23 (6.11.23)	**High Needs Funding Formula 2024/25:** To approve changes to the High Needs Funding Formula, as agreed by Schools Forum, to be used for the allocation of Dedicated Schools Grant – High Needs Block to schools in Walsall for the 2024/25 financial year.	Cabinet Key Decision	Richard Walley Richard.Walley@walsall.gov.uk	Schools Forum, Internal Services	Cllr M. Statham	20 March 2024

59/23 (6.11.23)	**Early Years Funding Formula 2024/25:** To Cabinet approve the Early Years Funding Formula, as agreed by Schools Forum, to be used as the allocation of funding to early years providers in Walsall.	Cabinet Key Decision	Richard Walley Richard.Walley@walsall.gov.uk	Schools Forum, Internal Services	Cllr M. Statham	20 March 2024
46/23 (4.9.23)	**SEN Place Requirement:** To approve finance for additional special educational needs school places.	Cabinet Key Decision	Alex Groom Alex.Groom@walsall.gov.uk	Internal Services	Cllr M. Statham	20 March 2024
14/23 (6.2.23)	**Growth Funding for Schools:** To enable the Local Authority to fulfil its duty to secure sufficient primary and secondary school places, through the adoption of a policy for the application of revenue funding for school growth.	Cabinet Key Decision	Alex Groom Alex.Groom@walsall.gov.uk	Internal Services, Schools Forum	Cllr M. Statham	20 March 2024
66/23 (4.12.23)	**Waste Management Strategy Update - Fryers Road Household Waste Recycling Centre redevelopment (HWRC):** That Cabinet approve the pre-tender budget for the redevelopment of a larger Fryers Road HWRC and agree to use the Pagabo framework (design and build stages) for the procurement of Fryers Road HWRC.	Cabinet Key Decision	Katie Moreton Kathryn.Moreton@walsall.gov.uk Stephen Johnson Stephen.Johnson@walsall.gov.uk	Internal Services	Cllr Andrew Cllr Murphy	17 April 2024

67/23 (4.12.23)	**Council Plan 2022/25 – Q3 23/24:** To note the Quarter 3 2023/24 (outturn) performance against the Markers of Success in the Council Plan 2022/25.	Cabinet Non-key Decision	Elizabeth Connolly Elizabeth.Connolly@walsall.gov.uk	Internal Services	Cllr Bird	17 April 2024
13/24 (5.2.24)	**Multifunctional Devices leasing contract:** To consider the award of a 5-year contract for the leasing of multifunctional devices (MFDs) and production print devices. *This will include a private session report containing commercially sensitive information.*	Cabinet Key Decision	Sharon Worrall Sharon.Worrall@walsall.gov.uk	Internal Services	Cllr Ferguson	17 April 2024
10/24 (5.2.24)	**Surveillance and Access to Communications Data:** To review the authority's performance as regards directed surveillance and to approve an updated policy for surveillance and the interception of communications data.	Cabinet Key Decision	David Elrington David.Elrington@walsall.gov.uk	Internal Services	Cllr Perry	17 April 2024
57/23 (6.11.23)	**Walsall Net-Zero 2041 Climate Strategy:** To approve the Walsall Net-Zero 2041 Strategy.	Cabinet Key Decision	Katie Moreton Kathryn.Moreton@walsall.gov.uk	Internal Services	Cllr Flint	July 2024

Black Country Executive Joint Committee
Forward Plan of Key Decisions

Published up to May 2024

Date Created	Key Decision	Contact Officer	Main consultee	Date of meeting
	Black Country Executive Joint Committee Governance			
04/09/2023	**Change Control and Delegated Authority** Approval of BCJC Delegated Authority to the Single Accountable Body Section 151 Officer (SAB s151 officer) and approval of the revised Black Country Local Enterprise Partnership (BCLEP) Assurance Framework Change Control and Delegated Authority delegations, as detailed in the attachment of the report (BCLEP Assurance Framework Appendix 23).	David Moore David.Moore@walsall.gov.uk Mark Lavender Mark.Lavender@walsall.gov.uk	Walsall Council	24/01/2024
	Land and Property Investment Fund			
04/12/2023	**Dudley Brownfield Land Programme** Approval of the withdrawal of the Dudley Brownfield Land Programme project (Dudley Council) from within the Land and Property Investment Fund Programme.	Helen Martin Helen.Martin@dudley.gov.uk	Dudley Council	24/01/2024

Date Created	Key Decision	Contact Officer	Main consultee	Date of meeting
04/12/2023	**Loxdale Residential Scheme** Approval for the Accountable Body for the Land and Property Investment fund (Walsall Council) to proceed to enter into a Grant Agreement with Wolverhampton City Council to deliver the Land and Property Investment fund funded elements of the Loxdale Residential Scheme project with delivery to commence in the 2023/24 financial year.	Richard Lawrence Richard.Lawrence@wolverhampton.gov.uk	Wolverhampton City Council	24/01/2024
04/12/2023	**Programme Management Costs** Approval of the balance of Land and Property Investment Fund funds to be allocated to Accountable Body (Walsall Council) programme management costs, to cover additional due diligence and contracting costs associated with the replacement of a project.	David Moore David.Moore@walsall.gov.uk Mark Lavender Mark.Lavender@walsall.gov.uk	Walsall Council	24/01/2024