Health and Care Act 2022

Briefing for scrutiny practitioners in England

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About Centre for Governance and Scrutiny

CfGS exists to promote better governance and scrutiny, both in policy and in practice. We support local government, the public, corporate and voluntary sectors in ensuring transparency, accountability and greater involvement in their governance processes.

Governance and scrutiny are essential for the successful working of any organisation. Now, more than ever, trusted decisions are needed. We believe that decisions are better made when they are open to challenge and involve others – whether that's democratically elected representatives, those affected by decisions, or other key stakeholders.

At the heart of better governance and scrutiny are the right behaviours and culture. Our work champions these relational aspects and designs the structures to support them, leading to more effective decision-making and improved outcomes for organisations and people.

1. Introduction

The Health and Care Act 2022 received Royal Assent on 28th April 2022. This briefing provides an interim guide for scrutiny practitioners on the main elements likely to be of relevance and interest, while we wait for more detail in the form of Regulations and statutory guidance.

Formal changes will be coming into force in the coming months – statutory Integrated Care Boards and Integrated Care Partnerships will be introduced on 1 July 2022. New powers for the Secretary of State to intervene in local health services will begin in July 2023. Around this, the role and functions of health scrutiny will be changing, and it is important that scrutineers prepare for these changes.

Substantial ongoing uncertainty on key elements of the new arrangements will make preparation a challenge however. A suite of statutory guidance is expected; further

guidance from NHS England is also forthcoming. Changes will be needed to the current health scrutiny Regulations. As part of this emerging picture, CfGS is planning later this year to produce its own material setting out to practitioners the practical steps they can take to ensure that they can engage productively in their review, challenge and scrutiny of health and care services.

The Act makes some substantial changes to the organisation of health and care functions across England. You can find general briefings about the Act and its contents here:

- Government press release: https://www.gov.uk/government/news/health-and-care-bill-granted-royal-assent-in-milestone-for-healthcare-recovery-and-reform
- BMA briefing: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/integration/the-health-and-care-act
- The King's Fund briefing: https://www.kingsfund.org.uk/blog/2022/05/health-and-care-act-2022-challenges-and-opportunities
- LGA briefing (based on the situation applying during consideration of Lords amendments at the end of March 2022): https://www.local.gov.uk/parliament/briefings-and-responses/health-and-care-bill-consideration-lords-amendments-house
- NHS Confederation briefing: https://www.nhsconfed.org/publications/health-and-care-bill-five-influencing-successes

What this briefing covers, and how it covers it

This briefing focuses on accountability, specifically the local accountability of NHS bodies to local authorities' overview and scrutiny arrangements. In explaining the new arrangements it makes reference to existing health scrutiny systems, which are those introduced following the passage of the Health and Social Care Act 2012. Regulations on health scrutiny were passed in 2014 and remain in force for the time being.

In common with other recent health legislation (including the Health and Social Care Act 2012), by and large the Act operates by making amendments to the National Health Service Act 2006 (although it also makes some amendments to the Local Government and Public Involvement in Health Act 2007). This means that the Act has to be read in conjunction with those Acts to make sense.

CfGS published a briefing in summer 2021 on the Health and Care Bill as introduced into Parliament. While there were a number of significant, substantive amendments to the legislation as it progressed through both Houses, its fundamentals remained the same.

2. Policy background

System, place, and neighbourhood level

The new structures in the NHS bring into statute new models of working within the NHS which have been developing since around 2016. At that time, local NHS bodies were coming together to develop Sustainability and Transformation Plans (STPs), which were meant to address need at three geographic levels.

These three levels form the basis of the structures being established by the Act, and are:

- System level: covering a wide geographic area of between several hundred thousand and well over a million people, and covering the areas of multiple local authorities. It is at this level that new integrated care systems (ICSs) will operate;
- Place level: covering (usually) a single local authority area. Up until now policy and services at "place level" has been focused on the work of clinical commissioning groups (CCGs). In some areas "system level" and "place level" will be the same or very similar – Lincolnshire, for example);
- Neighbourhood level: covering smaller areas, with a focus on primary and community care. Structurally, these might be co-ordinated through primary care networks (PCNs).

Statutory Integrated Care Systems

The main structural change in the Act is the abolition of CCGs and the development of Integrated Care Systems (ICSs). In this paper we (like the NHS itself) use "integrated care system" as an umbrella term to cover two bodies in particular:

- Integrated Care Boards (ICBs), new bodies with a range of duties around the commissioning of health services;
- Integrated Care Partnerships (ICPs), bodies comprised of ICBs and representatives of local authorities in the area, with a responsibility for jointly planning health and care services across an area.

It is likely however that the language used to describe these bodies individually and collectively will evolve over time.

Integrated Care Boards

ICBs will be bodies with a duty to commission and provide a range of health services to specified "groups" of people, set out in the Act. Generally these groups will consist of those entitled to receive primary care in the area covered by the ICB concerned. This does not affect the fundamental obligation in the 2006 Act to provide a comprehensive health service.

This general duty for ICBs is set out in a new section 3 of the 2006 Act. There are a range of more specific duties on ICBs set out from s14Z32 and onwards of the 2006 Act. These duties are:

- To promote the NHS Constitution;
- On effectiveness, efficiency and economy ("value for money");
- On improvement in quality of services (an obligation to delivery continuous improvement);
- On reducing inequalities;
- On promoting involvement of each patient (this is involvement in personal healthcare as opposed to general public involvement in NHS business);
- On patient choice;
- On appropriate advice (so, having advice from medical professionals and public health professionals);
- To promote innovation;
- On research;
- To promote education and training;
- To promote integration (which is about service quality, and reducing health inequalities, across health and social care);

- To have regard to the wider effects of decisions (in general, an obligation to have regard to the health and well-being of people in England – so, other ICBs, NHS trusts and NHS England). There is a separate obligation elsewhere for ICBs in border areas to work with Welsh Local Health Boards, where joint committees may be formed;
- On climate change.

NHS England will have a responsibility for reviewing performance against these duties annually, and holds some intervention powers where ICBs are not deemed to be performing. It may be that scrutiny committees can speak to ICBs about the role they can play in providing local assurance on these duties.

ICBs have a range of other obligations:

- To produce a rolling five year forward plan. This plan is subject to local consultation, with the public at large and specifically with relevant Health and Wellbeing Boards.
- To produce an annual report.
- To produce a constitution (different to the national NHS Constitution).
- To consult on the design and provision of health services more generally.

Because ICBs will cover a much wider footprint than individual CCGs it remains to be seen how design and delivery will be managed at the more local, "place" level. It seems likely that ICBs will establish individual Boards, as "prime committees", for each local authority area previously covered by a CCG, but the content of forthcoming ICB constitutions will provide more clarity on this. Certainly, Health and Wellbeing Boards will remain in place.

Government will be producing statutory guidance on the operation of ICBs, presumably in advance of them coming into place in July 2022.

Integrated Care Partnerships

ICPs are joint committees.

They will be comprised of a member nominated by the ICB and a member nominated by each of the local authorities (county and unitary) in the area.

ICPs once constituted can also appoint other members, and an important element of the dynamics of ICP operation will rest on where decisions are made to appoint additional people, and who those people will be.

ICPs must prepare an "integrated care strategy" based on the joint strategic needs assessments (JSNAs) drafted by authorities in the area.

Government has set out more information on the operation of ICPs, in particular obligations in engagement: https://www.gov.uk/government/publications/integrated-care-partnership-icp-engagement-document/integrated-care-partnership-icp-engagement-document-integrated-care-system-ics-implementation

Other pertinent changes

The Act brings into force some other structural changes which are likely to have an impact on health and care accountability and governance. These include:

- Changes to the functions of NHS England. For some time NHS England and NHS Improvement have been functionally merged, but this is now being formalised. Monitor and the NHS Trust Development Authority (which have both for some time been a part of NHS Improvement) are being technically abolished although their functions will continue to be transacted by NHS England;
- The abolition of clinical commissioning groups (CCGs). From now on the functions of CCGs will be carried out by Integrated Care Boards. Whether ICBs will retain local offices, teams and structures remains to be seen.

3. Changes to health scrutiny

Existing powers

Detail on existing health scrutiny powers can be found here - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf

These powers can be found in Part 12, s244 of the 2006 Act, and more explicitly in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Briefly, current legislation allows local authorities (usually through an overview and scrutiny committee, but different arrangements apply for committee system authorities) to:

- Review and scrutinise any matter relating to the planning, provision and operation of the health service in its area;
- Take account in doing so of comments by any interested parties and relevant information available, particularly information provided to it by Local Healthwatch;
- Make reports and recommendations to a "responsible person", and to the local authority itself.

The Regulations also provide for a responsibility on "responsible persons" to consult on substantial variations to local health services. Responsible persons are required to engage with scrutiny's response to that consultation. This can result in a determination by scrutiny that a consultation has not been adequate. Under these circumstances – or where scrutiny feels that the proposals are not in the interests of the health service in its area – a referral can (currently) be made to the Secretary of State.

In order to transact these duties, scrutiny has power to access information held by responsible persons.

In our view the fundamental elements of effective health scrutiny, in legislative terms, are:

- The power for scrutiny to investigate matters relating to local health, to make recommendations (which should be responded to) and to have access to information held by responsible persons;

- The power to bring to the attention of the public, and the Secretary of State, concerns over substantial variations to services (hitherto through referral, in future through "consultation");
- The power and opportunity to integrate health scrutiny within scrutiny across a place – by recognising and acting on the wider determinants of health and care; in our view this requires that powers be transacted, as far as possible, by an overview and scrutiny committee.

How powers may change in general

There is still uncertainty about which of these powers in Regulations will remain in light of the Secretary of State's new powers of intervention. We know that the Act designates the ICB as a "responsible person" for the purposes of the Regulations, and that therefore some of these critical powers will, indeed, persist.

These will form the basis of ongoing discussions with NHS England and the Department of Health and Social Care.

Changes to powers on substantial variations to health services

The Secretary of State's new powers of intervention

One of the most controversial elements of the Act was the granting of significant discretion to the Secretary of State to intervene in the operation of local health and care services. Where before the Secretary of State was only able to intervene after the referral from a local authority (usually, from a scrutiny committee) had taken place, the original provisions of the Bill were that he or she would be able to do so essentially unilaterally.

Along with a range of other organisations, CfGS carried out sustained work to raise concerns about the effectiveness and proportionality of those powers.

The powers are now subject to some control, further to amendments tabled by Government shortly before the Bill received Royal Assent. Powers to intervene:

- Will be subject to the issuing of a "direction", relating to substantial variation of health services. This direction will remain active for six months;
- Will be subject to consultation with the relevant NHS commissioning body, NHS England (if the commissioning body is an ICB), with every local authority in the area affected (that is, county and unitary authorities, not shire districts), and anyone else that the Secretary of State considers appropriate;
- Will be subject to an obligation to publish any representations received as a result of the above consultation.

While the direction is in place, and until the Secretary of State has finished considering the proposal, the NHS commissioning body will be stopped from taking further action to implement the change.

The abolition of health scrutiny's referral powers, and what will replace them

The power hitherto held by scrutiny to refer matters to the Secretary of State is being removed and replaced by an obligation on the Secretary of State to "consult".

Consultation will still provide a health scrutiny committee with an opportunity to directly influence the Secretary of State's decision but it will remove a degree of proactivity from the arrangements.

These formal steps will need to be preceded by some form of engagement between scrutiny and the ICB itself. Its status as a statutory consultee should mean that – as has been the case with the referral power – scrutiny has, in theory, a degree of clout in the system and can expect early engagement with the ICB on change plans.

If a scrutiny committee is concerned about the adequacy of change plans it could contact the Secretary of State to ask that powers to intervene be exercised – but this request would have no formal status. It remains to be seen how the Secretary of State proposes to develop the insights and data needed to be able to make accurate judgements as to where intervention might be necessary – again, it is likely that statutory guidance will make this clearer. CfGS and other partners have highlighted how local bodies, scrutiny included, can provide evidence (transparently) to bring matters to the Secretary of State's attention.

While the obligation to consult in the Act refers to "local authorities", an ordinary reading of the Act (and existing legislation on health scrutiny) leads to the conclusion that the consultation should be with the relevant health overview and scrutiny committee, where one is present, or with another committee of council in other circumstances. It is not tenable that consultation could be with the council's executive, as the executive may well be involved in the decision-making process of the ICB through a formal role played through the ICP, and consultation from the Secretary of State would either by duplicative or, more likely, constitute a conflict of interest. The wording of the Act does though give rise to the opportunity for uncertainty, and CfGS will be ensuring the Regulations and/or statutory guidance, when produced, remove any opportunity for ambiguity.

4. Practical actions for scrutiny practitioners

There are several areas where practical thinking is likely to be necessary for health scrutineers.

1. Understanding what happens next

Originally Government's plans were that all the provisions of the Act would come into force in April 2022. Because of the length of time that the Bill took to move through Parliament these plans were amended. Currently, the expectation is that statutory ICBs (and ICPs) will be established in July, with other structural changes coming into force at the same time. Meanwhile, the Secretary of State's powers of intervention (and the withdrawal of the existing power to refer) will be introduced in July 2023. This means that there will be a transitional period between July 2022 and July 2023 during which ICBs and ICPs will be in place but the Secretary of State's wider powers will not yet be acting, and scrutiny's current powers will remain.

The Act obliges the Secretary of State to produce statutory guidance to cover a range of ICS operations. Much of this is likely to be produced before 1 July 2022 but some may be produced later.

Existing health scrutiny Regulations will need revision, given that portions relate to the powers to refer discussed above.

Familiarisation with all of this new material is likely to be important for scrutiny practitioners to ensure that they can play a full part in subsequent conversations with NHS partners.

2. Relationship building

There is concern from some scrutiny practitioners about the skill, capability and capacity of ICBs, and others in the system, to engage productively with local authorities and health scrutiny in particular.

The level of awareness of health scrutiny within the NHS has always been highly variable. While some authorities have built up positive working relationships with staff working for CCGs and NHS trusts that has not been the case everywhere. A change in personnel, and the focus of ICBs on a much wider area, raises the risk that health scrutiny will come further down the priority list, and the risk that it will be difficult to engage with an organisation trying to manage relationships with a large number of local authorities.

Interim guidance is being produced by Government, supported by the LGA and CfGS, which will set out expectations on how scrutiny of ICSs (covering ICBs and ICPs) will be supported by strong relationships between the NHS and local government; this guidance is expected to set out some general principles to govern the development and maintenance of these relationships.

It is expected to be supplemented or replaced by further, statutory, guidance to apply once the new arrangements for Secretary of State intervention (see below) are in force.

3. Considering options on joint committees / joint scrutiny

The logic behind commissioning health services over a large geographical footprint is that some services may be redesigned and rationalised. If this happens in a way that affects the whole area – as seems likely – there may be a perceived need for more work for joint health overview and scrutiny committees (JHOSCs).

While JHOSCs have been a feature of the health scrutiny landscape for many years, with a few exceptions they have been established on a time-limited basis to provide assurance on specific service reconfigurations. The operation of ICBs suggests that the establishment of "standing JHOSCs" will be a possibility. While we are keen to see more joint working between councils on health scrutiny issues we are concerned about the resource and capacity implications should there be an expectation that JHOSCs are established under these circumstances.

We produced, in a briefing published in 2021, a process and mechanism which could form part of future health scrutiny Regulations. A consistent system set out in legislation for the establishment and support of joint arrangements would provide consistency and predictability, and proportionality, in arrangements, without the need for their being designed from scratch in every case. You can find our briefing at https://www.cfgs.org.uk/wp-content/uploads/2021-09-09-parliamentary-briefing-hscb.pdf.

CfGS proposes to produce more material on the detail on joint scrutiny arrangements later in 2022.

4. Understanding where plans for substantial variations are likely to emerge

A wide variety of new formal documents will be emerging in the coming months – documents which scrutiny can usefully review to understand future plans. These include:

- The annual five year forward plan produced by the ICB;
- The ICB's annual report;
- Any information on performance in relation to the ICB's duties and functions, which the ICB will report to NHS England;
- The results of performance assessment carried out by NHS England;
- The JSNAs, and other assessments, forming the basis for integrated care strategies developed by ICPs;
- The ICP integrated care strategies themselves.

While detailed review of all of this material as it becomes available is likely to be difficult, some of it (the integrated care strategy, and the five year forward plan) are likely to flag where future major changes to services are possible. Future CfGS material will explain this new set of documents, and the wider governance framework for ICSs, in more detail.