The law and practice of the major reconfiguration of NHS Services

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Contents:

List of abbreviations used in this chapter

The NHS Act	National Health Service Act 2006

The 2012 Act	Health and Social Care Act 2012
CCG	Clinical Commissioning Group
NHS England	The National Health Service Commissioning Board
NHS Improvement	The collection of NHS bodies, including Monitor, which now operates under the name of NHS Improvement.
HWB	Health and Wellbeing Board
JSNA	Joint Strategic Needs Assessments produced by the HWB.
JHWS	Joint Health and Wellbeing Strategy produced by the HWB.
IRP	Independent Reconfiguration Panel
HOSC	Health Overview and Scrutiny Committee
PCBC	Pre-Consultation Business Case
DMBC	Decision Making Business Case
The Guidance	*Planning, assuring and delivering service change for patients: A good practice guide for commissioners on the NHS England assurance process for major service changes and reconfigurations*" published by NHS England (2015 Edition)

Introduction

1. There are few more vexed and contentious subjects in the NHS than the management of major service change to NHS services and buildings. In his introduction to his judgment in *R (London Borough of Lewisham & Anor) v Secretary of State for Health & Ors* [2013] EWHC 2381 (Admin), Silber J said:

> "There are few issues which prompt such vociferous protest as attempts to reduce the services at a hospital which is highly regarded and which is much used by those who live in its neighbourhood"

2. However, running the NHS without change is virtually impossible, and delaying essential change is hugely inefficient and may lead to poorer services for patients. Medicine is changing all the time, often at a faster rate

than the public understand, and so the management of change is and has always been part of NHS management. Maintaining an efficient and effective service often means changing the way that the service is delivered or the place at which it is delivered. However, there can be a marked difference of perspective between the public, hospital staff and NHS managers about the reasons for change and its likely effects.

3. One approach is that the "bricks and mortar" of a hospital are merely the setting within which NHS services are delivered by caring, dedicated professionals. On this analysis, the services are more important than the buildings in which the services are delivered, and if the way that the buildings are used needs to change to make the services more efficient or effective, then the demand to deliver efficient and effective services takes precedence over maintaining the existing footprint of services in existing buildings. That may be a sensible and logical approach which commends itself to an NHS manager or a health economist, but NHS services are "human" services at all levels and reactions to service change proposals are governed by the heart as well as the head[1].

4. Staff who work at the hospital may see service change in a totally different way to NHS managers (who may not work at that site) or external consultants. There is a strong belief amongst many NHS staff that reconfiguration exercises are largely driven by a desire to save money, but that they are dressed as being for patient benefit when, in fact, they are all about cutting budgets, reducing staff and thus making existing staff deliver the impossible. Many staff will have been through numerous previous

[1] The author does not suggest that these passages are anything but his anecdotal musings on the causes and effects of disputes concerning NHS service change, but they are informed by multiple experiences. He served as the MP for Wyre Forest, until displaced by a candidate who opposed service change at Kidderminster Hospital (despite having no alternative plan for the services and the changes subsequently saving many lives). He has also advised numerous NHS bodies about service change issues and also acted for patients opposing service change as, for example, in the Lewisham Hospital case. He has lectured about these issues on many occasions, including to the NHS Confederation annual conference.

change programmes and have see the extent to which they have (or often have not) delivered on the promised improvements for patients or working efficiencies, and thus a degree of cynicism can be justified by past experience. Usually, there is a good deal of truth in these broader concerns. Perhaps the worst perennial "sin" around reconfigurations is for NHS management to fail to be honest with both staff and the public by not admitting that one of the primary drivers for change, if not the sole driver, is cost saving.

5. Any proposed change to the existing services that NHS staff deliver can, if not communicated properly, be seen as an attack on the professionalism of those same staff. Staff will have developed their own ways of working, may be operating within a comfort zone and service change will impose unwelcome change, threatening their security and possibly their jobs. Staff, especially senior clinical staff, working for the NHS can have incredible power and, on occasions, groups of clinicians have proved themselves hugely resistant to change. Any opposition will, of course, always be expressed as being mediated through the interests of the patients, but this may be coincidental with the staff's own financial and professional interests. On other occasions senior clinical staff are leaders and promoters of change, even if it is to their personal or professional disadvantage, and are in the vanguard to persuading other staff and the public that change will deliver improved services.

6. Local authorities may see things differently again. Local authority officers and members may well be primarily concerned about how changes in the delivery of NHS services will affect their delivery of social services, particularly around delayed discharges of care. Local authority members will be concerned that the NHS is communicating its plans effectively and sympathetically with the public, or members who do not oppose change in a sufficiently robust way may become victims at the ballot box.

7. The perspective of the public can be very different again. Where service change is well managed, communicated well and the public feel they have had a genuine say in final decisions, major service change has rarely attracted support but it public opposition can be muted. However in the author's experience over several decades, this is sadly a rarity. There are a huge variety of reasons for this but the following are (anecdotally) relevant.

a. The public are suspicious of change in NHS services and will tend to link any changes to a "cuts agenda". Closing an NHS community hospital because, for example, beds for patients can be purchased at nursing homes for half the cost, with the savings being delivered as increased community services attracted huge opposition despite its obvious common sense[2]. This was seen as "cutting" community services, not investing in them.

b. NHS managers often underestimate the extent to which the public have a profound emotional attachment to particular NHS buildings. This attachment can be out of all proportion to the medical importance of the buildings and may be based on a false understanding of the type of services that are delivered there. However such myths are persistent and can endure in the popular imagination. Hence, "saving" a hospital A & E or maternity unit can become a cause celebre based on a belief that this is needed to save lives, even if more patients with life threatening conditions are not in fact treated at the local hospital, but are routinely referred to another centre with greater facilities.

c. Having a fully functioning hospital with a full range of services can be seen as being symbolic of the standing of a community. Thus removing services from a hospital can be seen as diminishing the importance of the

[2] This is an example from a recent reconfiguration exercise in the Midlands.

local area. This emotional attachment to buildings often starts at birth and ends with the death of loved ones.

d. In the balance between safety and convenience, the public have the ability to measure convenience but are reluctant to engage with safety arguments. Local services are convenient for local people and the opposition arising from the inconvenience of moving services to a distant hospital, with associated parking problems, is often underestimated by those planning services. In contrast, the prevailing culture is a disbelief of experts who rely on population cohort statistics to conclude that, for example, patients needing emergency treatment will have better outcomes if they are treated in larger centres by specialist staff. The history of change in the NHS is full of well researched plans to centralise services which, where implemented have saved lives, that attracted disbelief when they were proposed and continue to attract opposition from the public.

e. Finally, there is the fact that NHS change will inevitably become a hot local political issue. MPs and local councillors who have to respond to NHS service change can be in a difficult (if not impossible) position. However much they may be intellectually convinced of the case for change, it can be electoral suicide for an elected politician to take the moral high ground of supporting change. There are always those who will campaign against NHS changes, characterise them as "cuts" even if they will cost hundreds of millions of pounds to implement and seek to get elected on the back of manufactured public opposition to NHS service change. Ultimate responsibility for NHS services lies with the Secretary of State and so service change is inevitably political.

8. It is thus entirely understandable that the NHS has been wary about implementing widespread service change, whatever the compelling medical

and financial case that change will deliver benefits for patients, staff and the wider community. However the factors driving change have not stayed constant. At the time of writing there are an increasing number of schemes coming forward, driven by a variety of factors:

a. First, the NHS does not have the resources to continue to work inefficiently. Hence austerity drives the change process.

b. Secondly, and perhaps more importantly, many change programmes are driven by the inability of smaller hospitals to recruit and retain sufficient clinical staff to meet CQC standards.

c. Third, the Five Year Forward programme published by NHS England (whatever its flaws and unfulfilled ambitions) is driving a service change programme which gives local health economies permission to propose reconfiguration schemes even if these are politically unpopular.

9. So it seems inevitable that NHS managers and clinical leaders will have to grapple with unpopular service change issues in the months and years ahead. This chapter seeks to guide them through the steps they need to take to deliver a lawful reconfiguration scheme, as well as assisting those who want to object to change proposals to understand what the NHS should be doing in advance of any final decision.

Terminology used in this chapter.

10. A decision to make significant changes to NHS services can be made by a commissioner or a provider Trust. This chapter concentrates on proposals for change which are led by commissioners. Changes to NHS services made by providers, without the involvement of commissioners, tend to be unplanned changes to services made in response to urgent situations such as emerging clinical problems or staff shortages. But, in general, planned reconfigurations

are led by commissioners and not providers. Changes can be led by a single CCG, a joint committee of a number of CCGs, NHS England (in its role as a commissioner) or a combination of NHS England and CCGs. The same principles apply regardless as to whether the body bringing forward the changes is a CCG or NHS England, and whether it is a single CCG or a group of CCGs. For convenience, the body bringing forward proposals to make the proposed services changes in this chapter will be referred to as "the CCG", but the same approach should be taken by a group of CCGs or NHS England.

The NHS England Guidance concerning reconfigurations.

11. In 2013, NHS England published detailed Guidance about the processes to be followed in order to implement major service change called "*Planning, assuring and delivering service change for patients: A good practice guide for commissioners on the NHS England assurance process for major service changes and reconfigurations*" ("**the Guidance**")[3]. This Guidance was revised in 2015[4] and references in this chapter are to the revised document. It sets out the internal NHS processes that commissioners and providers are recommended (but in reality required) to follow in order to give effect to major NHS service changes. The Guidance needs to be read with some care as it focuses on the management processes that should be followed without having full regard to the legal duties that are imposed on NHS bodies whilst they are following the processes.

12. Although the Guidance does not expressly provide that it is statutory guidance, the tone of the Guidance is worded in a way that CCGs are expected to follow it closely. It thus seems likely that the guidance has the

[3] Available on the NHS England website: www.england.nhs.uk

[4] The document states "*This guidance will be revised annually to take into account changes in the commissioning landscape and feedback from stakeholders*". However no revisions were published in either 2016 or 2017. Readers should check the NHS England website before relying on the text above as the document may be updated in accordance with this commitment.

status of being formal guidance issued by NHS England under section 14Z8 of the NHS Act. It follows that CCGs have a legal duty to have regard to the Guidance when undertaking reconfiguration exercises. Thus a CCG may well be challenged by way of Judicial Review if it fails properly to have regard[5] to the Guidance. NHS England will also have a legal duty to have regard to its own guidance document.

The relationship between procurement duties and NHS reconfiguration exercises.

13. Implementing any NHS service reconfiguration decision will almost certainly involve making substantial changes to the contracts between the CCG and the NHS body (or private provider) that is delivering changed NHS services. CCGs should therefore satisfy themselves that they are complying with their procurement obligations before any contracts are signed. The reconfiguration decision is usually about the type of services that the CCG wishes to commission. There will be occasions where there is only one possible provider of those services such as, for example, where changes are made to consultant led maternity services at a local hospital. Procurement issues are unlikely to arise in such cases because there are no other economic operators who could have delivered those services. However in other cases the reconfiguration decision is about "what" services should be delivered. A procurement decision may then need to be made about "who" should be contracted to deliver those services.

14. The details of the procurement obligations on a CCG are set out in the procurement chapter but CCGs need to be mindful of the way in which procurement obligations can arise within NHS reconfiguration exercises throughout a reconfiguration exercise.

Which NHS body makes final decisions about NHS Service Change?

[5] Include cross reference to section in commissioning chapter on the meaning of a "have regard duty".

15. The question as to which NHS body is the final decision maker about NHS service change can be far from straightforward. NHS commissioners (CCGs and NHS England) make decisions about the services they wish to commission from NHS providers and the places at which they wish to commission particular services. However, CCGs do not deliver services to NHS patients and do not run hospitals. Hence, once a CCG (or group of CCGs) has made a decision to go forward with a particular form of service change, the CCGs have to change the contracts with providers of NHS services to implement the changes determined by the CCG. However, CCGs cannot insist that NHS Trusts, NHS Foundation Trusts or other providers of NHS services sign contracts which change the way in which the provider[6] operates. Contracts can only be agreed if both parties consent to the terms, and so changes to the terms of an on-going service can only be delivered with changes to the terms of the contract, and that requires the consent of the Trust. A CCG which was seeking to decommission a service entirely would need to terminate an existing contract with a Trust. In all other cases, the changes can only be brought into effect once the contracts have been changed so that the CCG is commissioning services in accordance with the new arrangements for the delivery of services.

16. Changes to services are not solely matters for a commissioner. A Trust which was substantially changing the way in which it functioned would have to seek consent from Monitor to change the terms of its NHS licence in order to vary the services that it provided to NHS patients. If consent is not given, the Trust will remain under a statutory duty (pursuant to the terms of its licence) to deliver the services even though it is not commissioned by any CCG to do so and, perhaps more importantly, has no basis to charge any CCG for the provision of these services. Thus, in practice, decisions about changes to NHS

[6] The word "Trust" is used in this chapter to refer to NHS Trusts, NHS Foundation Trusts and can include other providers of NHS services. Substantially the same issues arise whether the provider is a Trust, an NSH Foundation Trust or a commercial provider of NHS services. Almost all of the caselaw concerns changes which have been proposed for services by NHS bodies and thus the word Trust is used here in a "generic" sense meaning "any provider of NHS services"

services can only be made by commissioners and providers working in partnership throughout the processes leading up to final decisions.

17. Paragraph 4.1 of the Guidance recognises this in explaining that all major service change should be led commissioners but emphasising that this is a leadership role rather a case of CCGs acting alone. It states:

> "All service change needs commissioner ownership, support and leadership (even if change is initiated by provider or other organisation). This is so any major service change aligns with commissioning intentions and plans. Where services are commissioned by two or more commissioners, it is essential that proposals align with each organisation's commissioning intentions, including estates strategies"

18. Thus, in practice, although final decisions about NHS service change will usually be made by CCGs or joint committees of multiple CCGs, successful NHS change processes can only be delivered by commissioners and providers working in partnership from an early stage. Final decisions will only come at the end of a long and complex process, which is described in the Guidance and is explained below, all of which has to be delivered co-operatively between commissioners and providers.

The roles of other public bodies (and others) within the reconfiguration process.

19. There are a large number of bodies that are involved in any successful reconfiguration process. The involvement of other bodies is, in part, a result of the complex processes set out in the Guidance and partly the result of the legislative schemes within which CCGs and NHS England are required to operate.

20. It may be helpful to summarise the roles played by different bodies before describing the processes in detail. The key players are as follows:

a. **Health and Wellbeing Boards** ("**HWBs**"). The role played by HWBs is described elsewhere[7]. The HWBs consist of CCG and local authority representatives. The HWB devises the Joint Strategic Needs Assessments ("**JSNA**") and then produces the Joint Health and Wellbeing Strategy ("**JHWBS**"). Section 116B of the Local Government and Public Involvement in Health Act 2007 (as amended by the 2012 Act) provides that, in exercising any functions including proposing service changes, both a CCG and NHS England are required to "have regard" to the JSNA and the JHWS. This is a potentially onerous duty and, in effect requires CCGs to produce service change plans which are consistent with the plans set out in the JHWS or could only depart from the terms of the JHWS if the CCGs had clear, rational reasons for doing so. This requirement is reflected in para 4.2 of the Guidance which says that CCGs should:

> "work with Health and Wellbeing (H&WB) Boards to ensure service reconfiguration proposals reflect JSNA and JHWS"

b. **NHS England and NHS Improvement**: Neither NHS England nor Monitor (now part of NHS Improvement) have any direct statutory role in approving CCG service reconfiguration plans. However, the Guidance provides that NHS England has a substantial "assurance" role and recommends that CCGs *"have early and ongoing discussions with their local NHS England team"*. There is also a practical reason why CCGs have to work co-operatively with NHS England in any change management process, namely that NHS England and NHS Improvement are key decision makers concerning the availability of NHS capital funding. Almost all reconfiguration schemes require amounts of capital to implement them. Accordingly, securing the agreement of NHS England and NHS Improvement to the plans is a key part of the planning process leading up to any final decision. NHS England makes capital investment

[7] See sub-para 7 following of the Commissioning NHS services chapter.

decisions through its Investment Committee. NHS England has set up a Service Change and Reconfiguration ("**OGSCR"**) sub-committee which the Guidance explains:

> "supports the Investment Committee to oversee the implementation and continued working of the assurance process. Membership includes (but is not limited to) Regional Directors, Clinical Director - Medical, Director of Strategic Finance, and Head of Operations, Commissioning Operations".

Thus, in practice, few reconfiguration proposals can progress unless supported by the OGSCR (on behalf of the Investment Committee). The Guidance also explains that:

> "Monitor offers independent advice to commissioners about achieving reconfiguration. The decision to request external clinical advice should follow discussions between the relevant commissioners and regional teams at the strategic sense check"

Thus these national NHS bodies should be closely involved in any major reconfiguration exercise.

c. **The affected clinicians:** The Guidance repeatedly emphasises the need for NHS Trust managers and those acting for commissioners to involve the clinicians whose practices will be affected by any proposed changes, so that there is a clear input from the clinical frontline. This does not only include doctors but all clinical staff whose roles will be affected by NHS changes, and so should include nursing, physiotherapists, radiographers and the many other clinical roles needed to make the modern NHS function.

d. **The Clinical Senate:** The creation of clinical senates was an administrative as opposed to statutory process. CCGs are not legally required to seek the views of the Clinical Senate about reconfiguration

proposals but often assume they are required to do so. The Guidance recommends CCGs to seek independent assurance of any reconfiguration proposals. As part of this process it provides:

> "Where the clinical case for change is more complex, commissioners may require an independent clinical review. This would usually be through the clinical senate, although in some cases (for example, very specialist services) it may be appropriate to obtain a review from another independent source such as a royal society or clinical networks"

e. **Local Authority Officers**: Any changes to NHS acute services will have effects on the delivery of social care services and may affect public health services. The Guidance thus stresses the importance of the involvement of key local authority officers as follows at para 4.3:

> "Directors of public health, directors of adult social services and directors of children's social services have an important role in bringing their professional perspectives where reconfigurations span health, social care and public health"

f. **Local Authority Members**: The local services authority will have a Health Overview and Scrutiny Committee ("**HOSCs**"). Proposals for substantial changes to NHS services are required to be referred to the HOSC as part of the consultation process, as described below. A HOSC that does not support the proposals is entitled to refer the proposals to the Secretary of State for final decision.

g. **The Secretary of State**: Although the Secretary of State is politically responsible for the NHS to parliament, the Secretary of State can only directly act as a decision maker on local reconfiguration proposals where a referral has been made to the Secretary of State by a HOSC. In all other cases the Secretary of State is required to accept that NHS services operate under a system of local decision making and, however much he

or she may disagree with a local decision, a CCG or group of CCGs have the right to make whatever decisions they consider most appropriate for the NHS in their area. Whilst that is the legal theory as set out in the legislation, the Secretary of State and junior ministers have substantial practical "influence" over the final shape of all politically contentious reconfiguration decisions, usually mediated through NHS England.

h. **The Independent Reconfiguration Panel**: Where a referral is made by a HOSC to the Secretary of State, the Secretary of State will usually seek a view on the wisdom of the plans from the Independent Reconfiguration Panel ("**IRP**"). The Secretary of State is not bound to follow the advice of the IRP but almost invariably does so.

The Four – or now possibly Five - Tests.

21. The Guidance sets out 4 tests which NHS England recommends should be met by any reconfiguration proposal. The relevant part of the Guidance provides:

> **"3.1 The four tests of service reconfiguration**
>
> There must be clear and early confidence that a proposal satisfies the four tests and is affordable in capital and revenue terms.
>
> The government's four tests of service reconfiguration are:
> - Strong public and patient engagement.
> - Consistency with current and prospective need for patient choice.
> - Clear, clinical evidence base.
> - Support for proposals from commissioners.
>
> The four tests are set out in the Government Mandate to NHS England. NHS England has a statutory duty to deliver the objectives in the Mandate. CCGs have a statutory duty to exercise their commissioning functions consistently with the objectives in the Mandate and to act in accordance with the requirements of relevant regulations, such as Procurement, Patient Choice and Competition Regulations and associated guidance from Monitor. (

22. There is a considerable history behind the "Four Tests" which was partially explored in *R (London Borough of Lewisham & Anor) v Secretary of State for Health & Ors* [2013] EWHC 2381 (Admin). It may be worthwhile to recount the background in order to set the present policy in its proper context. The policy position of the Labour government in office prior to 2010 was set out in Guidance issued in May 2008 called "*Changing for the Better*". The 2008 Guidance sets out various principles, principles 3 and 4 of which were:

> "3. **All change will be locally-led.** Meeting the challenge of being a universal service means the NHS must meet the different needs of everyone. Universal is not the same as uniform. Different places have different and changing needs - and local needs are best met by local solutions.
>
> 4. You will be involved. The local NHS will involve patients, carers, the public and partners. Those affected by proposed changes will have the chance to have their say and offer their contribution. NHS organisations will work openly and collaboratively"

23. Thus it was the policy of the previous government that reconfiguration decisions should be made locally by NHS Managers as opposed to being made by the Secretary of State. The Guidance provided at that:

> "The Interim Report of the NHS Next Stage Review recognised the benefit of clinical involvement when considering major service change proposals. It also set out a recommendation that any proposals to change services should, prior consultation, be subject to independent clinical and management assessments ...
>
> The Gateway Review Process is a series of short, focused, independent peer reviews carried out at key stages of a programme or project. The reviews are designed to highlight key risks and issues, which if not addressed would threaten the successful delivery of the business outcomes"

24. In 2010, the newly elected coalition government signalled a substantial change in policy. This was shown in a letter from Sir David Nicholson, the Chief

Executive of the NHS in England, to all NHS Chief Executives dated 20 May 2010 which said:

> "I am writing to let you know how we intend to take forward the Secretary of State's policy commitments on service reconfiguration. This will have an immediate impact on those of you currently undertaking consultation on service reconfiguration, and contains important information about how the system will change for any future reconfiguration plans.
>
> The Secretary of State has identified four key areas in which reconfiguration processes need to improve as plans for significant service change are developed and consulted upon.
>
> 1. support from GP commissioners will be essential;
> 2. arrangements for public and patient engagement, including local authorities, should be further strengthened;
> 3. there should be greater clarity about the clinical evidence base underpinning proposals.
> 4. that proposals should take into account the need to develop and support patient choice.
>
> Future reconfiguration proposals will be expected to meet clear standards in each of these areas, which I intend to set out in further detail during June. .... PCTs and other NHS bodies with current reconfiguration proposals will be asked to revisit their processes to date to ensure they meet these new requirements. This applies to all future reconfigurations and those that are ongoing. I expect that in many cases this will require further work to be done locally and, in consultation with the IRP, assure the Department that these standards are now being applied.
>
> Clearly the detail of these new standards will be important, but I thought I should write to you with these clear signals so that you can begin to think about how you should respond.
>
> Given the complexity and scale of the change issues in London, I have asked NHS London to make separate recommendations about how service change in the capital should be taken forward to meet these requirements"

25. The Secretary of State followed up this letter by an article in the Daily Telegraph[8] on the following day, 21 May 2010, which explained the purpose of the new policy. The article was in the name of the Secretary of State and clearly was intended to be a clear public statement of the position adopted by the new government. The beginning of the article set out the promises made by the Secretary of State as follows:

> **"The NHS must put patients first.**
> *Bureaucracy and a top-down approach have undermined the health service, writes Andrew Lansley. Patients and clinicians must be put in control.*
>
> The first duty of any health service is to serve its patients – to ensure that people do not have to fit their lives around an inflexible system, but that the system bends to fit them. It sounds like a simple aim, yet too often in recent years, the reality has been quite different.
>
> Perhaps the most frustrating example of this is the closure of local A&E and maternity units around the country – against the wishes not just of clinical staff, but also of the communities that they are there to serve. It reminds me of Bertolt Brecht's dark joke that a government which has lost the faith of its people and is contemplating reform might find it easier simply to "dissolve the people and elect another.
>
> ……
>
> As of today, I am calling a halt to the current process. I have asked Sir David Nicholson, the chief executive of the NHS, to inform the service of this immediately and to signal a complete change to the way we deal with these issues. This moratorium will provide a chance to reset every proposal, to reconsider every decision and to ensure that in each case they are consistent with the following key criteria.
>
> First, there must be clarity about the clinical evidence base underpinning the proposals. Second, they must have the support of the GP commissioners involved. Third, they must genuinely promote choice for their patients. Fourth, the process must have genuinely engaged the public, patients and local authorities.

[8] See http://www.telegraph.co.uk/health/7747870/The-NHS-must-put-patients-first.html .

> This will not merely be another tick-box exercise – it will be a tough test, which every proposal must pass if it is to proceed.
>
> More importantly, this will not be about me, as the Secretary of State, going back over these decisions. This time the power won't be at the centre, it will be at the grassroots – in the hands of the patients, the communities and the clinicians who are directly involved. The critical point is that the key criteria are met.
>
> So I am issuing a challenge to GPs to work with community leaders and their local authorities, to take the reins and steer their local services to meet the quality standards and achieve the outcomes that people expect.
>
> It is time we recognised that the real headquarters of the NHS is not on Whitehall, it's wherever there are patients, it's the doctors and nurses whom we register with at our local practice. These are the people whom we rely on and trust. They should be the ones making the decisions about the management of our services as well. That is how we will create a service that is centred on the needs and the wishes of patients.
>
> And it is only by pushing power to the front line that we will get away from the stultifying focus on inputs and processes that has dominated the healthcare debate.
>
> I've talked to staff in hundreds of hospitals, surgeries and clinics across the country and there's one thing predominant in their minds – how to improve the service and care they provide to their patients.
>
> By instituting this moratorium and putting patients and clinicians in control we are taking a first, and immediate, step towards improving outcomes and creating a less centralised, less bureaucratic, stronger NHS"

26. A revised 2010 Operating Framework for the NHS was then published on 21 June 2010. Paragraph 15 was headed "New Rules on Reconfiguration". It said:

> "These [*referring to specific reconfiguration proposals referred to earlier in the paragraph*] and any other current and future reconfiguration proposals must meet four new tests before they can proceed. These tests are designed to build confidence within the service, with patience and communities"

27. The document repeated the 4 tests set out in the newspaper article and in the letter of 20 May 2010, namely:

- support from GP commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

28. Further Guidance on the meaning of the 4 tests emerged from the then Chief Executive of the NHS, Sir David Nicholson, in a letter dated 29 July 2010. This letter said:

> "The Secretary of State has identified four key tests service change, which are designed to build confidence within the service, with patients and communities. The tests were set out in the revised Operating Framework for 2010-11 and require existing and future reconfiguration proposals to demonstrate:
>
> - support from GP commissioners;
> - strengthened public and patient engagement;
> - clarity on the clinical evidence base; and
> - consistency with current and prospective patient choice"
>
> ……
>
> "The Secretary of State has also made it very clear that GP commissioners will lead local change in the future. With that in mind, I am asking local GP commissioners, in conjunction with PCTs, to lead this process locally and assure themselves, and their SHAs, that proposals pass each of the tests"

29. The revised 2010 Operating Framework also provided:

> **"New and future reconfiguration schemes.**
>
> The four tests also apply to all future proposals for substantial service change. As GP commissioning structures develop, GP commissioners will want to take a greater role in proposing and leading future service reconfigurations. The tests should be embedded as an integral part of pre-reconfiguration discussions

> between GP commissioners, PCTs, providers, SHAs, LINks, OSCs and other relevant local stakeholders. This is illustrated in the flowchart overleaf.
>
> This means that, in future, schemes would not proceed to formal OGC and NCAT review, and then formal consultation, without a robust assessment being made first of compliance with the four tests"

30. The effect of this Guidance was considered by Silber J in the *Lewisham* case. The Judge decided that the ministerial statements constituted guidance to which those arranging NHS reconfigurations were required to "have regard". That conclusion was plainly correct given the judgment of Dyson J about the effect of NHS Ministerial Guidance in *R (Fisher) v North Derbyshire Health Authority* [1997] EWHC Admin 675 which has been approved by the Court of Appeal on repeated occasions.

31. Secondly, Silber J decided, following *Tesco Stores Limited v Dundee City Council* [2012] PTSR 983 that the meaning of the Four Tests was a matter for the courts and not a matter where the NHS (or those advising the Secretary of State) were entitled to reinterpret the policy to fit the circumstances of the individual case. In that case Lord Reed explained that a meaning of a policy *"should be interpreted objectively in accordance with the language used, read always in its proper context".* Thus if, as the Judge decided in the *Lewisham* case, the Secretary of State had misunderstood the meaning and effect of his own policy when making a decision, the Secretary of State was acting unlawfully.

32. It is important to note that this does not mean that an NHS reconfiguration will be unlawful if CCG decision makers fail to satisfy themselves that all of the 4 tests are met. CCG decision makers need properly to understand the tests and to demonstrate they have considered them. It is potentially lawful for a CCG to consider the tests, and proceed with a reconfiguration even if the CCG concludes that one or more of the tests are not satisfied, provided the CCG has good reasons for departing from the recommended policy that

all reconfigurations should comply with the 4 tests. However, decision makers will act unlawfully if they wrongly claim the tests are all satisfied when, objectively considered, one or more of the tests is not in fact met.

33. It may be helpful to consider the practical effect of the "tests" in reverse order. The final test is "*support from GP commissioners*". Some Guidance is provided on this test at page 23 of the Guidance. It states:

> **"Support for proposals from clinical commissioners test**
>
> - CCGs should assure themselves that those proposals have the support of their member practices.
> - For directly commissioned services, regional teams should ensure proposals have support of their medical directors and understand the views of CCGs on the proposed change to ensure alignment between commissioners.
> - Commissioners need to be sensitive to any actual or perceived conflicts of interest. For more information please refer too: www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid- 1214.pdf
> - Disputes should be acted upon in accordance with the CCG's dispute resolution process as set out in its Constitution. Refer to: www.england.nhs.uk/resources/resources-for-ccgs/ccg-mod-cons-framework/"

34. As per the *Lewisham* case, this will usually be interpreted to mean that the CCG which is actually commissioning the relevant services supports the proposals. It is not sufficient for a wider group of CCGs to be supportive if the key local CCG is against the reconfiguration exercise. In the normal case, the relevant CCG governing body will be the decision maker and so "support" can be assumed from the decision to proceed with the reconfiguration. However, this test will be relevant where the commissioning decision is made by a party other than the local CCG (such as where it is made by a committee

of CCGs). The reference above to proposals having the support of "member practices" probably does not mean that every single member practice needs to be supportive, but the test will probably not be met unless a majority of the practices indicate their support. Thus a set of proposals which was supported by the CCG elected governing body but which was opposed by a majority of the GP practices within the CCG (i.e. a situation where CCG elected governing body had not managed to secure the positive support of members) may well fail this test.

35. The requirement that the reconfiguration should be supported by a clear clinical evidence base is explained in the Guidance by the need for decision makers to show that they have sought independent clinical assessments concerning the proposed changes. This independent assessment can come from Monitor, NHS England, the Clinical Senate or possibly one or more of the Royal Colleges. This does not mean, of course, that the independent assessment is required to support every detail of the proposed changes or that the CCG is required to comply with every single recommendation contained within an independent report. There will be occasions when the independent assessment offers broad support but comes with caveats or makes additional assurance recommendations, which may or may not be either sensible or affordable. A view should be reached by the CCG about the overall level of support demonstrated by the assessments in determining whether they can say that there is a clear clinical evidence base to support the proposals. As long as the CCG properly understands the test, the question as to whether it decides whether it is met is a discretionary decision for the CCG (and thus can only be challenged on rationality grounds).

36. The requirement that the changes should meet the test of "*Consistency with current and prospective need for patient choice*" is perhaps the most opaquely worded of the tests. In the *Lewisham* case, there was evidence that removing consultant led maternity services from Lewisham Hospital was not

what women in Lewisham wanted. It was thus argued that this test was not met because the proposed changes were not consistent with "patient choice", since women in Lewisham wanted to choose to give birth at their local hospital. Although this was, perhaps, the original meaning of the test (for the reasons explained above), interpreting the test in this way would give a local population an effective veto over NHS changes. Whilst that is probably the natural meaning of the words of the test (adopting Lord Reed in the *Tesco Stores* case), it would mean that local campaigns against NHS changes would be placed in a very strong position (or more changes would have to happen with this test not being met but departed from for good reason).

37. The judgment given by Silber J on this argument is not wholly convincing[9] albeit it is perhaps understandable in policy terms. Silber J accepted a slight convoluted submission from the Secretary of State's counsel that the:

> " … requirement to be "*consistent with*" in this requirement cannot and does not mean "*the same as*". The Secretary of State was quite entitled to accept the view that concentrating clinical sites to drive up clinical quality so that although it inevitably reduces patient's choice, it still increases choice between high quality services.
>
> In connection with this requirement, there was the Equality and Health Impact Assessment commissioned by the TSA to understand the impact of the proposals on patient choice. It noted that the reduction of maternity facilities meant that patients would benefit from centres with a large number of consultant surgeons and multidisciplinary team and a wide choice of surgeons. In addition the midwife-led maternity unit would increase choice"

[9] The author declares an interest since he was leading counsel for the successful campaign claimants in this case, albeit the claimants were not successful on this point.

38. Thus, assuming that Silber J's interpretation is accepted by other Judges[10], it appears that the test will be met as long as the reconfiguration proposals continue to offer choices to patients, even if these are not the choices that patients wish to make based on the present footprint of services.

39. However this part of the decision was obiter and, in any event, the doctrine of precedent does not apply as the Court of Appeal did not rule on this point. It would thus be open to another Judge to depart from this interpretation to give the words of the test their natural meaning. It might be thought that Silber J's interpretation of the wording of the test makes it fairly meaningless since the ability of NHS patients to access or be referred to other NHS hospitals means that "patient choice" will be maintained (to a greater or lesser extent) in almost every case. The only case where the test is not met will be where a reduction in the locations at which specialist services are provided means that there is no effective "choice" remaining for an NHS patient with that particular condition.

40. The first test is "Strong public and patient engagement". The public engagement requirements in any major reconfiguration are considered below.

The fifth test – added assurance when in-patient beds are closed.

41. On 3 March 2017, Mr Simon Stevens, the NHS England Chief Executive announced an additional test or criterion which should be met by NHS commissioners where bed closures were proposed to the existing four general tests. This additional bed-closure-specific test was to take effect on 1 April 2017. The additional test announced on 3 March was that an NHS Body which is proposing to make changes to NHS services that will result in a reduction in in-patient beds must:

[10] This point was argued in the Court of Appeal in the case but the court decided the issue purely on the vires question and thus there was no judgment on the effect of the Four Tests.

a. demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or

b. show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; and/or

c. where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

42. The status of this new "test" was considered by Mostyn J in *R (Cherwell District Council & Ors) v Oxfordshire CCG* [2017] EWHC 3349 (Admin). The Judge decided that the new test had the same status as the other tests and that the public ought to have been consulted about their views as to whether the new test was satisfied. However, judicial review is a flexible remedy and the Judge decided that the legal flaw by the CCG in not seeking public views on the new test was not sufficiently serious to justify a finding either that the consultation was unfair. The Judge thus refused to quash the consultation despite the fact that this test was not properly the subject of public comment. This was, perhaps, a benevolent interpretation which allowed the CCG to rely on a consultation document which became inadequate during the consultation process (since the new test was announced during the consultation process). It seems doubtful that NHS bodies will be able to rely on such an approach again. Accordingly, any reconfiguration proposals that involve a reduction of in-patient beds should seek public views on the fifth test and decision makers should be carefully advised on the outcome of the

consultation responses on this area, along with the responses on the other 4 tests.

The danger of pre-determination.

43. Throughout the decision making process, CCGS need to be careful about the language they use to avoid any later claim that the CCG had a closed mind to any option other than its preferred option. At this point the CCG can only have developed proposals and should not put out any document which indicates a substantial degree of commitment by the CCG to follow any course set out in the documents. The requirements of a lawful consultation are considered in some detail below, but one of the key considerations is that consultation must take place when proposals are at a "formative stage". That means that the documents generated by the CCG must all speak of these proposals in a conditional sense and not give the impression that the CCG (or its lead officials) have made up their minds that this is the way in which service changes will be managed. If the documents suggest that there has been any "pre-determination", any subsequent consultation may well be struck down as unlawful. It is not open to a public body to make a decision to proceed with a set of service changes and then seek to "consult" the public about the proposals (because the consultation will not be held at a time when the proposals are at a formative stage): *see R (Sardar) v Watford Borough Council* [2006] EWHC 1590 (Admin).

44. The question as to what amounts to unlawful "pre-determination" was examined by the High Court *in R (Royal Brompton & Harefield NHS Foundation Trust) v Joint Committee of Primary Care Trusts & Anor* [2011] EWHC 2986 (Admin). The issue was whether the joint committee of PCTs had decided that there would only be 2 NHS centres in London providing paediatric heart surgery prior to consulting on whether there would be 2 or 3 such centres. The Judge, Mr Justice Owen, carefully looked at all the relevant material and asked himself whether it demonstrated that the joint

committee had a "closed mind" to the possibility of retaining 3 centres: see para 98. The Judge said it was:

> "… open to a consultee to take issue with the proposal for two London centres, and … to take issue with the exclusion of the RBH Trust. A fair reading of both documents does not lead to the conclusion that either issue had been pre-determined"

45. There are 3 important points to note from this judgment and the subsequent decision of the Court of Appeal in the same case (reported as *R (Royal Brompton and Harefield NHS Foundation Trust) v Joint Committee of Primary Care Trusts & Anor* [2012] EWCA Civ 472). First, the key evidence relevant to any claim of predetermination is contained within the relevant documents. This has far greater standing than witness statements produced after the event which seek to explain the mind of decision makers. The court will look at all of the contemporaneous documents to ask whether they show that the decision makers had already de facto decided to proceed with the proposals and were only going through the motions of a consultation. There is no objection to the documents promoting a "preferred option" and there is no duty to evaluate all potential options. The question is whether the documents show that the public body had moved beyond having a preferred option to having taken a *de facto* decision that these changes would be implemented, so that no other outcome was reasonably open to decision makers.

46. Secondly, proving pre-determination by a decision maker is not straightforward. The fact that there are some statements in documents which appear to show that a clear path has been set in favour of an option falls a long way short of showing that the relevant decision makers had a closed mind. The key issue is the mind of the public body. Thus showing that a junior official who prepared a report had not understood that a decision had not yet been made will not necessarily amount to a decision

that the public body had a closed mind.

47. Thirdly, the Court of Appeal made the additional point that, as long as it was open to a consultee to raise the issue that concerned them (i.e. it was not removed as a possible consultation response), the consultation process can be "self-correcting" to avoid any concern about pre-determination (see para 93). The court said at para 87:

> "One of the functions of a consultation process is to winnow out errors in the decision-maker's provisional thinking. The JCPCT owes a public law duty to reconsider matters in the light of responses"

48. Thus a challenge to a consultation process on the ground that the decision maker had a closed mind may well be met by an objection that the challenge is premature because the consultee can point this out in a consultation response and the decision maker can correct the mistake. Thus a judicial review challenge to the consultation process may be premature because the objector has an alternative way of putting things right. Nonetheless, CCGs would be well advised to ensure that committee members understand the dangers of expressing views orally at an early stage which are indicative of final decisions having been made and should go through documents carefully to ensure that they do not suggest that key decisions have already been taken.

The various stages to a reconfiguration process.

49. The Guidance does not divide the reconfiguration process into clear steps. However it describes a series of steps which should be taken in virtually all reconfiguration decision making processes and thus it is possible to outline the way in which NHS bodies are encouraged to organise their work.

Stage 1: Developing proposals.

50. The first stage is for commissioners to develop outline proposals for service change. The Guidance states at page 18:

> "Commissioners should build their proposal by identifying the range of service change options that could improve outcomes within available resources"

51. The crucial role played by the JHNA and JHWS in the statutory scheme governing the development of NHS services, the Guidance arguably goes beyond the statutory duty on CCGs to "have regard" to the JHNA and JHWS and states that "there is an expectation" of "clear alignment" with these jointly agreed documents. The full wording of the relevant part of the Guidance is as follows:

> "In light of the legal duty consider JSNA and JHWS, there is an expectation that proposals will have a clear alignment to the JSNA and JHWS. There are a number of advantages to this:
>
> - H&WB boards can bring a multi-service and professional perspective, meaning proposals can be considered holistically across the local health and care system.
> - H&WB boards must involve local diverse communities when preparing JSNAs and JHWSs.
> - Where communities have already been involved in the shape of health services in their area it provides a strong platform for more in-depth conversations on potential changes.
> - Where there is local consensus about health and care needs and priorities it creates space for conversations on what this could mean for the configuration of front line services"

52. It thus seems that, in order to act lawfully, a CCG would need to have well reasoned and clearly developed justifications for developing a set of proposed changes which departed from the plans and priorities which had been jointly agreed between CCG and local authority representatives in the JHNA and JHWS.

53. It is also essential that the proposals are consistent with the CCG's own annual commissioning plan (as required under section 14Z11 of the NHS Act). That plan requires advance public consultation and so developing proposals that contradict the annual plan (if it exists) may lead a CCG into areas of significant legal risk. Proceeding with a substantial reconfiguration without having complied with the statutory duty to have an Annual Commissioning Plan in place would place a CCG at considerable risk of legal challenge.

54. The Guidance makes the following recommendations about how a CCG should work to develop initial proposals:

"A proposal should cover:

- analysis of the full range of potential service changes that can achieve the desired improvement in quality and outcomes;
- the development of a range of options based on the above analysis;
- an assessment against legal duties and obligations including the Public Sector Equality Duty(PSED) and the duty to have regard to the need to reduce inequalities;
- dialogue that seeks to align proposals with the plans and priorities of partners;
- consideration of whether proposals represent a substantial service change (to be agreed locally);
- assessment against the four tests;
- any potential financial implications (capital spend, transactional or transitional funds, savings, core costs etc.) which may impact on the range of options taken forward;
- any outline plans which can demonstrate how each of the options would be implemented and show that there are plans to ensure that safe services are maintained in the interim;
- a privacy impact assessment identifying requirements for lawful information sharing;
- analysis of demographic and other factors likely to influence future demand for the service;
- service models and learning from elsewhere including national/international experience; and
- deliverability in estates terms (if appropriate).

Commissioners should assure themselves that they have sought a comprehensive range of perspectives for the case for change. Proposals should be discussed with TDA and Monitor where appropriate. This will be particularly important where trusts will need to access Public Dividend Capital to deliver options which may be consulted upon.

The level of planning, clinical and management input should be proportionate to the and complexity of the change being proposed scale"

55. It follows that the development of initial proposals is a far from straightforward task. Later in the Guidance (at page 20), CCGs are recommended to develop a "Pre-Consultation Business Case" ("**PCBC**") which sets out the proposals and is used for the various assurance steps that are recommended. The Guidance explains what should be in a PCBC as follows:

"Pre-consultation business case

The PCBC will vary, however they should:

- be clear about the impact in terms of outcomes;
- outline how stakeholders, patients and the public have been involved, proposed further approaches and how their views have informed options;
- outline the case for change;
- identify governance and decision making arrangements;
- be explicit about the number of people affected and the benefits to them;
- identify indicative implementation timelines;
- include an analysis of travelling times and distances;
- outline how the proposed service changes will promote equality, tackle health inequalities and demonstrate how the commissioners have met PSED;
- explain how the proposed changes impact on local government services and the response of local government;
- demonstrate how the proposals meet the four tests;
- demonstrate links to relevant JSNAs and JHWSs, and CCG and NHS England commissioning plans;
- summarise information governance issues identified by the privacy impact assessment;
- identify any clinical co-dependency issues, including any potential impact on the current or future commissioning or provision of

specialised or other services; and

- show that options are affordable, clinically viable and deliverable:

    - To inform assessment of proposals against the four tests of service change, and NHS England's best practice checks, the proposing body should develop a pre-consultation business case (PCBC). The lead commissioners will prepare the business case.
    - Demonstrate evaluation of options against a clear set of criteria.
    - Demonstrate affordability and value for money (including projections on income and expenditure and capital costs/receipts for affected bodies). Demonstrate proposals are affordable in terms of capital investment, deliverability on site, and transitional and recurrent revenue impact.

The PCBC can also form the starting point for a Strategic Outline Case (SOC) as required by TDA and Monitor for those trusts for whom they will be required to provide approval on health community schemes"

56. In most cases, the PCBC eventually evolves into the full business case to support the final shape of the proposed changes.

Public involvement at the initial stages.

57. The Guidance recommends that the PCBC explains the steps that the CCG proposes to take to discharge the duty to involve patients and the public in its decision-making processes. It states:

"The pre-consultation business case should include clear involvement plans. Involvement activity should:

- Be proactive to local populations.
- Be accessible and convenient.
- Take into account different information and communication needs.
- Consider how clinicians should be involved.

Commissioners should assure they have taken appropriate involvement for each stage of the process.

Further guidance on public participation is available in NHS England's website"

58. This Guidance appears to assume that CCGs should devise a special set of public involvement procedures for a major reconfiguration exercise. However that may be a mistaken approach. Section 14Z2 of the NHS Act requires CCGs to have a set of arrangements which define how they commit themselves to involving all of their patients and the public in their decision making. These "arrangements" ought to be a Patients and Public Involvement Policy which describes how the CCG commits itself to involving patients in all of its commissioning decisions. Thus, in devising the precise way in which the public are able to influence decisions in any proposed major reconfiguration exercise, CCGs should start by working out how to implement their existing PPI policy for the reconfiguration exercise. There may, of course, need to be supplemental steps taken to involve patients and the public in a significant reconfiguration exercise, but these should be additional to the working out of the processes set out in the PPI policy and not a substitute for following the PPI policy.

59. However, planning for public involvement later in any process cannot be used to justify excluding public involvement at the initial stages. Possibly contrary to established NHS management practice, the Guidance confirms that the public have the right to be involved in discussion around the development of proposals. The fact that there is likely to be formal public consultation later in the process is not a proper reason for developing proposals away from the public eye at the early stage. CCGs have a duty under section 14Z2 of the NHS Act to have arrangements which give the public the right to be involved:

> "(a) in the planning of the commissioning arrangements by the group,
>
> (b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

> (c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact"

60. The details of the steps that a CCG is required to take to satisfy this obligation are explained elsewhere[11] but, for present purposes, it is sufficient to note that the public must be involved from the start of anything that could be described as a reconfiguration proposal that will have an effect on how or where patients access NHS services. This is recognised in the Guidance which states at page 19:

> "Commissioners have a statutory duty to involve service users in the development of proposals It is good practice for commissioners to involve stakeholders in the early stages of building a case for change"

61. A standard practice has built up in many NHS reconfiguration exercises of retaining strict confidentiality about the early stages of the development of proposals on the grounds that NHS staff need space to develop contentious proposals internally without exposing them to public scrutiny at any early stage because either this would only confuse the public or would generate scare stories about changes which may, in the end, never be seriously considered. Whatever the attractions for NHS staff and the external consultants who support them of such an approach, this is not a legally permissible way to proceed as it is inconsistent with the obligations under section 14Z2 of the NHS Act. NHS staff are paid public servants and are using public money when discussing the future shape of public services. Parliament has decided that the public have a right to know what proposals are being discussed and developed and to have their say at all stages.

62. Having said that, "public involvement" around the development of proposals does not mean continuous "public consultation". The statutory duty is likely

[11] Please insert reference to the relevant part of the CCG chapter.

to be satisfied if information relating to the development of proposals is available to patients and the public and they have the chance to feed their views back to those who are concerned with the development of any proposals. Any feedback which comes from the public must be considered as part of the development of any proposals.

63. Part of the Guidance suggests that a degree of caution should be exercised before sharing any proposals with the public. It states at page 20:

> "If the commissioner is content the options are viable, it should then progress with undertaking an assessment of these proposals against the four tests.
>
> For each option to be shared with the public, further consideration of the financial proposal and its sustainability should be made at this stage. It is essential that only those options that are sustainable in service, economic and financial terms are offered publicly. At this early stage, before pre-consultation business case (PCBC), and again before the decision making business case (DMBC) it is helpful to take account of the requirements that individual providers' capital investment business cases will need to satisfy if they are to be able to support the formal proposals endorsed at DMBC stage"

64. There appears a measure of contradiction between this part of the Guidance and the guidance on page 13 which says:

> "It is critical that patients and the public are involved throughout the development, planning and decision making of proposals for service reconfiguration. Early involvement with the diverse communities, local Healthwatch organisations, and the local voluntary sector is essential, as well as engaging Monitor and TDA where appropriate. Early involvement will give early warning of issues likely to raise concerns in local communities and gives commissioners' time to work on the best solutions to meet those needs"

65. In resolving this contradiction, primacy should be given to the statutory duty on the CCG to involve the public in the "*development and consideration of*

proposals" for possible service changes (the wording of the statutory duty under section 14Z2(b)) and the Guidance which suggests that proposals should only be "*offered publicly*" which have already been shown to be sustainable in service, economic and financial terms. The statutory duties must take precedence over the Guidance and thus CCGs should share emerging proposals with the public as and when they are developed. However, it may be sensible to make it clear at this stage that the proposals are only in the very early stages of consideration and thus cannot be taken to amount to fully worked up proposals.

Stage 2: The initial assurance process concerning the emerging proposals.

66. NHS England's Guidance suggests that it should conduct an initial "Strategic Sense Check" to viability of the proposals. The Guidance explains:

> **"Stage 1 - Strategic sense check** This will determine the level for the next stages of assurance and decision making. Clinical senates may at this stage be asked to review a service change proposal against the appropriate key tests (clinical evidence base).
>
> 1. Takes place once the commissioner concludes they have a sufficiently robust case for change and set of emerging options, or earlier if the potential implications are far reaching.
>
> 2. Involves a formal discussion between commissioners leading the change and the relevant local office within the NHS England regional team.
>
> 3. Purpose:
>
> - Explore the case for change and the level of consensus for change.
> - Ensure a full range of options are being considered; that potential risks are identified and mitigated; and that options are feasible.
> - Ensure high level capital cost and revenue affordability implications are being properly considered.
> - Show impact on neighbouring commissioners and populations has been considered.
> - Ensure assessment against the 'four tests' is ongoing and other best practice checks are being applied proportionally.

- Agree a proportionate framework for stage two assurance based on the four tests and best practice checks
- Determine the level of assurance and decision making and whether the process is likely to require sign off from IC, the CFO or whether it rests with the relevant RD.

The level of involvement of the IC, CFO or RD will be indicated in relation to financial thresholds therefore it is important that initial financial information is available as soon as possible, particularly where there may be a call on capital, transitional or transactional funds

The strategic sense check provides the opportunity to discuss:
organisational roles (particularly relevant for multi-organisation schemes);

- the level of key stakeholder involvement and support to date, and ongoing involvement plans;
- financial and legal considerations;
- interdependencies with other commissioning plans or services, including neighbouring health economies; and
- to determine any subsequent level of independent assurance or external advice (for example from clinical senate or Health Gateway Team). For the majority of schemes, it is expected they will undergo a subsequent assurance checkpoint"

67. If a scheme is rejected by NHS England at the initial "Strategic Sense Check" stage, the CC will have significant problems in making progress with the proposals. However the Guidance states:

"For the majority of schemes, it is expected they will undergo a subsequent assurance checkpoint"

It thus appears that NHS England expects the majority of schemes to get through this initial stage.

Stage 3: External assurance.

68. The Guidance suggests that the next stage is to seek external assurance on

the proposals. The Guidance states:

> "For significant service change, it is best practice to seek the clinical senate's advice on proposals again at this stage.
>
> - Takes place in advance of any wider public involvement or formal consultation process or a decision to proceed with a particular option.
>
> - Involves assurance of the evidence provided by commissioners against the four tests and NHS England's best practice checks by a panel decided upon in the strategic sense check. It may also incorporate other external independent advice.
>
> - The purpose is to undertake formal assurance of, and minimize risk in commissioner proposals. The assurance panel will need to consider whether it was assured, partially assured or not assured against each of the agreed criteria. This would form the basis of the panel's report, along with any risks, issues or other recommendations they identified"

69. The papers seeking assurance and any responses provided by any body considering the proposals should, in principle, be publicly available documents.

Stage 4 : Initial discussions with the Health Overview and Scrutiny Committee of the local authority.

70. Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the 2013 Regulations") creates a power on a local authority to scrutinise the functioning of local NHS services. Where local government operates "two tiers" of local authorities, the HOSC is a committee of the local authority that discharges social functions, which will usually be the county council as opposed to a district council.

71. Regulation 23(1) provides:

> "A local authority may review and scrutinise any matter relating to the planning, provision and operation of the health service in its area"

Thus the HOSC has a power (but not a duty) to scrutinise any aspect of local NHS services that it is minded to look into. Following preparation of the PCBC and the obtaining of positive views from NHS England, Monitor and the Clinical Senate (or other body undertaking the external clinical assurance process), the next stage is for the CCG to approach the HOSC of the relevant local authority or local authorities (if more than one are affected by the proposals) for their views on the proposals. The Guidance provides:

> **"5.4 Discussion of formal proposal with local authorities**
>
> The purpose of this stage is to:
>
> - Ensure commissioners legislative requirements on consulting local authorities responsible for discharging health scrutiny functions are met.
>
> - Follow good practice that H&WB boards have an opportunity to feed into the development of proposals. **Health scrutiny** NHS bodies have a legal duty to consult local authority OSC.
>
> Commissioners should discuss their proposals with local stakeholders prior to any formal consultation, in particular with local OSC. The discussion ensures alignment of the case for change, avoids proposals being developed in isolation, and ensures the wider health system is considered.
>
> Although it is strongly advised that local authority scrutiny functions are involved throughout development, commissioners should hold a separate formal discussion"

72. There is a slightly difficult question for a CCG as to whether the HOSC should be formally consulted before or after public consultation. The Guidance recommends that the HOSC is consulted before the CCG goes out to public consultation but, in practice, that does not seem appropriate because the final proposals for service change may well change after public consultation. It thus seems far better for a CCG to make initial contact with the HOSC

before public consultation but only to undertake final (legal) consultation with the HOSC once public consultation has been completed and the CCG have clearly worked up proposals to put to its governing body (or other decision making body). The role of the HOSC as a legal consultee is thus considered below.

73. However, in advance of formal consultation, CCGs should work closely with relevant HOSCs to explain the emerging thinking and hopefully build a consensus in support of change.

Stage 5: Public Consultation.

74. There has, on occasion, been a degree of cynicism expressed by some NHS managers as to the utility of consulting the public before changes are made to NHS services. A traditional NHS management view could be characterized as "decide first, consult afterwards"[12]. This misunderstands both the legal duties and the practical utility of consultation. NHS services are not "free". They are paid for by the public out of their taxes and the public make a continuing commitment to support the NHS by electing politicians who pledge to support the NHS. However, the "quid pro quo" is that the public have a key say in how they health service they fund should be organized. The public also offer a "consumer perspective" on NHS services, and frequently this differs substantially from the perspective of those whose role is to supply health services. Genuine and sustained public engagement in NHS services is vital to prevent the arrangement of services being organized around "supplier interests".

75. There is a short and helpful guide from the Cabinet Office concerning consultation which is worth repeating in full. It provides:

[12] An extreme version of this approach was a senior NHS manager who, when advised to conduct a consultation exercise before closing an in-patient facility, asked the author "*why should the public tell me how to do my job*?" It is difficult to know where to start in unpicking the mindset which leads to this perspective.

"Consultation Principles 2016

1. Consultations should be clear and concise

Use plain English and avoid acronyms. Be clear what questions you are asking and limit the number of questions to those that are necessary. Make them easy to understand and easy to answer. Avoid lengthy documents when possible and consider merging those on related topics.

2. Consultations should have a purpose

Do not consult for the sake of it. Ask departmental lawyers whether you have a legal duty to consult. Take consultation responses into account when taking policy forward. Consult about policies or implementation plans when the development of the policies or plans is at a formative stage. Do not ask questions about issues on which you already have a final view.

3. Consultations should be informative

Give enough information to ensure that those consulted understand the issues and can give informed responses. Include validated assessments of the costs and benefits of the options being considered when possible; this might be required where proposals have an impact on business or the voluntary sector.

4. Consultations are only part of a process of engagement

Consider whether informal iterative consultation is appropriate, using new digital tools and open, collaborative approaches. Consultation is not just about formal documents and responses. It is an on-going process.

5. Consultations should last for a proportionate amount of time.

Judge the length of the consultation on the basis of legal advice and taking into account the nature and impact of the proposal. Consulting for too long will unnecessarily delay policy development. Consulting too quickly will not give enough time for consideration and will reduce the quality of responses.

6. Consultations should be targeted

Consider the full range of people, business and voluntary bodies affected by the policy, and whether representative groups exist. Consider targeting specific groups if appropriate. Ensure they are aware of the consultation and can access it. Consider how to tailor consultation to the needs and preferences of particular groups, such as older people, younger people or people with disabilities that may not respond to traditional consultation methods.

7. Consultations should take account of the groups being consulted

Consult stakeholders in a way that suits them. Charities may need more time to respond than businesses, for example. When the consultation spans all or part of a holiday period, consider how this may affect consultation and take appropriate mitigating action.

8. Consultations should be agreed before publication

Seek collective agreement before publishing a written consultation, particularly when consulting on new policy proposals. Consultations should be published on gov.uk.

9. Consultation should facilitate scrutiny

Publish any response on the same page on gov.uk as the original consultation, and ensure it is clear when the government has responded to the consultation. Explain the responses that have been received from consultees and how these have informed the policy. State how many responses have been received.

10. Government responses to consultations should be published in a timely fashion

Publish responses within 12 weeks of the consultation or provide an explanation why this is not possible. Where consultation concerns a statutory instrument publish responses before or at the same time as the instrument is laid, except in exceptional circumstances. Allow appropriate time between closing the consultation and implementing policy or legislation.

11. Consultation exercises should not generally be launched during local or national election periods.

If exceptional circumstances make a consultation absolutely essential (for example, for safeguarding public health), departments should seek advice from the Propriety and Ethics team in the Cabinet Office"

76. Whilst this document comes with the rider "*This document does not have legal force and is subject to statutory and other legal requirements*", but it is suggested that this rider is unnecessary. The Guidance is model of good governance and, with suitable adaptions to reflect that the consultation is by an NHS body and not central government, it entirely reflects the approach that should be taken by public bodies to a consultation exercise.

77. There is no explicit statutory duty on a CCG to conduct a formal consultation exercise before making a decision on a reconfiguration proposal. The duty on

a CCG under section 14Z2 of the NHS Act is to have Patient and Public Involvement ("**PPI**") arrangements which "involve" the public in its decision making. Consultation is one of the stated methods by which the public can be "involved" in decision making by NHS commissioners, but there are other methods apart from a formal consultation exercise, including a regular dialogue with the public under which emerging proposals and the arguments for and against them are published, with a continuing invitation for the public to respond to the material which is put into the public domain. However, the courts have long held that the "involvement" duty should be fulfilled by a pro-active consultation exercise where there are substantial or locally contentious proposals so all of the public have a say, rather than just the provision of information where IT savvy or particularly interested members of the public who tend to get involved in informal communication exercises. A pro-active consultation exercise may also be needed to discharge the CCG's duty to tackle health inequalities.

78. The meaning of the duty to "involve" the public in decision making was explored by Collins J in *R (Smith) v North Eastern Derbyshire Primary Care Trust & Anor* [2006] EWHC 1338 (Admin). This concerned the re-provision of a primary care practice where the local PCT wanted to contract with a commercial provider of GP services to deliver the GP practice services, as opposed to contracting with a more traditional GP led service. The PCT argued unsuccessfully that the involvement duty did not arise because the services to the public would be unchanged[13]. That argument was rejected by the Judge (on the then wording of the duty). Collins J appears to have been unclear what was meant by the statutory duty to "involve" patients in decision making. He said at para 4:

[13] The present PPI duty under section 14Z2 may not be engaged by such an exercise now because the duty only arises "where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them". However if the services are to be delivered at a different location or with different access arrangements, the PPI duty will be engaged.

> "Thus 'involved in' really means no more than informed and able to express a view (which adds little to 'consulted on'). What is important is that the public must know what is proposed or what changes are to take place or how the services which affect them are to be operated and must have the opportunity, at least through a representative body, to comment on such matters. Their views must be obtained"

79. The reference to "through a representative body" reflected the wording of the then PPI duty (in section 11 of the Health and Social Care Act 2001). The option to discharge the duty through an allegedly "representative body" is not in the wording of the section 14Z2 duty and thus is not a permissible option for a CCG. The duty under section 14Z2 is designed to ensure that *all* patients affected by a decision or who may be affected by a decision have the opportunity to express their views and influence decision-making. This means that it is almost certainly not open to a CCG to argue that it has fulfilled its patient involvement duty by inviting only members of a Patient Participation Group, or a representative from the local Healthwatch, for example, to (possibly confidential) meetings to discuss the proposed service change. The Guidance does not appear to recognise the significant differences between the previous section 11 duty and the section 14Z2 duty and advises that the PPI duty can be discharged through representatives. However a close reading of this wording of the PPI duty shows this to be mistaken.

80. There was a discussion in the first instance judgment in *Smith* about whether the duty to "involve" meant a duty to consult, or could be discharged by a more informal approach to involving patients. The trial Judge said:

> "It will only be necessary to undertake a more formal and wider consultation exercise if the proposals are for major changes"

81. That limited view of the circumstances where a duty to consult arose did not

commend itself to the Court of Appeal. Lord Justice May said at para 9:

> "The simple fact is that the defendants had a duty to consult and they did not properly perform it"

Thus the Court of Appeal appear to have treated "involvement" and "consultation" as being substantially the same concept. That does not appear to be correct and the remarks may well not be binding (as they are arguably *obiter dicta*) but nonetheless they carry some weight. That approach is consistent with the decision of Hodge J in *R (Morris) v Trafford Healthcare NHS Trust* [2006] EWHC 2334 (Admin) who was faced by an NHS body that tried to argue that the public involvement duty did not arise where the case for change was based on urgent patient safety issues. That argument was robustly rejected by the Judge who said:

> "The section 11 duty to consult is of high importance. The public expect to be involved in decisions by healthcare bodies, particularly when the issues involved are contentious as they clearly were with AGH. I do not accept that the need to close the wards at Altrincham General Hospital was so urgent that it was right that no public consultation should take place. There ought to have been consultation under section 11 about the closure of the wards in so important a local provision as Altrincham General Hospital. In those circumstances I regard the decision to close the wards as unlawful and will quash it"

This case also equated the duty to "involve" patients with a duty to consult patients. However, it is noteworthy that, whilst the Judge quashed the decision in that case, he did not order the services to be reinstated.

82. The Guidance makes it clear that NHS bodies which are involved in substantial reconfigurations of NHS services ought to undertake formal public consultation because it provides that public consultation should be a key part of any reconfiguration process. The question as to how a CCG can "involve" patients in lesser sets of changes, short of consultation, thus does not arise within the context of this chapter. It should, however, be treated as an area

where NHS commissioners should seek detailed legal advice in the light of the conflicting caselaw. The Guidance makes it clear that it is "good practice" for NHS bodies undertaking substantial configurations to consult the public in a formal way, stating:

> "Subject to feedback from local OSC, the proposing body may decide to progress to formal public consultation on the range of options that will be tested with staff, patients and the public, subject to assurance by NHS England.
>
> NHS England has a role in the assurance of all schemes and a role in the decision making stage for those meeting the agreed thresholds. This will ensure consistency across the NHS commissioning system and ensure that good practice and lessons learnt are shared.
>
> It is good practice that when undertaking formal consultation on a specific set of configuration options, proposing bodies have:
>
> - An effective public communication and media handling plan.
> - A detailed plan for reaching all groups who will be interested in the change, including those that are hard to reach
> - Staff involvement plans.
> - Clear, compelling and straightforward information on the range of options being tested.
>
> Schemes have struggled to build public support where they have not adequately addressed public concerns that:
>
> - The proposals are perceived to be purely financially driven.
> - Patients and their carers will need to make journeys that may reduce access.
> - Emergency services will be too far away, putting people at risk.
>
> By the time a scheme moves to formal consultation, effective involvement will have identified any potential issues or barriers from within the local population and health economy which could compromise plans. Final proposals should take into consideration these concerns and seek to address them where appropriate.
>
> Further guidance on involving the public in commissioning processes and

> decisions is available from NHS England's publication 'Transforming Participation in Health and Care' and also 'Statement of arrangements and guidance for involving the public in commissioning'"

83. It is beyond the scope of this book to provide an exhaustive explanation on the law on consultation or to explain how every reconfiguration consultation can be conducted in a lawful manner (or how a defective consultation process can be challenged). Nonetheless, as the Court of Appeal made clear in *R (Coughlan & Ors) v North & East Devon Health Authority* [1999] EWCA Civ 1871:

> " … whether or not consultation of interested parties and the public is a legal requirement, if it is embarked upon it must be carried out properly"

84. The key issue in determining whether a consultation has been carried out properly, is whether it is "fair" process. Fairness was described in *R (Moseley) v London Borough of Haringey* [2014] UKSC 56 as being a "*protean concept, not susceptible of much generalised enlargement*". That has, however, not prevented Judges ruling on numerous occasions as to whether an NHS consultation has been run fairly or not. In *Moseley* the Supreme Court decided that the "*Sedley Rules*" were a *"a prescription for fairness"* for the consultation process. These "rules" can be summarised as follows:

> "First that consultation must be at a time when proposals are still at a formative stage. Second, that the proposer must give sufficient reasons for any proposal to permit of intelligent consideration and response. Third…that adequate time must be given for consideration and response and, finally, fourth that the product of consultation must be conscientiously taken into account in finalising any statutory proposals."

77. Webster J observed in *R v Secretary of State for Social Services ex parte Association of Metropolitan Authorities* [1986] 1 WLR 1, at p 4 that:

> 'In any context the essence of consultation is the communication of a genuine invitation to give advice and a genuine receipt of that advice.'

Thus, as a minimum, NHS bodies should ensure that they both act in accordance with these principles when conducting a public consultation and have an audit trail of documents to be able to demonstrate clearly that they have conducted the consultation in accordance with these principles. It must be a genuine attempt by NHS decision makers to seek advice from the public and, once they get that advice, carefully to consider the responses and decide on a reasoned basis whether to accept or reject the advice that the public have given.

85. How much information to put in a consultation document is always a difficult judgment. In *R v Devon County Council, ex parte Baker* [1995] 1 All ER 73 Simon Brown LJ said at p91[14]:

> "… the demands of fairness are likely to be somewhat higher when an authority contemplates depriving someone of an existing benefit or advantage than when the claimant is a bare applicant for a future benefit".

Hence a greater level of detail is likely to be required to justify a proposal to remove existing NHS services than where services are being expanded.

86. The main purpose of the consultation document is enabling members of the public to know which services the CCG is proposing should be the subject of change and why the CCG is making these proposals. Over many years there has been a tendency for NHS bodies to shy away from admitting that reconfiguration decisions are primarily driven by the need to make the best use of the limited financial resources available to the NHS. In contrast, the courts have long accepted that NHS funds are limited and that NHS decision makers have to make choices between what services to support and which they should not support. The *locus classicus* of this is Lord Bingham's oft-quoted words in *R v Cambridge Health Authority, ex parte B [1995] 1 WLR*

[14] An observation that was quoted by Lord Reed with approval in *Moseley*.

898 at 906 where the Judge said:

> "It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet… Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients."

87. The author has seen numerous consultation documents which suggest that the proposed service changes are being driven solely by a commitment to improving outcomes for patients, when the internal NHS documents show that saving money is the driving force behind the plans. NHS bodies who misrepresent the justifications for plans for service change run very serious legal risks because it could be argued that the second Sedley principle has been breached. This requires a public body to put forward "sufficient reasons for any proposal" to allow an intelligent response by the public. However, a key part of that duty involves being honest with the public about the reasons for the proposed changes. The paradox here is that CCGs who pretend that they are only making changes to improve patient outcomes and not (also) to save money (or make the best use of limited NHS resources are unlikely to persuade the public that this is true (and it is usually not wholly true). The public tend to assume that all service change is "cuts" by any other name. They will thus assume that money is at the heart of NHS service change plans, and are very unlikely to accept any other explanation. There are, of course, reconfigurations where the delivery of the service will cost more than the current costs of delivering the service, but are justified by the need to recruit and retain appropriate staff and/or to improve clinical outcomes. Where this is the case, a CCG can overcome public scepticism by setting out the financial implications of the change plans in the document and hence explaining very carefully and clearly that the objective is not to save the NHS money. However, even then, the public may take some convincing.

88. One of the most difficult questions for any NHS consultation is what options to put forward for public consultation. The cases suggest three key principles should be adopted by those making these decisions. First, NHS bodies should seek the views of the public about any clinically and financially sustainable options. Refusing to set out the arguments for or against a particular option in a consultation exercise merely because the CCG prefers a different option could well give rise to a complaint that the consultation was unfair because, instead of genuinely seeking the views of the public on options, it was used by the CCG an attempt to persuade the public of the acceptability of a single option.

89. Secondly, the consultation document should expressly make it clear that the CCG remains open to consultees devising their own options and putting them forward as part of the consultation, and that if they do so additional options will form part of the post-consultation analysis.

90. Thirdly, there is no duty to eek public views on options that the CCG honestly and reasonably believes cannot be delivered either because they are too expensive or because they cannot be staffed or for other justifiable reasons.

91. It is legally acceptable for a consultation document to advance a "preferred option" for change and, if the CCG has formed a clear view on which option is preferable, there is an argument that the public are entitled to know which option has emerged as the CCG's preferred option in the work undertaken prior to formal public consultation. In *R v Hillingdon Health Authority ex parte Goodwin* [1984] ICR 800 at page 809 Woolf J said:

> "Whenever there has to be consultation, there has to be an indication of what there is to be consultation about; and, although an authority must enter into the consultation without a closed mind, it seems to me that there is nothing objectionable in the authority having decided on a course it would seek to adopt, if after consultation it decided that that is the proper course to adopt."

92. A CCG is likely to have taken considerable steps to analyse the options before public consultation and sought external assurance about its plans. It thus ought to have a clear body of evidence upon which to rely in making the case in favour of its preferred option. This needs to be explained in the consultation document, along with the reasons that other options did not attract provisional support, whether or not the public is invited to express their views about alternative options. However, a CCG is not obliged to put all of the technical information available to it in the public domain as part of the consultation document (although it may need to make this information available in response to requests under the Freedom of Information Act 2000). It also may not have complete answers to all of the questions likely to be raised by the public or relevant to a service change programme, and will act lawfully by properly putting such information that it does have in the public domain. This issue was explored in *R (Copson) v Dorset Healthcare University NHS Foundation Trust* [2013] EWHC 732 (Admin) where a challenge to a proposed closure of an in-patient mental health unit (with a transfer to home based services) was partly based on a failure of the Trust to explain how patients who still needed in-patient treatment would travel to get it. The Trust accepted that this would be an issue for a minority of patients and, in effect, said it was working on solutions. That was not held to be unlawful. HHJ Keyser QC said at para 51(9):

> "It was for the defendant to judge what information to disclose for the purposes of the consultation and that judgement had to be exercised with regard to the factors that were liable to affect the ultimate decision on the proposals and to the purpose of the consultation. In that regard, the decision was a practical one; the edge of the consultation might as well be dulled by a surfeit as by a lack of information. I hold that the manner in which the defendant approached the consultation was well within the scope of its discretion, and I reject the contention that the consultation was so unfair that it was unlawful"

93. Thus the CCG will have a considerable area of discretion to decide what level

of information to put into the consultation document (and associated documents) and will only act unlawfully if a paucity of information makes the consultation exercise unfair.

94. There will be occasions where such so much consultative work has been undertaken with stakeholders (including the public) prior to public consultation that there is, in the view of the NHS commissioner, only one realistic option. That raises the question as to whether it is lawful for an NHS body to seek views on only one option, whilst still indicating that it remains open to consultees putting forward other options in response to the consultation process. That was the situation in *R. v (Kidderminster and District Community Health Council) v Worcestershire Health Authority*[1999] EWCA Civ 1525. The argument that there was anything unlawful in consulting on one option was firmly rejected by the Court of Appeal. Simon Brown LJ said:

> "If, as is clearly established (and is, in any event, only plain common sense) an authority can go out to consultation upon its preferred option, per O'Connor LJ, or with regard to "a course it would seek to adopt if after consultation it had decided that that is the proper course to adopt" per Woolf J, then it seems to me plain that it can choose not to consult upon the less preferred options. It does not, in other words, have to consult on all possible options merely because at some point they were developed, crystallised, canvassed and considered"

95. However, following *Moseley*, there can be risks in not consulting on other options because it gives the impression that the CCG is only considering a single option and so has, in effect, already made up its mind. As a minimum, the CCG needs to make it very clear that it is open to other proposals or to the possibility of rethinking the whole reconfiguration exercise.

The consultation process.

96. The NHS England Statutory Guidance "*Patient and public participation in commissioning health and care: Statutory guidance for clinical*

commissioning groups and NHS England[15]" outlines a wide variety of ways in which patients can become involved in consultation exercises. A CCG will want to publish a "consultation document" which explains the proposals, the options under consideration and the reasons why the CCG proposes to make changes to local NHS services. That document will seek views from the public and may well ask specific questions to help guide the decision making process. CCGs should resist the temptation to frame closed questions in a way that points to their preferred outcome. Open questions which give the public the chance to express their views are far better guides to the public mood.

97. Respondents should be offered a wide variety of ways to make their views known, including electronic and "paper and ink" responses. Many CCGs hold meetings as which those who are promoting the proposals have the chance to explain the details and to answer questions. These should be properly minuted and reported faithfully, whatever the level of opposition expressed to the CCG plans. Such meetings need careful handing where there are sensitive or controversial proposals, but they can be an important opportunity for NHS decision makers to understand the public views.

98. The duty to tackle health inequalities is particularly relevant here because it requires a CCG to consider how to ensure that voices of those who are rarely heard are listened to within the consultation exercise. If, for example, the proposals affect mental health patients, children or the elderly, the design of the consultation process will have to ensure that these voices are heard. There are also groups of patients such as travellers or those living in nursing homes who, for different reasons, may not make their voices heard unless arrangements are made to seek out their views. The duty to tackle health inequalities may not be discharged if insufficient attention is paid to the

[15] See https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf

needs of under-represented groups.

The length of the consultation process.

99. Former Cabinet Office guidance recommended a period of 13 weeks for consultation. There is now no set length for a consultation exercise. Longer than 13 weeks will rarely be necessary but it is good practice to avoid large parts of a consultation period covering public holiday periods (namely Christmas, Easter and August) or to extend the consultation to take account of those who are away. For example this is particularly relevant if the proposals are for changes to services which are used by transient or seasonal populations such as students. In practice, 4 weeks is probably the shortest period for any serious consultation exercise and there will rarely be a need to to conduct a consultation that is longer than 13 weeks. The choice between those periods is a matter for the discretionary judgement of the body holding the consultation.

Changes to the plan – when is there a need to conduct further consultation?

100. As proposals develop, so it is perhaps inevitable that changes will be made to the final details of changes to NHS services. Thus a CCG can find itself consulting on one set of proposals but find that, by the time of the final decision, the final shape of the proposals is somewhat different to the proposals set out in the consultation document. Part of the reason for change can, of course, be a desire to accommodate the views of the public as expressed during the consultation process. However, there may be a myriad of other reasons which mean that the CCG comes to the view that the original proposed model is no longer the most appropriate way to deliver local NHS services. This can lead to complaints that the final model for services has never been the subject of public consultation.

101. The question as to when an NHS body has a duty to conduct a further public consultation exercise was considered in *R (Smith) v East Kent Hospital NHS*

Trust & Anor [2002] EWHC 2640 (Admin). In that case, Silber J considered a number of previous cases which had wrestled with the extent of the duty of a public body to conduct a further round of consultation. He finally settled on a "fundamental difference" test, saying at para 45:

> "In determining whether there should be further re-consultation, a proper balance has to be struck between the strong obligation to consult on the part of the health authority and the need for decisions to be taken that affect the running of the Health Service. This means that there should only be re-consultation if there is a fundamental difference between the proposals consulted on and those which the consulting party subsequently wishes to adopt"

102. In that case, the NHS body consulted on 4 options and then implemented a 5th option which had elements from various of the options. That was not fundamentally different and hence the duty to re-consult did not emerge. However different considerations may arise if the factor which causes the changes is not a response to consultation but an entirely new or independent factor. This was the subject of the following observations from Lord Justice Sullivan in *R (Stirling) v London Borough of Haringey* [2013] EWCA Civ 116.

> "23. …. we heard submissions on the relevance of the Smith case, and I think it appropriate to express my view on the applicability "fundamental change" test in the context of the present case. While I do not doubt the correctness of Silber J's decision in Smith, I do not consider that it is of assistance in this case. As Underhill J pointed out, Silber J was dealing with a case where four options were consulted upon, and having considered the consultees' responses, the decision maker decided to proceed with a fifth option which incorporated elements from the other options. Underhill J rightly identified the distinction between those cases where, following consultation the decision maker decides to adopt a new proposal, and cases, such as the present case, where a new factor emerges during the course of a consultation
>
> 24. In the latter type of case, I am not persuaded that the "fundamental change" test is appropriate. Mr. Wise accepted that there would often be a "moving target", and a decision maker was not obliged to draw each and every change of circumstance during what might be a lengthy consultation process to the attention of consultees. It is easy to postulate the test – that

> the new factor must be of such significance that, in all the circumstances, fairness demands that it must (not may) be drawn to the attention of consultees; it is much more difficult to decide what fairness demands in any particular set of circumstances. A holistic approach should be adopted, all relevant factors should be considered, and these may include, in addition to the nature and significance of the new material, such matters as the extent to which the new material is in the public domain, thereby affording consultees the opportunity to comment upon its relevance to the proposal the subject of the consultation, and the practical implications, including cost and delay, of further consultation"

103. Thus the real issue is not whether there is a fundamental difference between the original proposals and those implemented in the light of the new factors, but whether fairness requires a period of further consultation. This approach seems consistent with the approach taken by the Supreme Court in the same case, which was known as *Moseley* albeit that the Supreme Court reached a different final decision on the lawfulness of the consultation under challenge in that case.

104. In practice, if new factors which could affect the commissioning decision to any substantial extent arise during a consultation, CCGs would be well advised to publicise them and expressly seek public views on the new factors, and if necessary extend the period of formal consultation to allow for additional responses. This should ensure that the "fairness" of the consultation is maintained. It will be rarely necessary to commence an entirely fresh consultation process.

Stage 6: Assessing the results of public consultation.

105. The duty on a public body undertaking consultation must ensure that the product of consultation must be conscientiously taken into account in finalising any proposals. There is no right or wrong way to assess the outcome of a consultation because the assessment process depends on the facts of an individual process. However the following pointers may assist CCG staff who are preparing a response for decision makers:

a. If the consultation paper asked the public a series of questions, decision makers should be provided with an analysis of the responses provided by the public;

b. Qualitative comments in response to the consultation should be provided as well as quantitative. These should be selected (there is no need to report all comments) but a balanced selection of the representative and the perceptive should be provided;

c. If there is a very strong public expression of support or opposition to proposals, this should be carefully explained along with the reasons for the expression of views;

d. If alternative models for the provision of services are advanced by the public (or pressure groups on behalf of the pubic), these should be reported together with any analysis that has been conducted of the viability and preferability of this alternative model;

e. Particular attention should be paid to the views and perspectives of those patients or patient groups who are directly affected by the service changes, "hard to reach" or suffer from significant health inequalities.

106. However one of the significant problems that NHS bodies often find is that the pubic express very strong views in favour of the existing pattern of services, but do so without engaging with the reasons that a CCG is advancing a case for change. Hence, for example, there may be strong support for retaining a "full" A & E service at a small hospital when this cannot be staffed in a sustainable manner and is delivering outcomes which are below those possible at a larger unit. The report of the consultation responses must faithfully report this expression of opinion and it is a factor which the CCG

has to take into account when making the final decision. However decision makers are also required by law to discharge their functions in an effective and efficient way. Hence they may well lawfully conclude that delivering services in accordance with the strongly expressed opinions of the public is not possible. Nonetheless, decision makers need to ask themselves how far they can accommodate the strong views of the public, consistent with their overriding legal duties. There will however be occasions where a CCG is faced with a "binary" decision. If, for example, full A & E services are currently provided at 2 hospitals and the CCG's assessment is that continuing to deliver services at both hospitals is not clinically sustainable, decision makers can be put in a position where there is no viable middle ground. One set of supporters will have their views supported and the other set will be bitterly disappointed.

107. However, as the Court emphasised in *Copson*, a consultation process does not turn those consulted into decision makers. Their views have to influence the final decision makers but this process is not a plebiscite. Hence there is nothing inherently unlawful in a CCG preferring a minority view or indeed adopting a decision which has little, if any support, provided the decision makers have genuinely and carefully considered the views expressed by the public as part of the consultation process.

Stage 7: Preparing the Decision Making Business Case.

108. Once the results of consultation have been carefully considered, CCG staff should move to the preparation of final proposals for the CCG Board, as set out in a Decision Making Business Case (**"DMBC**"). The Guidance explains the process as follows:

> "The commissioners' decision is to be based on the best balance of clinical evidence and evidence gained through public support and consultation. A clear audit trail to evidence how the decision was reached, and the considerations taken, is to be captured. If capital requests to TDA or Monitor are likely to be made, these discussions should have occurred well before the pre-consultation

business case and should be refreshed well before the production of the decision making business case (DBMC).

Before individual organisations incur major cost on health community schemes, they should ensure that they have agreed with NHS England, TDA and/or Monitor (as the case may be) how the requirement for demonstrating at Strategic Outline Case (SOC) level of confidence will be satisfied; with what formality; and that they have a reasonable indication that a source of funding will be available for the scheme. Until approval for the SOC is in place organisations - particularly NHS trusts - should not incur material costs progressing to the next formal stages of the scheme (OBCs and FBCs).

109. The DMBC is essential to support any application for capital funding and thus, in practice, is a key document for both internal and external consumption.

Stage 8: Formal consultation with the Local Authority Health Overview and Scrutiny Committee ("HOSC")

110. The role of the local authority HOSC has been introduced above. Regulation 23 of the 2013 Regulations explains the procedures which have to be followed if a CCG is proposing any "substantial development" to local NHS services. It provides:

> **23.**—(1) Subject to paragraphs (2) and (12) and regulation 24, where a responsible person ("R") has under consideration any proposal for a substantial development of the health service in the area of a local authority ("the authority"), or for a substantial variation in the provision of such service, R must—
>
> (a) consult the authority;
>
> (b) when consulting, provide the authority with—
>
> (i) the proposed date by which R intends to make a decision as to whether to proceed with the proposal; and
>
> (ii) the date by which R requires the authority to provide any comments under paragraph (4);
>
> (c) inform the authority of any change to the dates provided under paragraph (b); and

(d) publish those dates, including any change to those dates.

(2) Paragraph (1) does not apply to any proposals on which R is satisfied that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff.

(3) In a case such as is referred to in paragraph (2), R must notify the authority immediately of the decision taken and the reason why no consultation has taken place.

(4) Subject to regulation 30(5) (joint committees) and any directions under regulation 32 (directions as to arrangements for discharge of health scrutiny functions), the authority may make comments on the proposal consulted on by the date or changed date provided by R under paragraph (1)(b)(ii) or (c).

(5) Where the authority's comments under paragraph (4) include a recommendation to R and R disagrees with that recommendation—

(a) R must notify the authority of the disagreement;

(b) R and the authority must take such steps as are reasonably practicable to try to reach agreement in relation to the subject of the recommendation; and

(c) in a case where the duties of R under this regulation are being discharged by the responsible commissioner pursuant to paragraph (12), the authority and the responsible commissioner must involve R in the steps specified in sub-paragraph (b).

(6) This paragraph applies where—

(a) the authority has not exercised the power in paragraph (4); or

(b) the authority's comments under paragraph (4) do not include a recommendation.

(7) Where paragraph (6) applies, the authority must inform R of—

(a) its decision as to whether to exercise its power under paragraph (9) and, if applicable, the date by which it proposes to exercise that power; or

(b) the date by which it proposes to make a decision as to whether to exercise that power.

(8) Where the authority has informed R of a date under paragraph (7)(b), the authority must, by that date, make the decision referred to in that paragraph and inform R of that decision.

(9) Subject to paragraph (10), the authority may report to the Secretary of State in writing where—

(a) the authority is not satisfied that consultation on any proposal referred to in paragraph (1) has been adequate in relation to content or time allowed;

(b) in a case where paragraph (2) applies, the authority is not satisfied that the reasons given by R are adequate; or

(c) the authority considers that the proposal would not be in the interests of the health service in its area.

(10) The authority may not make a report under paragraph (9)—

(a) in a case falling within paragraph (5), unless the authority is satisfied that—

(i) the steps specified in paragraph (5)(a) to (c) have been taken, but agreement has not been reached in relation to the subject of the recommendation within a reasonable period of time;

(ii) R has failed to comply with its duty under paragraph (5)(b) within a reasonable period of time; or

(b) in a case to which paragraph (6) applies, unless the authority has complied with the duty in paragraph (7) and, where applicable, paragraph (8).

(11) A report made under paragraph (9) must include—

(a) an explanation of the proposal to which the report relates;

(b) in the case of a report under paragraph (9)(a) or (b), the reasons why the authority is not satisfied of the matters set out in paragraph (9)(a) or (b);

(c) in the case of a report under paragraph (9)(c), a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area of the authority;

(d) an explanation of any steps the authority has taken to try to reach agreement with R in relation to the proposal or the matters set out in paragraph (9)(a) or (b);

(e) in a case falling within paragraph (10), evidence to demonstrate that the authority has complied with the applicable condition in that paragraph;

(f) an explanation of the reasons for the making of the report; and

(g) any evidence in support of those reasons.

(12) In a case where R is a service provider and the proposal relates to services which a clinical commissioning group or the Board is responsible for arranging the provision of—

(a) the functions of R under this regulation must be discharged by the responsible commissioner on behalf of R; and

(b) references to R in this regulation (other than in paragraph (5)(c)) are to be treated as references to the responsible commissioner.

(13) Where the functions of R under this regulation fall to be discharged by more than one body under paragraph (12)(a), the duties of those bodies under that paragraph may be discharged by those bodies jointly or by one or more of those bodies on behalf of those bodies.

(14) In this regulation—

"service provider" means an NHS trust, an NHS foundation trust or a relevant health service provider;

"the responsible commissioner" means the clinical commissioning group or groups or the Board, as the case may be, responsible for arranging the provision of the services to which the proposal relates.

What is a "substantial development of the health service in the area of a local authority"?

111. The duty on a CCG to consult the HOSC arises where the CCG is considering any "substantial development of the health service in the area of a local authority". There is no definition of "substantial development" in the Regulations. However, the Guidance published by the Secretary of State in 2003[16] gave the following explanation as to what is meant by these words:

> "**10.6 Understanding 'substantial variation and substantial development'**
> 10.6.1 The Regulations for overview and scrutiny do not define 'substantial'. Local NHS bodies should aim to reach a local understanding or definition with their overview and scrutiny committee(s). This should be informed by discussions with other key stakeholders including patients' forums.
>
> 10.6.2 In considering whether the proposal is substantial, NHS bodies, committees and stakeholders should consider generally the impact of the change upon patients, carers and the public who use or have the potential to use a service.
>
> 10.6.3 More specifically they should take into account:
>
> a) **changes in accessibility of services**, for example both reductions and increases on a particular site or changes in opening times for a particular clinic. Communities attach considerable importance to the local provision of services, and local accessibility can be a key factor in improving population health, especially for disadvantaged and minority groups. At the same time, development in medical practice and in the effective organisation of health care services may call for reorganisation including relocation of services. Thus there should be discussion of any proposal which involves the withdrawal of in-patient, day patient or

[16] See "Overview and Scrutiny of Health – Guidance: July 2003"

diagnostic facilities for one or more speciality from the same location;

b) **impact of proposal on the wider community** and other services, including economic impact, transport, regeneration;

c) **patients affected**, changes may affect the whole population (such as changes to accident and emergency), or a small group (patients accessing a specialised service). If change affects a small group it may still be regarded as substantial, particularly if patients need to continue accessing that service for many years (for example, renal services). There should be an informed discussion about whether this is the case and which level of impact is considered substantial;

d) **methods of service delivery**, altering the way a service is delivered may be a substantial change – for example moving a particular service into community settings rather than being entirely hospital-based. The views of patients and patients' forums will be essential in such cases"

112. Further Guidance was published in 2014, namely "Guidance to support Local Authorities and their partners to deliver effective health scrutiny" ("**the 2014 Guidance**") although it does not offer any views on what is meant by the term "substantial development". It thus seems that the best guide to the meaning of this term remains in the 2003 Guidance.

When does the CCG not have to refer a reconfiguration to the HOSC?

113. The 2014 Guidance explains the provisions in the Regulations about when consultation is not required. It states:

"The Regulations set out certain proposals on which consultation with health scrutiny is *not* required. These are:

• Where the relevant NHS body or health service commissioner 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 or health service provider 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 or vary the constitution of a CCG or establish or dissolve an NHS trust, unless the proposal involves a substantial development or variation.

- Where proposals are part of a trusts special administrator's report or draft report (i.e. 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"

114. However, as explained below, the HOSC has the power to refer a proposal to the Secretary of State if it was not consulted but considers that it ought to have been consulted.

When can a referral be made by the HOSC to the Secretary of State?

115. Where the HOSC is satisfied that there has been adequate information as part of the consultation and adequate time for the consultation, the primary test for the HOSC is whether:

> "the authority considers that the proposal would not be in the interests of the health service in its area" [see Regulation 23(9)(c)]

116. Where the HOSC and the CCG disagree on the proposed changes, the regulation sets up a process under which the HOSC and the CCGs are required to attempt to resolve their differences. Regulation 23(5) provides that the HOSC and the CCG:

> "… must take such steps as are reasonably practicable to try to reach agreement in relation to the subject of the recommendation"

117. There will, however, be occasions on which the CCG and the HOSC cannot agree on the final shape of a proposed NHS reconfiguration. If this point is reached, or if the HOSC is dissatisfied with the quality of the consultation exercise undertaken by the CCG or objects to the fact that there has been consultation, the HOSC has the power to refer the matter to the Secretary of State. The 2014 Guidance explains when an HOSC can and cannot refer a case to the Secretary of State. It states:

> "4.7.4 The circumstances for referral of a proposed substantial development or variation remain the same as in previous legislation. That is, where a health scrutiny body has been consulted by a relevant NHS body or health service provider on a proposed substantial development or variation, it may report to the Secretary of State in writing if:
>
> - It is not satisfied that sufficient time has been allowed for consultation.
> - It considers that the proposal would not be in the interests of the health service in its area.
> - It has *not* been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate.
>
> 4.7.5 However, there are certain limits on the circumstances in which a health scrutiny bodies may refer a proposal to the Secretary of State.
> In particular, where a health scrutiny body has made a recommendation and the relevant NHS body or health service provider has disagreed with the recommendation, the health scrutiny body may not refer a proposal unless:
>
> - it is satisfied that reasonably practicable steps have been taken to try to reach agreement (with steps taken to involve the provider where NHS England or a CCG is acting on the provider's behalf) but agreement has not been reached within a reasonable time; or
> - it is satisfied that the relevant NHS body or health service provider has failed to take reasonably practicable steps to try to reach agreement within a reasonable period.

In a case where a health scrutiny body has not commented on the proposal or has commented without making a recommendation, the health scrutiny body may not refer a proposal unless:

- It has informed the relevant NHS body or health service provider of-
  - its decision as to whether to exercise its power of referral and, if applicable, the date by which it proposed to exercise that power, or
  - the date by which it proposes to make a decision as to whether to exercise its power of referral.

- In a situation where it informed the relevant NHS body or health service provider of the date by which it proposed to decide whether to exercise the power of referral, it has made that decision by that date and informed the body or provider of the decision"

118. However, para 4.1.2 the 2014 Guidance explains more of the government's thinking about the way in which referral powers should be used. It observes:

> "The backdrop to consultation on substantial reconfiguration proposals is itself changing. The ideal situation is that proposals for change 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 representation of service users and the public on health and wellbeing boards and through the boards' own public engagement strategies. With 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"

119. The Guidance thus emphasises that formal consultation under the 2013 Regulations should be the last stage in an on-going dialogue between the NHS commissioners and the local authority about the future shape of NHS

services in the area of the local authority (as well as on-going dialogue with patients and the public).

120. The HOSC is not obliged to refer the matter to the Secretary of State, even if the test is met. It could properly decide not to make a referral. However the political reality is usually that, where there is a fundamental disagreement between the HOSC and the CCG over, for example, the relocation of an A & E unit or a reduction from a consultant-led maternity service to a nurse-led service, the depth of local feeling means the HOSC has little choice but to refer a matter to the Secretary of State.

The report which must accompany a referral to the Secretary of State.

121. Where the HOSC decides that it wishes to refer a proposed reconfiguration to the Secretary of State, the HOSC has to prepare a detailed report to explain the basis of the referral. Regulation 23(11) requires the HOSC to provide the Secretary of State with a report covering the following areas:

- an explanation of the proposal to make substantial changes to the local NHS services;;
- if the referral is made because the HOSC is dissatisfied with the quality of the consultation exercise undertaken by the CCG or objects to the fact that there has been consulation, the report needs to set out why the authority is not satisfied with the actions of the CCG;
- if the referral is made because the HOSC considers that the proposal would not be in the interests of the health service in its area, the report needs to include a summary of the evidence considered, including any evidence of the effect or potential effect

of the proposal on the sustainability or otherwise of the health service in the area of the authority;

- The HOSC must provide an explanation of any steps the authority has taken to try to reach agreement with the CCG and that it is not barred from being able to report because of the conditions in 23(10) (namely that it did try to reach agreement but failed to do so within a reasonable time or the CCG failed to attempt to reach agreement and that it did follow the processes to try to reach agreement before the referral was made);

- The report must set out an explanation of the reasons for the making of the report any evidence in support of those reasons.

The powers of the Secretary of State when an HOSC referral is made.

122. Regulation 25 of the 2013 Regulations provides the powers for the Secretary of State to act as decision maker when an HOSC referral is made. It provides:

> "25.—(1) Where a local authority has reported to the Secretary of State under regulation 23(9) in relation to a proposal, the Secretary of State may—
>
> (a) in the case of a referral under regulation 23(9)(a) or (b), make a decision in relation to the subject matter of the referral;
>
> (b) in the case of a referral under regulation 23(9)(c), make a final decision on the proposal; and
>
> (c) in the case of a referral under regulation 23(9), give directions to the Board, including directions as to the exercise of its power under paragraph (2), in relation to the proposal.
>
> (2) Where a local authority has reported to the Secretary of State under regulation 23(9) in relation to a proposal, and the Secretary of State has made a decision pursuant to paragraph (1)(a) or (b), the Board may, subject to any directions under paragraph (1)(c), give directions to a clinical commissioning group in relation to the proposal.

(3) The powers conferred by paragraphs (1)(c) and (2) include powers to require the person to whom the direction is given—

(a) to consult (or consult further) with the authority in relation to the proposal;

(b) to determine the matter in a particular way;

(c) to take, or not to take, any other steps in relation to the matter"

123. The Secretary of State thus has wide decision making powers concerning the proposals referred to him by the HOSC. It has been the established practice of successive Secretaries of State to refer contentious reconfigurations to the Independent Reconfiguration Panel ("**IRP**") for an independent assessment of the proposals and for advice as to what decision to make on the referral. This has the distinct advantage for the Secretary of State of "de-politicising" a decision, particularly where the issues have become of local political interest (as will often be the case). The IRP publishes reports of its findings in the form of reports[17]. These explain the way that the IRP has assessed the robustness of the cases.

The interim position where a referral is made.

124. There is nothing in the 2013 Regulations which governs the management of the interim position. There have been occasions on an NHS commissioner has, in effect, taken a final decision and implemented the changes before the Secretary of State has reached a final decision, accepting that this process may have to be reversed if the Secretary of State reaches a decision that is adverse to the NHS commissioner. However, the usual position is that the CCG seeks to maintain the status quo pending the decision of the Secretary of State. This often occurs because NHS England is unlikely to agree to release

[17] See https://www.gov.uk/government/publications?departments%5B%5D=independent-reconfiguration-panel&page=1

capital to finance change programmes until there is clarity about the way forward.

125. Nonetheless, there does not seem to be any basis to suggest that a CCG is deprived of its decision making powers in the interim period merely because a referral has been made to the Secretary of State. However if the Secretary of State were to uphold the complaint, the CCG would be obliged to act in accordance with the Secretary of State's decision.

Stage 9: Final decision making.

126. Having gone through all of the above processes, the last stage of decision making is for the CCG Governing Body, or often a committee of multiple CCGs, to meet to consider all of the relevant material and to make the final decision concerning any proposed reconfiguration. The papers for this final meeting should carefully consider all of the factors set out in the Guidance, as described above. Board members should be provided with:

- A clear explanation of the decision that the CCG is invited to make, including its financial implications, the benefits for patients and staff implications.
- The CCG's assessment of the Five Tests
- A detailed explanation of the outcome of public consultation
- Details of any capital requirements of the scheme and the proposed source of the capital
- Views expressed in support or against the proposal by the HOSC, local councillors or Members of Parliament
- Views expressed in support or against the proposal by NHS England and Monitor (NHS Improvement)

- How the CCG has satisfied itself that it has discharged each of its procedural duties regarding the said proposal[18], and in particular how the proposals will discharge the CCG duty to tackle health inequalities.

127. The meeting should be held in public and a detailed note should be taken of the discussions, recording any views in favour or against the proposals. It is important that there is a clear vote of members of the decision making body in favour or against the proposals. The minutes need to record clearly what decision has been reached

128. Particular attention should be paid to the management of any conflicts of interest which might arise for members of the body which has been charged with making the final decision[19].

Stage 10: Implementation of the decision.

129. Whilst making a decision to change NHS services may appear complex, these difficulties can seem small in comparison to the challenges of implementing a decision to change the way that NHS services are delivered. This should be an NHS management process rather than a legal process, but it is often a protracted and complex process which is far more expensive than originally anticipated. Legal issues can arise where the proposed decision turns out to be difficult (if not impossible to implement) and thus the final model and involve substantial changes from that originally anticipated. In such a case the CCG needs to monitor the position carefully to ensure that it services on the ground reflect decisions made by the governing body, and that there is no breach of the continuing duty to involve the public in commissioning decisions.

[18] These are described in detail in the chapter on the duties of a CCG. Like duties are imposed on NHS England.
[19] For details of the law on managing conflicts of interest, please see XXX XXX.

130. Prior to implementing a decision by making changes to contracts, the CCG also needs to satisfy itself that it has satisfied any procurement obligations that arise as a result of the proposed changed to the contractual arrangements.

[Ends]