

Reconfiguration of NHS Services: The framework for decision making

1. There are few topics which get local communities energised as much as changes to local NHS services – or hospital services in particular. There are few marches through the town centre to object to the closure of a mental health unit or a Stop Smoking Service. But, any threat to a town’s Accident and Emergency or maternity service means people will be out in their thousands with banners and – these days – an active social media campaign. Despite the risks, NHS commissioners are proposing making radical and deeply unpopular changes to local NHS services.

2. So what is driving changes to NHS services? Each proposed service change has its own particular facts but there are a series of common themes which run through most – if not all – NHS service changes. These are:
 - a. **A lack of money.** The NHS does not have enough money to fund all the establishments that it presently operates. A wise NHS Chief Executive told me a long time ago that the NHS only really saves money when it closes and sells off buildings. Not only does the closure of buildings reduce the rent or capital charges, but it also reduces staff numbers – bearing in mind something like 70% of the cost of running the NHS is staff costs¹. Conversely, NHS buildings that are not closed are always used for other services, staffed by NHS workers and serving the needs of patients. That produces no reduction in overall costs even if there are reductions in some budget heads. So cost savings almost inevitably means closing buildings. The logic for keeping buildings open comes into sharp focus when for example, it costs 3 times as much to operate an NHS community hospital bed than it costs to purchase a nursing home bed when both could provide a reasonable service to the same patient. That is part of the reason why

¹ See page 3 of Kings Fund Report at https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Workforce-planning-NHS-Kings-Fund-Apr-15.pdf

the future of NHS community hospital beds has come under close scrutiny in recent years;

- b. **A lack of trained staff.** This is perhaps an even more serious problem than money. There is a longstanding lack of NHS doctors, especially middle grade doctors, to staff the wards. However the NHS now has a severe lack of nurses in some specialities and a lack of technical support staff. The NHS has always had shortcomings over staff planning, and has made the assumption that it can fill gaps with trained healthcare staff recruited from abroad. But of course this is now more difficult in the light of the xenophobic vibes this country is giving off in a post-Brexit world. In June 2017 the BBC reported:

“There has been a sharp drop in nurses registering to work in the UK since the EU referendum, figures suggest.

Last July, 1,304 nurses from the EU joined the Nursing and Midwifery Council register, compared to 46 in April this year, a fall of 96%”

Many NHS change plans are driven by a recognition that securing a configuration of services that can attract and retain a sustainable workforce is essential;

- c. **Changes in the way medicine is delivered.** The methods of delivering medicine change at a bewildering rate particularly driven by technology and, with each change, a different form of configuration of services is needed. Every change which moves a hospital based service into the community is great for patients as they end up getting a service closer to home, but it also means that less space is needed in hospital;
- d. **Demographic changes.** Our population is growing older and, perhaps more importantly, the divide between the well-elderly and the unwell elderly is

growing at an alarming rate. At least 3% more patients over the age of 75 are attending at A & E every year, and many present with multiple co-morbidities and many more need admission to hospital; and

- e. **The demands of the STP process:** NHS England has set up 44 Sustainable and Transformation Partnerships – STPs – as an entirely non-statutory process to drive through change processes. These partnerships have operated largely in secret – allegedly to give space to NHS commissioners and providers along with local authorities that run social care to have frank conversations – to try to plan the future shape of health and social care services. However STPs are, in legal terms, non-statutory and hence purely advisory. NHS bodies that forget who is the real decision maker may be acting unlawfully.
3. So the forces promoting change to NHS services are strong but how does the NHS actually manage to change the footprint of services on the ground? The answer – to be honest – sometimes well but often pretty incoherently. There are – I count - 7 interest groups who have a say in NHS changes:
- a. NHS commissioners – usually clinical commissioning groups;
 - b. NHS providers of NHS services, which in practice usually means NHS Trusts and NHS Foundation Trusts;
 - c. NHS staff, without whose buy-in change cannot be delivered;
 - d. Local authorities, who have a key role in NHS service planning;
 - e. NHS England and NHS Improvement, who oversee NHS changes under an “assurance process”;
 - f. Politicians, particularly MPs, who have a direct line to Ministers and can be hugely influential in reconfiguration processes; and
 - g. Patients and the public – whose taxes pay for the services, who are the end users and who have a statutory right to be involved in decision making.

4. In broad terms, NHS commissioners decide what services they want to commission and NHS providers deliver those services they agree to provide under commissioning contracts. So decision making on the future of NHS services is shared between commissioners and providers. However each of the above groups has an involvement in any change process, as I will seek to outline in the next few minutes.
5. NHS England is entitled to publish statutory guidance to assist NHS commissioners exercise their powers: see section 14Z8 of the National Health Service Act 2006 (“the NHS Act”). In November 2015 NHS England published “*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*”. This document describes the features of a well-run NHS reconfiguration exercise and the hoops that NHS England requires CCGs and providers to jump through before any major reconfiguration process is delivered.
6. The purpose of the Guidance is explained in the Forward:

“This guidance is designed to be used by those considering, and involved in, service reconfiguration to navigate a clear path from inception to implementation. It will support commissioners to consider how to take forward their proposals, including effective public involvement, enabling them to reach robust decisions on change in the best interests of their patients.

In addition, it sets out how new proposals for change are tested through independent review and assurance by NHS England, taking into account the framework of Procurement, Patient Choice and Competition Regulations. The guidance sets out some of the key considerations for commissioners in designing service change and reconfiguration. Clinical Commissioning Groups (CCGs) are under a statutory duty to have regard to this guidance”

7. However, as the Guidance accepts decisions about the future of NHS services are not for the NHS alone.

The role of Health and Wellbeing Boards in NHS commissioning decisions.

8. Full details of the NHS commissioning process are set out in the detailed Guide to NHS Commissioning on the Landmark website². However in summary, the first stage to any NHS commissioning process should be an understanding the needs of the population for NHS and social care services, since the 2 are so intertwined that understanding one without the other would give an incomplete picture. The function of assessing the population's need for health and social care services is required to be carried out by the Health and Wellbeing Board ("**HWB**"), acting on behalf of both the CCGs operating within a local authority area and the local social services authority. HWBs, as joint NHS and local authority committees, were created by section 194 of the Health and Social Care Act 2012 ("**the 2012 Act**").
9. Section 196(1) of the 2012 Act provides that the functions of preparing the joint strategic needs assessment ("**JSNA**") and the joint health and wellbeing strategy ("**JHWS**") under the Local Government and Public Involvement in Health Act 2007 are to be discharged by the HWB. HWBs have considerable powers to require CCGs and NHS England to provide them with information: see 199 of the 2012 Act. Further

² See

<http://www.landmarkchambers.co.uk/userfiles/documents/resources/Commissioning%20NHS%20Services.pdf>

details of the functioning of HWBs are set out in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013³.

10. **Joint Strategic Needs Assessments:** The purposes of the JSNA is to create an objective assessment for the overall need for statutory health and social care services of the local population and thus ensure that NHS and social care planning is informed by a proper evidence base. This process should, to some extent, combat the inevitable tendency to continue to fund services as “business as usual”. The statutory scheme imposes a series of steps that CCGs, working through the HWB, are required to take each year, in co-operation with their local authority colleagues, to assess needs and thus inform decisions whether the pattern of existing statutory services best meets the local needs and, if not, to make appropriate changes.
11. The duty to carry out a JSNA is set out in section 116(1) of the Local Government and Public Involvement in Health Act 2007. Section 116(4) then provides:

“It is for—

- (a) the responsible local authority, and
- (b) each of its partner clinical commissioning groups,

to prepare any assessment of relevant needs under this section in relation to the area of the responsible local authority”

12. Hence, each CCG is required, working through the HWB, on an annual basis to work with the local authority to carry out an assessment of all of the actual and potential needs in the local authority area for NHS or social care services. The identification of a “need” as part of an assessment does not impose any direct legal obligation on either the NHS body or the local authority to provide a service to meet that need. The primary purpose of the assessment is to inform the priority setting decision making

³ See <http://www.legislation.gov.uk/ukxi/2013/218/contents/made>

process which is undertaken by both the NHS and by local authorities so as to ensure that the NHS and social services authorities are fully aware of the range of needs in their area and can thus make the best use of the resources available to them to fulfil as many of those needs as possible.

13. The local authority is under a specific duty to publish the joint strategic health needs assessment: see section 116(5) of the 2007 Act. The Department of Health has published non-statutory “best practice” Guidance concerning these functions in March 2013⁴. This explains the purpose of these documents as follows:

“The purpose of JSNAs and JHWSs is to improve the health and wellbeing of the local community and reduce inequalities for all ages. They are not an end in themselves, but a continuous process of strategic assessment and planning – the core aim is to develop local evidence-based priorities for commissioning which will improve the public’s health and reduce inequalities. Their outputs, in the form of evidence and the analysis of needs, and agreed priorities, will be used to help to determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing”

14. The Guidance explains the purpose of the JSNA as follows:

“JSNAs are assessments of the current and future health and social care needs of the local community. – these are needs that could be met by the local authority, CCGs, or the NHS CB. JSNAs are produced by health and wellbeing boards, and are unique to each local area. The policy intention is for health and wellbeing boards to also consider wider factors that impact on their communities’ health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities. Local areas are free to undertake JSNAs in a way best suited to their local circumstances – there is no template or format that must be used and no mandatory data set to be included.

15. The JSNA thus ought to be a key document for the all local NHS and social services bodies. Once the joint strategic health needs assessment has been undertaken, the

⁴ See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277012/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-20131.pdf

next step is for the local authority and the CCGs to work together through the HWB to produce a Joint Health and Wellbeing Strategy (“JHWS”). The legal duty on the HWB to produce a JHWS is in section 116A of the 2007 Act.

16. Section 116B of the 2007 Act (as amended by the 2012 Act) provides that, in exercising any functions, both a CCG and NHS England are required in exercising any functions, to “have regard” to the JSNA and the JHWS. Accordingly to Mr Justice Collins in the recent *PSNC*⁵ case, the duty to have regard is the same as the duty to have “due regard” under section 149 of the Equality Act 2010. It is thus a procedural duty of high importance. The outcome of the statutory mandated planning process appears as a consideration that CCGs should take into account in the NHS England Guidance which says at paragraph 4.2:

“Commissioners should:

- *have early and ongoing discussions with their local NHS England team;*
- *ensure the four tests of service change are embedded into their planning process;*
- *set a high bar of evidence for change in the discussions with providers and local authorities;*
- *work with Health and Wellbeing (H&WB) Boards to ensure service reconfiguration proposals reflect JSNA and JHWS; and*
- *request regular updates to financial planning and forecasting as proposals are developed”*

17. However, there is a greater recognition of the importance of these documents later in the NHS England Guidance which says:

⁵ See §48 of *R (The Pharmaceutical Services Negotiating Committee & Anor) v Secretary of State for Health* [2017] EWHC 1147 (Admin) at <http://www.bailii.org/ew/cases/EWHC/Admin/2017/1147.html>

“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”*

18. Thus the NHS England Guidance expects NHS reconfiguration plans to be consistent with the conclusions of the JSNA and JHWS. Reconfiguration plans which are not consistent with the JSNA and JHWS are not necessarily unlawful, but CCGs would have to have formulated very good reasons for departing from the priorities identified in the JSNA and JHWS.
19. **The CCG Annual Commissioning Plan:** The 2012 Act imposes a statutory obligation on CCGs to consult the public and key stakeholders about their annual commissioning plans and then publish an annual commissioning plan saying how each CCG proposes to exercise its commissioning functions in the coming financial year. This is an area of considerable legal risk for CCGs because NHS England Guidance appears to have largely forgotten about this legal duty.
20. The planning process at a CCG level has largely been abandoned in favour of the wider plans of Sustainability and Transformation Partnerships (“STPs”). Whilst the STP

process may be an entirely laudable, it is entirely non-statutory. Accordingly, notwithstanding the Guidance from NHS England which has elevated the STP planning process above almost all other aspects of NHS planning, CCGs and NHS England need to take care to ensure that it does not take the place of the statutory planning processes which are set out in the 2012 Act.

21. The statutory processes under the 2012 Act may well have been found to be less than perfect, but the 2012 Act is an Act of Parliament and public bodies have a legal duty to comply with the provisions of the 2012 Act (at least until Parliament is called on to repeal the relevant parts of the 2012 Act). The duty to publish an annual commissioning plan is set out in section 14Z11 of the NHS Act and the duty to consult on a draft plan appears in section 13Z13.
22. Section 14Z14 of the NHS Act provides a power (but not a duty) for the HWB to provide NHS England with an opinion as to whether a CCG annual commissioning plan takes proper account of the JHWS published by the HWB. This is a power which enables the HWB to express its disagreement with the priorities identified by the CCG and would lay the ground for a legal challenge that, in making commissioning decisions, the CCG has failed to comply with its duty to have regard to the JHWS. A CCG may, of course, seek to defend that challenge by producing evidence that the CCG has properly had regard to the JHWS but, for defensible reasons, has come to a different view on the priorities for the local NHS. As far as I am aware, this power has not yet been used.
23. Interestingly, the NHS England “Operational Planning and Contracting Guidance 2017-2019”⁶ makes no mention of the duties on CCGs to produce annual commissioning plans. Further a review of CCG websites suggests few CCGs have published an Annual Commissioning Plan for 2017/18 and even fewer refer to any statutory consultation in

⁶ See <https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf>

advance of their planning for this year. However a CCG which brings forward plans to exercise its commissioning functions without having tested them in advance in a public consultation and made decisions in a publicly accessible annual commissioning plan may well be acting unlawfully. Section 14Z11(3) provides:

“The plan must, in particular, explain how the group proposes to discharge its duties under—

(a) sections 14R, 14T and 14Z2, and

(b) sections 223H to 223J”

24. Section 14R is the duty on the CCG as to improvement in quality of services, section 14T sets out duties as to reducing inequalities and section 14Z2 relates to the duties to have arrangements for public involvement and consultation, about which I will say more later. Sections 223H to 223J relate to the financial performance of a CCG. Hence a CCG that simply has no plan, and thus has no document explaining how it *“proposes to discharge its duties”* under these sections may well not be in a position to propose exercising its commissioning functions lawfully at all by making changes to local NHS services.
25. However, in place of the statutorily mandated NHS planning process, the “Operational Planning and Contracting Guidance 2017-2019” requires joint plans between commissioners and providers to be submitted to NHS England for approval. This is a completely non-statutory process. NHS England have no clear statutory powers to require any CCG to engage in these procedures but that will not prevent most CCGs from seeing their duties to comply with NHS England planning guidance at a far higher level of importance than statutory requirements. This is the planning process which NHS England is enforcing currently seeing to impose on CCGs, under the umbrella of the STP process. However, whilst it may be inconvenient to point this out, NHS

England has no power to permit CCGs to ignore their legal obligations to consult with the public about their annual commissioning plan. A CCG which fails to produce an annual commissioning plan will be acting unlawfully in the absence of a recommendation in the NHS Operational Planning and Contracting Guidance document will probably be no defence. Further, any major commissioning decision which is taken without the CCG having annual commissioning plan which describes the decision and has been the subject of prior public consultation could be the subject of a Judicial Review challenge.

26. **The Four tests:** In 2010, the government introduced 4 tests for service reconfiguration which it said should apply to all NHS service change going forward.

These are:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- Clear, clinical evidence base.
- Support for proposals from commissioners.

27. A failure to understand and/or follow these tests is likely to mean that the NHS commissioner is acting unlawfully: see Silber J in *R (London Borough of Lewisham & Anor) v Secretary of State for Health & Ors* [2013] EWHC 2381 (Admin).

28. As from March 2017, significant hospital bed closures are now subject to additional tests “before NHS England will approve them to go ahead”. The new tests:

- 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
 - Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
 - 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)
29. The fact that there is no statutory process which requires NHS England to approve CCG reconfiguration plans appears academic. NHS England have assumed this role and no one questions their right to approve or veto plans.
30. There is a complex NHS England assurance process under the Guidance. This starts with the preparation of a pre-consultation business case. The Guidance provides:

“Pre-consultation business case

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”

31. The next stage of the NHS England process is engagement with local authorities. The Guidance provides:

“5.4 Discussion of formal proposal with local authorities

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.

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”

32. The final stage, according to the Guidance, is public consultation, suggesting the public only get a say when the NHS has made up its mind about what changes should take place. There is a long tradition of “decide first, then consult”, which is another area of serious legal risk for NHS bodies as we shall explore later.
33. CCGs are required to have “arrangements” in place for involving the public in their decision making: see section 14Z2 of the NHS Act. The legal duty is to have arrangements in place. That creates a legitimate expectation that the arrangements will be followed. Hence a CCG that has no “arrangements” document in place to explain how it will involve the public in all parts of its commissioning decision making process will be acting unlawfully.
34. NHS England has issued Guidance concerning patient participation in commissioning decision-making. “*Transforming Participation in Health and Care*”⁷. This Guidance is long on rhetoric about the importance of public involvement and somewhat light on

⁷ See <https://www.england.nhs.uk/wp-content/uploads/2017/05/patient-and-public-participation-guidance.pdf>

details as to exactly what a set of legal arrangements should contain. It stresses proportionality saying:

“CCGs and NHS England need to consider their duty to involve the public alongside their duty to act effectively, efficiently and economically. Staff will need to consider the impact of proposals on people who may be affected. As a general rule, the greater the extent of changes and number of people affected, the greater the level of activity that is likely to be necessary. However, the nature and extent of public involvement required will always depend on the specific circumstances of an individual commissioning processes”

35. The Guidance is somewhat vague on “when” involvement should take place. It says:

“When should public involvement take place?”

Staff should decide on the best timing for public involvement, bearing in mind the need for fairness, as set out in the ‘Gunning’ principles in page 25. The public does not necessarily need to be involved at the earliest possible stage, especially if there is insufficient information for them to consider. It will sometimes be appropriate to first develop a proposal, a shortlist of options or a preferred option. However, involvement should never be left to a time when the views obtained could not make a meaningful difference to the approach being taken. Involvement should not typically be a standalone exercise such as a formal consultation. It will generally be part of an ongoing dialogue or take place in stages. A phased approach can often maximise involvement. It is good practice to develop a communications and engagement plan (in appendix C) to set out objectives and methods, and to provide regular communications to stakeholders throughout the commissioning activity. Publishing the timeline for engagement is an effective way of demonstrating that patient and public views have been adequately factored into a commissioning process”

36. That does not quite seem consistent with the statutory duty to involve patients “in the development and consideration of proposals by the group for changes in the commissioning arrangements”: see section 14Z2(2)(b).
37. However, a key difference between section 14Z2 and the public involvement duty on NHS providers under section 242 NHS Act is that CCGs cannot discharge their duties through “representatives” of patients. Representative bodies can be part of the involvement process but cannot be all of it.
38. The final stage of any reconfiguration process is decision making, which is almost always taken by CCG governing bodies, or joint committees of CCG governing bodies. Then it is necessary to change the terms of commissioning contracts between CCGs and providers so as to implement the decisions. And finally, when that happens, NHS services changes can be delivered on the ground.

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