Reconfiguring services: when must NHS bodies consult the public? How do they go about doing it? And how can they protect themselves from legal challenge?

As the squeeze on public funding continues, commissioners have difficult decisions to make about services - which to continue, which to commission, and which to stop. Service users and providers are more inclined than ever before to take a case to court to try to stop or reverse decisions to change or decommission services. Providers attempting to reconfigure services face the same challenges.
Introduction
The law requires commissioners (and providers) to involve the public when making changes to the provision of NHS healthcare. NHS bodies discharge this duty by carrying out consultations. This is an area fraught with difficulty and the potential for legal challenge.

There have been numerous reported cases in the last three years, where commissioners and other public bodies have faced a judicial review brought by individuals or groups angered by service changes. Not all of these have been NHS related – some, for example, relate to cuts in library services.

Readers in the NHS may particularly recall the following cases already in 2013:

- R (on the application of Save our Surgery Ltd) v Joint Committee of Primary Care Trusts – relating to specialist centres for paediatric cardiac surgery
- R (on the application of Copson) v Dorset Healthcare University NHS Foundation Trust – relating to Mental Health Urgent Care Services reconfiguration
- R (on the application of Lewisham LBC and Save Lewisham Hospital Campaign Limited) v Secretary of State for Health (and others) – relating to the Trust Special Administrator appointed to South London Hospital

Each case over the past few years has helped to provide guidance on what “involving the public” really means.

The broader topic is gaining prominence as the government is concerned about the numbers of judicial reviews generally (not just relating to health). A Ministry of Justice consultation has just been launched by Chris Grayling.

Grayling said: “We want to make sure judicial review continues its crucial role in holding authorities and others to account, but also that it is used for the right reasons and is not abused by people to cause vexatious delays or to generate publicity for themselves at the expense of ordinary taxpayers.”

The consultation proposes changing the rules around who has to pay the legal bills for cases so all parties have an equal interest in cutting costs. This could include making applicants who bring unsuccessful cases pay some of the defendant’s bill.

Legal aid funding will be targeted at cases “with merit”, although there is little detail in how these cases would be selected.

The appeals process could also be changed so it is possible for them to be considered by the Supreme Court without first going to the Court of Appeal.

Briefing
This briefing is not an academic review of the case law. That would not assist hard pressed commissioners trying to ensure that a controversial service redesign is properly administered. This document draws out the central principles from the case law and from published guidance, setting out the ground rules for a lawful consultation and pointing out the “elephant traps” to avoid.

Service changes are always likely to be controversial and even the best run consultation will not prevent that. Social media can quickly whip up a storm and local politicians often find there are votes in proclaiming their outrage about proposed changes. However, a well run consultation will do four things:

- It will ensure that your decisions are as well informed as possible. The whole point of consulting the public (ie, those who will use the services you commission) is to ensure that you make better commissioning decisions.
- It will reduce the prospect of a legal challenge (which, even if you fight it off, will be costly in time, money and reputation).
o It will reduce the poor publicity that can often accompany decisions to reduce or even just to alter a particular service.

o It will give you the best chance of winning if your decision is challenged in the courts.

Below, we aim to help you achieve each of these objectives.

The legal duty to consult

The law requires NHS bodies to engage with members of the public before making decisions on changes to health services. Currently, separate sections of the NHS Act apply to CCGs and to other organisations.

CCGs are governed by section 14Z2 of the NHS Act 2006, which states:

(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions (“commissioning arrangements”).

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):

(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.

There are two other relevant aspects to section 14Z2. Subsection 3 requires all CCGs to include in their constitution a description of their public engagement arrangements and a statement of the principles that they will follow in when implementing them. Subsection 4 empowers NHS England to publish guidance on compliance with this section, which CCGs must have regard to. This was published in September 2013 – see below for more details.

Section 13Q of the Act applies to NHS England and contains effectively identical provisions to section 14Z2. Section 242 of the Act contains the same obligations for NHS Trusts and Foundation Trusts. Any NHS body considering changing the services it commissions or provides must be aware of the obligations discussed in this note.

In summary, any significant commissioning decision or reconfiguration will be caught by these statutory requirements. You will note that the statute does not insist on “consultation”, but seeks to make sure that service users are “involved”. In practice, for any significant proposed change to services, some form of consultation exercise will be required to comply with this duty.

Guidance

The most recent guidance on consultations for the NHS was published in September 2013 by NHS England, and is called Transforming Participation in Health and Care.

Transforming Participation does not expressly replace the 2008 Department of Health document, Real involvement: working with people to improve services, but clearly commissioners should focus on it as the most recent guidance and the document that they have a statutory responsibility to take into account. The National Director of Patients and Information at NHS England comments in the guidance that “We must put every citizen and patient voice absolutely at the heart of every decision we take in purchasing, commissioning and providing services.” There is a clear focus on maximizing the participation of patients and the public.
The section most relevant to your consultation obligations - public participation - begins at page 29, and the “How?” to effect public participation can be found at pages 29 – 35. This guidance includes a number of specific tools designed to aid commissioners in their consultation, including the “Ladder of Engagement and Participation”. This sets out different levels of participation which may be appropriate when involving the public in decisions about healthcare. There is also a “Engagement Cycle”, setting out key points in the commissioning cycle for public participation.

The guidance then sets out a number of suggested features of public participation. The information provided should be of good quality, and in a number of different formats to ensure that it reaches the intended target. There should be a range of opportunities for participation, which could include online surveys and dedicated local events, as well as work through voluntary and community sector organisations. Patients and the public should be involved from the initial planning stages of service redesign, and special efforts should be made to reach out to diverse communities.

The guidance goes on to suggest an eight point action plan for commissioners, setting out the steps which ideally should be taken in order to involve patients and the public. These include identifying expertise in participation within your own organisation and making best use of it, working with health and wellbeing boards on shared approaches with communities, as well as developing a joint approach with local authorities, local Healthwatch, voluntary groups and other organisations with existing relationships with the local community. It also suggests that commissioners seek feedback through the CCG assurance process as to the efficacy of work to ensure public participation. This action plan can be found at page 35.

While we would advise all NHS staff involved in service redesign to be familiar with the “action plan”, we would strongly advise you to take into account our “ten rules” at the end of this document. These are more of a practical “how to” guide than the higher level policy guidance provided by the “action plan”.

The guidance also commits NHS England to provide practical support to commissioners, and this is detailed on pages 36-38. Such support includes, but is not limited to, online resources, national excellence award schemes, a digital participation space allowing anyone to start or join in a conversation about health and care as well as a learning network.

The 2008 guidance is now clearly quite dated and superseded by the NHS England guidance. However, it is still recommended that staff involved in service redesign are familiar with it, as it does contain some useful principles.

We would particularly draw your attention to the following sections of the Real involvement document:

- What involvement really means – pages 16-17
- Who should be involved – pages 21, 33-39 & 60-67
- What is involvement – pages 21 & 68-81
- When should users be involved – pages 21-22

As well as the 2008 and 2013 guidance, NHS bodies should be aware of the Cabinet Office Consultation Principles, published on 17 July 2012. This is aimed at Government departments and other public bodies – it is more a set of general principles than detailed guidance. It replaced the 2008 Cabinet Office Guidance. It states that the governing principle “is proportionality of the type and scale of consultation to the potential impacts of the proposal or decision being taken”.

NHS organisations should also ensure that they do not forget Andrew Lansley’s “four tests”. A lot of water has flowed under the bridge since they were first set out in May 2010. Their continued relevance and significance was highlighted in the recent judicial review concerning proposed service reductions at Lewisham Hospital. To recap, proposed reconfigurations must meet the following requirements:

1. Support from GP Commissioners.
2. Strengthened public and patient engagement (including with local authorities).
3. Clarity on the clinical evidence base underpinning proposals.

Where the proposed reconfiguration is being led by a CCG, the first test should be easily met, although interesting issues may arise where member practices (or individual GPs) object to a proposal made by the governing body. The importance of engagement with local authorities is dealt with below, and is only underlined by the second of the four tests.

As set out above, people affected by changes to services are increasingly willing to challenge the decisions of NHS bodies. Becoming familiar with the relevant guidance and putting it into practice will maximise your chances of avoiding such challenges.

What happens if you fail to consult?
The consequences of failing to comply with the requirement to involve the public can be severe. NHS organisations can face legal challenges from several different directions. Individual service users, groups of service users and current providers who risk “losing out” when a service is changed, can all bring a judicial review. It is no defence to point out to a judge that the decision you took was plainly the best one.

A judicial review is concerned with the process by which a decision was reached. If a public body does not comply with its legal obligations when planning and implementing service changes, the court is likely to strike its decisions down, whatever the merits of those decisions might have been. Injunctions can be sought as part of the court process to stop the public body from implementing its intended changes before the court case is decided. At the end of the court process, when making its final ruling, a court cannot usually substitute its own decision for that of the public body, but it can refer the decision back to be reconsidered. All of this takes time – often many months – and will hold up plans you may have wished to implement.

Defending a judicial review is a costly process. Judicial reviews have several stages. They involve a great deal of paperwork and often several separate court hearings. The “internal” costs in time and distraction and the “external” costs in legal fees are significant. The publicity is often damaging. If a judicial review is lost, the NHS body is likely to have to pay some or all of the claimant’s costs as well as its own. If the NHS body wins, it is unlikely to recover much of its own legal costs from a claimant who may well be in receipt of public funding from the Legal Aid Agency.

Are there some types of decisions where we do not have to consult?
You should apply a sense of proportion (remembering the 2012 Cabinet Office guidance). A public consultation is not needed for every minor or temporary change in the way a hospital functions or community health services are provided. However, any proposal that will lead to a significant change in the way that local health services will be provided should be consulted on. The law is clear that this applies even to changes that are temporary or are driven by clinical concerns.

Not every change requires a full 12-week consultation. If you expect to be challenged, however, you should consider obtaining legal advice before deciding to adopt a more truncated process. Care should be taken over fixed term contracts. Simply because a contract has a fixed end-date and makes no provision for extending or renewing the agreement, it does not follow that an NHS body can simply let the contract expire and allow the particular service to stop. If doing this would affect the way in which services are delivered, or the range of services that are available, the duty to consult will apply.

What about changes that implement government policy? Public involvement, ie, some form of consultation, is still required. The courts have ruled that even where a commissioner was simply implementing Department of Health policy, the provision of services was still the commissioner’s responsibility and therefore it had an obligation to consult.
The rule is this: if a commissioner or provider will be making significant changes to how services are provided, even if it is doing so because it is obliged to do so by external pressures, it is the commissioners’ obligation to carry out a consultation.

**The timing of a consultation**

Consultations should begin when proposals are still at a formative stage. Remember, the NHS Act requires you to involve the public in “the development and consideration of proposals”.

What does that actually mean? If a CCG is considering whether to continue commissioning a particular service, do they have to involve the public from the very first meeting when this issue is discussed? In short, no. You do not have to begin your consultations at such an early stage. Once you have considered what options are open to you and you are going to start looking at those options in more detail, that is the time to start consulting. By doing so at an early stage, you are consulting on “the development and consideration” of the proposals you are looking at.

*Real involvement* is helpful on this issue. It states, page 22: “Users must be involved not only in the consideration of proposals to change services, but also in the development of any proposal that will change the manner in which a health service is provided or the range of services offered. For example, users must be involved in the development of a range of options for the way community services could be provided within a PCT [or now a CCG] area, not just asked for their opinion on a model that has been developed behind closed doors by health professionals and managers”.

Importantly, the courts are clear that public bodies are entitled to have identified their “preferred option” before consulting. So long as the consultation is carried out with a genuinely open mind and the commissioner takes everything it learns from that exercise into account before making its final decision, having an initial preferred option is not a problem.

**Record keeping**

This is a good point at which to emphasise the importance of thorough record keeping and the need to be careful about the language you use in your records. This applies not just in the realms of consultation of course! Remember that if a commissioning decision is challenged in the courts, the court will look at how the decision was taken, not at the merit of the decision. Your paperwork is likely to be disclosable, if not under the Freedom of Information Act, then as part of the court disclosure process.

Staff should work on the basis that there is no such thing as an internal, private email. A throwaway remark that suggests a decision to close a service has already been taken but that a consultation has to be done “so the legalities are complied with” could undermine the whole process and result in a court order to redo the whole exercise and take a fresh decision.

The consultation paperwork itself and all minutes of meetings should be reviewed with particular care before they are finalised. It is very easy for the language to imply that the final decision has already been taken and that the consultation is mere window-dressing. For example:

**Don’t say:** “We have put in place arrangements with another provider which will mitigate the impact on service users of the closure of the service X.”

**Do say:** “We have discussed with another provider what services they could offer service users in the event of a decision to close service X. They have confirmed that they would be able to provide support that would mitigate the impact of such a closure.”

This is not Mills & Reeve being unnecessarily cautious. Our experience is that if commissioners are subject to legal challenge, every line of every document will be gone through with care by lawyers acting for the Applicant. Any loose language risks be used as the basis of an argument that the consultation was a sham. Even if a judge rejects such an argument at court, one loose remark may be the reason that a case gets all the way to a final court hearing.
What does a consultation actually involve?

Real involvement and the courts are clear that there is no set form for a consultation. It is for the NHS body undertaking the consultation to decide which form it will adopt. What matters is that clear information is given to the public; that they are able to respond; and that their responses are taken into account when making the final decision.

Typical methods of consultation would include:

- Public meetings
- Writing to all affected service users and their families/carers
- Poster campaigns in NHS buildings
- Information in the local media

In short, the greater the impact of proposed changes and the more people they are likely to affect, the more detailed and comprehensive the public involvement will have to be.

Local authority scrutiny

New regulations governing local authority scrutiny of health services are now in force, namely the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Local authorities are no longer required to have a Health Overview and Scrutiny Committee as the means by which they discharge their scrutiny function, although in practice most have retained them. The key points to note are these:

Under Regulation 23, NHS England, CCGs, public and independent sector providers of NHS services must consult with the local authority about any proposals for a substantial development or variation of the health service in the authority's area. “Substantial” is not defined. We would advise commissioners to be cautious about not mentioning a proposed change to a local authority on the basis that it is not substantial. If you are proposing to consult, you should tell the authority.

If the local authority ultimately disagrees with the decision of the NHS body, it is entitled to refer the matter up to the Secretary of State for a final decision.

Commissioners should ensure that they have good channels of communication with their local authority, and that its members are kept informed of proposed changes.

Public sector equality duty (PSED)

This duty applies when the NHS is exercising any of its functions. It particularly applies where an NHS body is proposing policy changes that will have an effect on a large number of patients who are in groups which have a “protected characteristic”.

NHS bodies must have “due regard” to the need to:

- Remove or minimise the disadvantage suffered by persons who share relevant protected characteristics (such as race, age, disability, or sexual orientation)
- Take steps to meet the needs of those who share such characteristics
- Encourage participation of those who share such characteristics

This duty – to “have regard” to these needs – must be met before or at the time any policy is being considered. Courts talk of it being an “essential preliminary” and not a “rearguard action”.

Importantly, the public body does not have to achieve these needs. This might be impossible given competing pressures (such as the need to reduce services to break even). The weight to be given to countervailing factors is a matter for a public body and not a court unless the assessment is unreasonable or irrational.
What matters is that the public body can demonstrate that it paid “due regard” to these needs. The due regard has to be with “rigour and an open mind” but if that is done then the PSED is not a back door by which challenges to the merits of decisions may be made.

What this means in practice is that NHS commissioners need to fully understand the likely impact of any proposed changes to local NHS services on disabled people, the elderly, racial minorities or any other group that has a protected characteristic under the Equality Act. Although not a requirement under the Act it will be helpful to undertake a proper Equality Impact Assessment (EIA) prior to any consultation on whether to alter or stop a particular service. The courts have recently restated that there is no requirement to undertake an EIA, but that it is a useful tool to demonstrate that an NHS body has had due regard to the relevant needs. Decision makers need to put themselves in a proper position to consider the question in the first place by gathering sufficient relevant evidence.

This duty does not mean that the NHS cannot take changes that adversely affect, for example, the access that disabled people have to local services. It does mean that those who take the decision need to have a proper understanding of how their decisions will impact on disabled people and take those factors into account when taking the final decision.

For more detail on the public sector equality duty, please follow the link to our briefing on that subject.

Lessons learned from recent cases
An academic review of recent case law is of little help to hard-pressed commissioners and providers faced with challenging budgets and a need to redesign services. What matters are the practical lessons you can learn from those cases.

>> We set out below a print out and keep guide to our ten rules for an effective, lawful consultation.

There is some comfort to be found in the case law! The courts have repeatedly acknowledged that, if a consultation exercise is challenged in court, it will be struck down only if it can be shown that something went “seriously and radically wrong”. The cases accept that, with hindsight, it will always be possible to suggest a way in which a consultation exercise could have been improved on. That is not the test. If the basics of the consultation exercise are properly consulted, the objectors should not succeed in their challenge.

Remember, though, that even the costs of successfully fighting a judicial review are high. Carrying out a consultation as well as possible will reduce the chances of having to do so. If an NHS body knows that a particular service change will be controversial, it should consider seeking legal advice to “health check” its proposed consultation process and documents.

Finally, if service users threaten a judicial review by way of a Pre-Action Protocol Letter then legal advice should always be sought as a matter of urgency. Often there are 14 days or less to respond. The courts pay careful attention to a public body’s first response to the threat of legal action even before proceedings are issued.
Ten rules for an effective, lawful consultation process

1. Consult when your proposals are at a formative stage

Making a decision on a change to services, and then consulting on that decision, is unlawful. If you are strongly of the view that only one of a number of alternatives is realistic, then you should say so and explain why, but you must give people the opportunity to disagree.

2. Mind your language!

Decisions by public bodies have been struck down by the courts simply for the use of language that gives an appearance to the public that a decision had already been taken and the consultation was a sham.

3. Set out what you are proposing; what the options are; and why these changes are needed

The public body must give out information that contains sufficient reasons for particular proposals, to allow those consulted to give those reasons intelligent consideration and an intelligent response. If the public do not know what they are being consulted about or why a change needs to be made, they cannot properly take part in the consultation process.

4. Be up front about the reasons for a proposed change

In the current climate, the driver for change will often be largely financial. If that is the case, say so. Set out the financial position that you are faced with and if this is the reason for the proposed changes. Hiding behind other, more palatable, reasons to change a service risks your consultation being struck down as unlawful.

5. Think about how long the consultation will last

The public must have adequate time to respond. The Cabinet Office Principles state “timeframes should be proportionate and realistic to allow stakeholders sufficient time to provide a considered response … and might typically vary between two and 12 weeks”.

6. Take the responses into account before making a final decision

NHS bodies are not bound by the views of the public. Consultation is not a vote. It is, however, essential that you put the public's views in front of the decision makers and that they take those views into account when reaching their decision. You must ensure that you have a paper-trail demonstrating that this was done. If a public body takes a decision that goes against the general views of the public, it needs to have good reasons for it and to make sure those reasons are recorded.

7. There is no set form for a consultation

How to conduct one is a decision for the public body. The courts have approved consultations that involve responses on paper or electronically, public meetings and even citizens juries. What matters is whether the consultation is fairly conducted.

8. You can consult on a single option

If a public body identifies only one serious option to put to the public, it is entirely lawful to consult on implementing that single option. However, you may need to justify why only one option was realistic. Also, you must allow members of the public to suggest alternative options and, if they do so, you must give those options genuine consideration.

9. You can reach a final decision that was not one of the options put forward for consultation

But remember two points. First, there must be good reason for such a change of approach – usually it will be based on information discovered as part of the consultation. Secondly, if the final decision departs very substantially from the initial options, it may be necessary to undertake a second consultation. You do not have to give consultees the opportunity to see and to comment on the responses of other consultees. However, if a response has opened up a new issue that you are taking into account, you should consider giving other consultees the opportunity to comment on that issue.

10. Be careful of making promises!

If clear, unequivocal promises have been made to individual service users or groups as part of the consultation process, the public body will have created a “legitimate expectation” that those promises will be kept. If you want to go back on them, you will need to redo the consultation exercise. Failure to do this risks the whole process being struck down by the courts. It is far safer never to make a promise or, if you do so, to qualify the circumstances in which you will be bound by it.
Get in touch

Duncan Astill
Partner
T +44(0)1223 222477
duncan.astill@mills-reeve.com

Jill Mason
Partner
T +44(0)121 456 8367
jill.mason@mills-reeve.com

Philip Grey
Associate (Barrister)
T +44(0)1223 222463
philip.grey@mills-reeve.com

Katrina McCrory
Associate
T +44(0)121 456 8451
katrina.mccrory@mills-reeve.com

Jane Williams
Senior Solicitor
T +44(0)121 456 8421
jane.williams@mills-reeve.com

Useful links

Resources

Transforming participation in health and care
Real involvement: working with people to improve health services (NHS)
Cabinet Office Consultation Principles
Department of Health smart guides to engagement
Where do public authorities stand in relation to the Public Sector Equality Duty?
Health Commissioning Portal
Sir David Nicholson’s letter to NHS Chief Executives - 20 May 2010
NHS Confederation: Tough times, tough choices

Legislation

NHS Act 2006
Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
Equality Act 2010