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Legal duties for service change: a guide

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1 Introduction

1.1 Background and context

This is an introductory guide to legal obligations for NHS service change programmes in England. It can be costly and time-consuming when NHS bodies do not act on these obligations. Sometimes legal challenges can stop proposed service changes being implemented altogether. NHS colleagues involved in service change programmes say[1] they want more support to help them understand these requirements better. This guide has been written for that purpose.

This guide describes the current legal framework and the likely steps required to discharge legal duties when making changes to services. It does not set out an exhaustive list of requirements or offer guidance on how individual processes should be run. It does not replace the need for local legal advice. Each service change programme is different. Programme leaders should refer to further reading material and seek appropriate specialist legal input where necessary.

1.2 What is in this guide?

This guide sets out relevant legal considerations for NHS bodies in the process of changing services. Legislation is only one element in a complex picture that includes:

- **Legislation** – a law or a set of laws that have been passed by Parliament or on its behalf. For example, an Act of Parliament, or statutory instruments such as Regulations drafted using powers given to a Minister in an Act of Parliament.
- **Statutory guidance** – Guidance issued using powers given to NHSEI by primary legislation[2].
- **Policy and guidance** – Policy or guidance issued by a relevant body.
- **Public law** – the type of law governing the conduct of public bodies including the NHS which is derived from cases (sometimes known as common law).

This guide draws on these and other sources to introduce legal considerations for service change in context. It should be read alongside and does not replace or supersede[3]:

- *Planning, assuring and delivering service change for patients,* (NHS England, 2018)
- *Effective Service Change – A support and guidance toolkit*[4]

[1] NHSEI Research 2020 - https://future.nhs.uk/reconfiguration/view?objectID=21336208
[2] CCGs must have regard to guidance published by NHSEI (s14Z8, National Health Service Act 2006 as amended)
[3] Every care has been taken to avoid the potential for ambiguity an additional document might create. Should such ambiguity arise, readers should refer to *Planning, assuring and delivering service change for patients,* NHS England 2018, as the primary document.
[4] Available from NHSEI regional teams

In April 2020, NHS England and NHS Improvement came together as a single, operational organisation: NHS England and Improvement (NHSEI). This document refers to NHSEI whenever it cites a duty placed on either of the predecessor organisations.

1.3 Who is the guide for?

This guide has been developed for those considering, and involved in, NHS service change to help them navigate the common legal and policy issues from the very start of a service change programme through to decision-making. This includes NHS commissioners and providers, as well as Integrated Care System (ICS) and Sustainability and Transformation Partnership (STP) leads and partners.

1.4 What is service change?

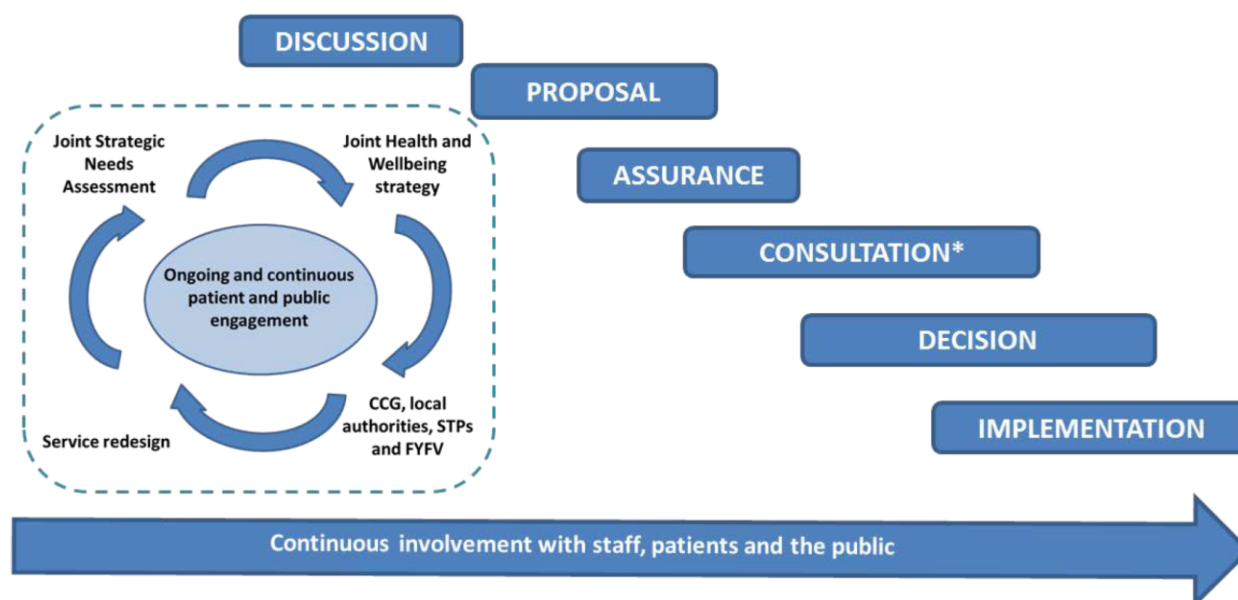
In this guide, service change is "any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services available and/or the geographical location from which services are delivered."[5]

Service change usually involves a change in the range of services available or a change to the location from which particular services are delivered. Most of the legal duties apply to any change that meets this description. Some duties apply where there is any change to services from the perspective of patients. Other duties are triggered only where discussions with a local authority lead to service change proposals being deemed to be 'substantial'. There is no single, generally accepted definition of service change and in particular no legal definition, so each case should be assessed on its specific attributes.

Service change is a complex, non-linear process. Many of the legal duties placed on NHS bodies take effect only at the decision-making point. Others have effect throughout. Preparing to discharge these duties requires regular assessment of when and how the duties are triggered and action at various planned points throughout a service change process.

Service change has several phases from setting the strategic context to implementation. *Planning, assuring and delivering service change for patients* illustrates a summary of these as[6]:

[5] p10, *Planning, assuring and delivering service change for patients*, NHS England 2018
[6] p9, *Planning, assuring and delivering service change for patients*, NHS England 2018; a footnote to the illustration states: "Public consultation may not be required in every case. A decision about whether public consultation is required should be made taking into account the views of the local authority." For more information refer to Section 6.2



1.5 Why do we have legal requirements for service change?

Parliament sets out in legislation the things NHS bodies must consider and do when they are undertaking the work for which they were established. The aims of the duties vary and affect service change programmes in different ways. The overall aim is to secure the efficient functioning of the NHS across England in line with government policy and, where appropriate, the expectations of patients and the public.

1.6 Are there exceptions for urgent or temporary service changes?[7]

NHS bodies may decide to change a service without allowing time for consultation with the relevant local authority, where they are genuinely satisfied there is an imminent risk to the safety or welfare of patients or staff.[8] This is the only specific exception to the statutory duties for urgent changes. Other duties will still apply and should be addressed appropriately. It is not acceptable for NHS bodies to delay addressing fragile service situations that might lead to such a risk occurring until they are so urgent that an imminent risk exists. The matter of whether a change is temporary or permanent is not addressed in legislation.

Where services need to be closed or suspended at short notice, NHS bodies and their partners should act in accordance with the *Joint Working Protocol.*[9]

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[7] See section 5.4
[8] s23(2), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
[9] *Joint Working Protocol: When a hospital, services or facility closes at short notice*, NHS England, 2017

In all cases NHS bodies should act in accordance with their legal duties, including:

- keeping good records of the factors they consider in making these decisions;
- communicating the changes to affected people; and
- informing the local authorities in the areas affected about changes and reasons for not consulting them under the regulations.

1.7 What can happen if NHS bodies fail to discharge their legal duties?

NHS bodies must act in accordance with the law as it applies to them. The legal requirements are designed to make sure NHS bodies take all relevant factors into account in decisions to commission and provide the best services possible. If stakeholders are dissatisfied with a service change decision made by an NHS body, there are two formal ways in which the thinking and process behind the decision can be tested publicly:

1. **The matter may be referred to the Secretary of State for review[10]**. This avenue is open only to local authorities in the affected area using powers given under health scrutiny legislation.[11] The Secretary of State may take independent advice on the matter[12] and respond to the referring authority setting out the course of action to be followed.
2. **Anyone with an interest may bring a claim for Judicial Review[13]** if they consider that the NHS body has failed to act in accordance with the law. In this legal process a judge will review the facts of the case by examining programme documents and considering written witness statements. The court can quash[14] decisions if a judge finds they have not been made in accordance with the law.

2 Programme leadership and governance arrangements

This section focuses on requirements that relate to governance and leadership on proposals for change.[15] It covers:

- Strategic leadership
- The footprint for governance arrangements
- Independent scrutiny and assurance

2.1 Strategic leadership of change

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[10] See Section 5.2
[11] Regulation 23(9), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
[12] *How we advise the Secretary of State for Health and Social Care*, IRP, 2020
[13] https://www.judiciary.uk/you-and-the-judiciary/judicial-review/
[14] Officially annul or void
[15] For issues relating to decision-making, please refer to Section 6

All service change programmes need ownership, support and leadership from commissioners to make sure legal requirements are met.[16] The Health and Social Care Act 2012 amended previous legislation to put clinicians at the heart of commissioning and give local NHS commissioners in England the strategic lead for deciding what health services should be provided and how they should be configured in their area.

Local NHS commissioners in England have the strategic lead for deciding what health services should be provided and how they should be configured in their area[17]. Service change programmes can be initiated by NHS commissioners, providers or other Sustainability and Transformation Partnership (STP) or Integrated Care System (ICS) partners. Decision-makers may begin service change programmes by investigating certain potential courses of action in response to identified challenges or opportunities. However, they must make sure other potential alternative approaches are explored in good faith and considered with an open mind.[18]

2.2 Governance arrangements

The governance arrangements for service change programmes must:

- Cover the geographic area impacted by the service change, using patient flows, not administrative boundaries to define that area[19];
- take account of the range of services under consideration, and interdependencies between services;
- reflect and respect the legal powers and responsibilities vested in each partner organisation involved in the service change programme[20]; and
- support decision-makers in keeping an open mind on proposals that might be subject to public consultation.[21]

NHSEI service change guidance requires that commissioners ensure that clinical ownership and leadership of plans is part of any governance arrangements.

Where the responsibilities of more than one commissioning organisation are the focus of a single change programme, Clinical Commissioning Groups (CCGs) have the power to form joint committees with other CCGs and NHSEI to exercise commissioning functions together.[22] The focus on Integrated Care Systems (ICS) and Sustainability and Transformation Partnerships (STP) as the forum for service

[16] p16, *Planning, assuring and delivering service change for patients*, NHS England 2018
[17] National Health Service Act 2006 (as amended by the Health and Social Care Act 2012)
[18] R (Royal Brompton Hospital) v Joint Committee of Primary Care Trusts [2011] EWHC 2986 (Admin) & [2012] EWCA Civ 472
[19] The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
[20] National Health Service Act 2006 (as amended)
[21] 29-30, R (Sardar) v Watford Borough Council [2006] EWHC 1590 (Admin)
[22] The Legislative Reform (Clinical Commissioning Groups) Order 2014

planning make it increasingly important for statutory decision-makers to be satisfied that they have properly delegated their relevant functions to joint committees.

Where proposals for change raise questions of what services are delivered or which provider should deliver them, change programme leaders must be mindful of their duties in relation to procurement and patient choice.[23] Commissioners may not be required to undertake a formal procurement process in situations where there is only one possible provider.

2.3 Independent scrutiny and assurance of service change

NHSEI requires service change programmes to integrate regulatory assurance checkpoints into the programme timeline.

Governance arrangements must take account of the need to liaise with regional NHSEI teams and local authorities in the area of the change programme. Note that local authorities have multiple roles as critical stakeholders, partners in STP/ICS, and have statutory scrutiny powers.[24]

In establishing governance arrangements for service change programmes, NHS bodies should take into account the need to meet the public law expectation that accurate records should be kept by public bodies when discharging statutory functions.

[23] The Public Contracts Regulations (2015); and The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013
[24] See Section 5.2

3 Developing a case for change and early discussion

This section focuses on requirements that relate to developing a case for change. It covers:

- The starting point for developing a case for change
- Duty to consider Joint Strategic Needs Assessments (JSNA) and Health and Wellbeing Strategies (HWBS)
- Duty to consult on and publish a commissioning plan
- Public Sector Equality Duty
- Duty as to reducing health inequalities
- The case for change

The development of a case for change should be:

- overseen by clinical commissioners and be driven by clinicians including medical directors and heads of clinical services;
- based on the best available evidence;[25] and
- informed by the learnings from continuous patient involvement.[26]

3.1 Strategic starting point

Clinical Commissioning Groups (CCGs) have statutory duties to:

- consider relevant Joint Strategic Needs Assessments (JSNAs) and Joint Health & Wellbeing Board Strategies (JHWSs);[27] and
- publish before the start of each financial period a plan that sets out how it will discharge its functions.

In developing or revising this plan, each CCG must:

- consult people who it is responsible for;
- consult each relevant Health and Wellbeing Board;
- publish a summary of the views gathered;
- publish a summary of how it took those views into account; and
- include in the published plan a statement of each relevant Health and Wellbeing Board's final opinion on the plan.[28]

Combined, these duties mean a range of stakeholders (including local authorities, Health and Wellbeing Boards, Health Overview and Scrutiny Committees, local voluntary, community and third sector organisations, CCG Member Practices, service providers and participants in local consultative arrangements) will be aware

[25] p17, *Planning, assuring and delivering service change for patients*, NHS England 2018
[26] s13Q, 14Z2 and 242, National Health Service Act 2006 as amended.
[27] s116B, Local Government and Public Involvement in Health Act 2007
[28] s14Z11-13 National Health Service Act 2006

of the potential for change and early discussions on the need for specific service change will be well-founded.

Early involvement with diverse communities, local Healthwatch organisations, patient groups and other local organisations is essential, as well as engaging NHSEI where appropriate. This 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.[29]

3.2 Equality and health inequality duties

The duties placed on NHS bodies by equality legislation permeate all stages of the service change process from early discussion through to decision-making and on to implementation. NHSEI has made available specific guidance for NHS bodies on discharging equality and health inequality legal duties.[30] Reflecting these duties and for reasons both of fairness and improvement in overall outcomes, the NHS Long Term Plan sets out commitments to take a more concerted and systematic approach to reducing health inequalities and addressing unwarranted variation in care.[31]

3.3 The Equality Act

The Equality Act (2010) places NHS bodies under a continuing duty "in the exercise of their functions" to "have due regard to the need to:

- eliminate discrimination, harassment, victimisation and other prohibited conduct; advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it."[32]

The relevant protected characteristics are:

- age;
- disability;
- gender reassignment;
- pregnancy and maternity;
- race;
- religion or belief;
- sex;
- sexual orientation.[33]

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[29] p17 & 18, *Planning, assuring and delivering service change for patients*, NHS England 2018
[30] Guidance for NHS commissioners on equality and health inequalities legal duties, NHSE 2015
[31] 2.23 *The NHS Long Term Plan*, NHS England 2019
[32] s149 (1), Equality Act 2010
[33] s149 (7), Equality Act 2010

This important duty, known as the Public Sector Equality Duty, is concerned with process. Public bodies must take appropriate steps to "be properly informed before taking a decision. If the relevant material is not available, there will be a duty to acquire it."[34] The courts have recognised that discharging this duty and ensuring evidence is available to demonstrate it has been discharged "imposes a heavy burden upon public authorities"[35] and has made clear that a "realistic and proportionate approach" must be taken in evidencing compliance.[36]

NHS bodies must avoid discrimination, harassment and victimisation and, where necessary, make reasonable adjustments for disabled people when undertaking activity that supports and informs decision-making and their other functions.[37]

3.4 Duty as to reducing health inequalities

The Health and Social Care Act 2012 amended the National Health Service Act 2006 to place on clinical commissioners' duties "in the exercise of their functions [to] have regard to the need to:

a) reduce inequalities between patients with respect to their ability to access health services, and
b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services."[38]

Commissioners should consistently have regard to the need to reduce inequalities when exercising their functions.[39]

[34] LJ Elias in Hurley and Moore v Secretary of State for BIS 2012 EWHC 201, cited by LJ McCombe in Bracking v Secretary of State for Work and Pensions [2013] EWCA Civ 1345, MoJ 2013
[35] p60, LJ McCombe in Bracking v Secretary of State for Work and Pensions [2013] EWCA Civ 1345, MoJ 2013
[36] p313 R(SG) v Secretary of State for the Home Department [2016] EWHC (Admin) 19
[37] p10, Equality Act 2010: Summary Guidance on Services, Public Functions and Associations, EHRC 2014
[38] s13G & s14T National Health Service Act 2006 as amended Health and Social Care Act 2012
[39] p13, *Guidance for NHS commissioners on equality and health inequalities legal duties*, NHSE 2015

4 Developing proposals for service change and a pre-consultation business case (PCBC)

This section focuses on requirements that relate to the development of service change proposals and a PCBC. It covers:

- Developing proposals
- Duty to involve service users
- The NHSEI Assurance process
- The five tests for service change proposals

4.1 Developing proposals

The way in which proposals for change have been arrived at will, if they progress, be exposed to scrutiny by NHSEI, by local authority health overview and scrutiny committees, by patients, the public and other stakeholders, possibly by the courts and possibly by the Independent Reconfiguration Panel after a referral to the Secretary of State.[40]

Development of proposals should be started by seeking a comprehensive range of perspectives to identify the full range of service change solutions that could meet the stated objectives of the programme within available resources.[41] Programme leaders must make sure good records are kept as potential proposals are whittled down to a shortlist.[42]

There is no duty to carry forward to public consultation, where it is required, proposals that in the view of the commissioners are unrealistic, unviable or unsustainable.[43] Commissioners may need to provide information about discarded proposals[44], if there is a requirement to consult on the proposals.[45]

4.2 Duty to involve service users

NHS commissioners have a statutory duty to secure that individuals to whom current or potential future services are being or may be provided are “involved in the development and consideration of proposals [for changes] 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 [at the point where the services are received by users].”[46]

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[40] See Section 1.7
[41] p25, *Planning, assuring and delivering service change for patients*, NHS England 2018
[42] See Section 2.2
[43] R(Nettleship) v NHS South Tyneside CCG and Sunderland CCG [2020] EWCA Civ 46
[44] 28, Wilson LJ in R(Moseley) v London Borough of Haringey [2014] UKSC 56
[45] See section 6.2

[46] S13Q & 14Z2 National Health Service Act 2006 as amended Health and Social Care Act 2012

The legislation states service users may be involved by "being consulted or provided with information or in other ways".

NHS providers are subject to similar duties.[47]

NHSEI guidance recognises that "A separate public involvement exercise is not required at every step, so long as existing arrangements are sufficient to secure the necessary public involvement in the commissioning process."[48]

NHSEI has set out in statutory guidance a three-step process for assessing whether the legal duty to involve applies.[49] NHSEI staff must document their assessment[50] and Clinical Commissioning Groups should ensure adequate records are kept of their decisions about the extent and nature of engagement they will undertake. Where commissioners rely on the outputs of patient and public participation activity undertaken by provider organisations, they should satisfy themselves that activity is sufficient to meet their statutory obligations.

4.3 NHSEI assurance process

NHSEI has set out a two-stage independent assurance process.[51] Stage 1 involves a strategic sense check of the case for change normally conducted before the detailed process of developing proposals is started. Stage 2 requires commissioners to produce a pre-consultation business case (PCBC) for the purposes of testing and assessing the robustness of the proposals before they proceed to consultation where required. Preparing for and completing stage 2 assurance will assist NHS bodies in meeting their statutory obligations. At stage 2, NHSEI will decide if additional assurance is needed prior to decision-making.

4.4 The five tests of service change

NHS commissioners are required[52] to apply the tests of service change.[53] These include the Government's four tests of service change:

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

[47] s242, National Health Service Act 2006 as amended
[48] p18, *Patient and public participation in commissioning health and care: statutory guidance for CCGs and NHS England*, NHS England 2017
[49] p19, *Patient and public participation in commissioning health and care: statutory guidance for CCGs and NHS England*, NHS England 2017
[50] NHS England staff acting as commissioners (e.g. for specialised services) should document their assessment using the public involvement assessment and planning form available on the NHS England intranet.
[51] p18-23, *Planning, assuring and delivering service change for patients*, NHS England 2018
[52] R (London Borough of Lewisham & Anor) v Secretary of State for Health & Ors [2013] EWHC 2381 & R (Cherwell District Council & Ors) v Oxfordshire CCG [2017] EWHC 3349 (Admin)
[53] p13, *Planning, assuring and delivering service change for patients*, NHS England 2018

- Support for proposals from clinical commissioners.

And in addition:

- NHSEI's Patient Care (bed closure) Test

It is for NHSEI to decide if the Patient Care Test has been met.[54] The assessment of proposals against the tests will likely need to be reviewed to include updated information and evidence prior to decision-making.

[54] p103-125 in R (Hinsull) v NHS Dorset Clinical Commissioning Group [2018] EWHC 2331 (Admin)

5 Local authority health scrutiny

This section focuses on legal requirements to formally consult local authorities on proposals for service change. It covers:

- Duty to consult local authorities
- Local authority scrutiny powers
- The duty to seek agreement
- Urgent service changes

5.1 Consulting local authorities

The 2013 Health Scrutiny Regulations[55] place on NHS commissioners a statutory duty[56] to formally consult a local authority where the NHS (commissioner or provider) has under consideration any proposal for a substantial development of the health service in the area of that local authority, or for a substantial variation in the provision of such a service. 'Substantial' is not defined in the Regulations and should be jointly agreed by the NHS and the local authority[57] taking note of locally agreed protocols and working arrangements where they exist.

Consulting local authorities on proposals for changes to NHS services is highly complex and requires a high level of preparation, co-operation and exchange of information.[58] Strong relationships and awareness of the issues underpinning the proposals are often critical to success. This can be developed through information-sharing and discussion at the points described in the preceding sections of this document.

Where an NHS body consults a local authority on a proposal under the regulations, it should state it is consulting under the regulations[59] and must give the authority two dates:

- the date by which the local authority must respond to the proposal; and
- the date by which the NHS body intends to decide whether to proceed with the proposal.

The NHS body must publish these dates and any changes to them.[60]

5.2 Local authority scrutiny powers

The Regulations give local authorities statutory powers to:

[55] The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

[56] Regulation 23 (1) and 23 (12) of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

[57] IRP Stoke-on-Trent referral advice, DoHSC 2017

[58] IRP Horton2 referral advice, DOHSC 2018

[59] 15, R (Juttla & Ors) v Hertfordshire Valleys Clinical Commissioning Group & Ors [2018] EWHC 267 (Admin)

[60] Regulation 23(1b), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

- require the relevant NHS body to provide information on matters it is scrutinising[61],
- require members or employees of the relevant NHS body to attend and answer questions in connection with the matters it is scrutinising[62], and
- respond to the consultation and make recommendations the NHS must consider and respond to[63].

Where substantial change proposals affect more than one local authority area, the affected local authorities must[64] form a Joint Committee to be consulted. Where a Joint Committee is formed only the Joint Committee may discharge these powers.[65] NHS bodies will have to take these arrangements into account from the earliest planning stages.

Local authorities have the power[66] to refer a proposed substantial development or variation to the Secretary of State for review if:

- It is not satisfied with the adequacy of content of, or time allowed to consult it (not the public) on the proposal.
- 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.

Some local authorities delegate the power to refer to the committee or joint committee discharging the scrutiny function. Some retain the power to a decision of the full council. NHS bodies should familiarise themselves with local arrangements.

Where the local authority does not comment on the proposal, or its comments do not contain a recommendation, the local authority must[67] inform the consulting commissioners of:

- its decision on whether to exercise its power to refer the proposal to the Secretary of State, or
- the date by which it proposes to make such a decision, make the decision by that date, and inform the commissioners of that decision.

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[61] Regulation 26 of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

[62] Regulation 27 of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

[63] Regulations 23(4-5) of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

[64] Regulation 30, The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

[65] Commonly, but not always known as a Joint Health Overview and Scrutiny Committee (JHOSC)

[66] Regulation 23(9), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

[67] Regulation 23(7 & 8), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

5.3 Duty to seek agreement

Where there is disagreement between NHS bodies and local authorities on the subject of recommendations made in the response to consultation on change proposals, both parties share a statutory duty to seek to reach agreement. [68]

5.4 Urgent service changes[69]

NHS bodies in England may proceed to make urgent changes to services without consulting local authorities where those bodies are genuinely satisfied the welfare of patients or staff is at risk.[70] Where NHS bodies invoke this provision in the Regulations, they should inform the local authorities in the areas affected about changes and reasons for not consulting. A local authority may still choose to refer the matter to the Secretary of State for review if it is not satisfied that the reasons given for not carrying out consultation are adequate.[71]

[68] Regulation 23(5), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
[69] See section 1.6
[70] Regulation 23(2), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
[71] Regulation 23(9), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013; See section 5.2

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6 Consulting patients and other stakeholders

Public consultation will not be appropriate for every service change proposal. This section focuses on legal requirements of formally consulting patients and other stakeholders on proposals for change where public consultation is required. It covers:

- Public law requirements for public consultation
- Deciding to consult the public
- Reporting consultation output
- Changed proposals

There are countless perspectives among stakeholders on service change. NHS bodies' duties mean they have to take each into account. NHS staff, patients, carers, visitors, clinicians, officers in partner organisations, elected representatives, action groups with a wider agenda, community groups, local businesses and others will have valuable insight to contribute.

6.1 Public consultation

Public consultation is a formal window of opportunity for any stakeholder to scrutinise and respond to proposals for change. Public consultation is liable to result in better decisions by ensuring that the decision-maker has access to all the relevant, properly tested information and must be conducted fairly[72]. The requirements for fairness in conducting a public consultation are set out in an extensive and growing body of case law, including the four Gunning Principles[73], which are:

1. **Proposals must be at a formative stage**

   The decision-making body's mind needs to be open to influence from responses to a public consultation.

2. **Consultors must provide sufficient information to allow consultees 'intelligent consideration' of the proposals**

   NHS bodies should satisfy themselves sufficient information is in the public domain, record and consider requests from consultees for additional information. Following the rigorous process of creating an externally assured pre-consultation business case (PCBC) will go a long way to meeting this requirement.

3. **Consultors must allow sufficient time for consultation**

   NHS bodies should consider their own policy and practice, and the volume and complexity of the information being published to support when determining the deadline for responses to a public consultation.

[72] 24, Wilson LJ in R(Moseley) v London Borough of Haringey [2014] UKSC 56
[73] R (Gunning) v Brent London Borough Council (1985) 84 LGR 168

4. **Consultors must conscientiously consider the output of the consultation**

   Following consultation, the response to the consultation exercise must be analysed, fairly reported and considered in detail by the decision-makers.

6.2 **Deciding to consult the public**

Decisions on whether to hold a public consultation on proposals for service change as a means to discharge the duty[74] to involve should take account of:

- the description of arrangements for patient and public involvement included in the CCGs' constitution in response to its statutory duty[75];
- their patient and public involvement strategy or policy documents; and
- other established practices, undertakings and previous commitments made.[76]

NHSEI guidance notes that where there is a duty for the commissioner to consult the local authority under the 2013 Health Scrutiny Regulations, it will almost invariably be the case that public consultation is also required.[77]

Irrespective of how a decision to hold a public consultation is arrived at, the common law duty of procedural fairness will inform the manner in which that consultation should be conducted.[78]

Each NHS organisation should satisfy itself that its public involvement duty and duty to consult affected local authorities has been met. In practice, a single, well-resourced period of consultation can be sufficient to satisfy commissioners' and providers' respective duties.[79] Note that public consultation will normally end before local authority consultation. "It is sensible for health scrutiny to be able to receive details about the outcome of public consultation before it makes its response so that the response can be informed by patient and public opinion."[80]

6.3 **Reporting consultation output**

The responses to a consultation must be reported fairly in a format that allows decision-makers to take them fully into account in their considerations.[81] It is advisable to engage an independent body to run the consultation analysis[82] and brief them on decision-making requirements before the public consultation is launched.

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[74] s13Q & 14Z2 National Health Service Act 2006 as amended
[75] s14Z2(c) National Health Service Act 2006 as amended
[76] R(Buckingham) v NHS Corby CCG [2018] EWHC 2080 (Admin)
[77] p11, *Planning, assuring and delivering service change for patients*, NHSE 2018
[78] R(Moseley) v London Borough of Haringey [2014] UKSC 56
[79] p12, *Planning, assuring and delivering service change for patients,* NHS England 2018
[80] s4.4.2, Local Authority Health Scrutiny**:** Guidance to support Local Authorities and their partners to deliver effective health scrutiny, DoH 2014
[81] 37, R (Kohler) v The Mayor's Office for Policing and Crime [2018] EWHC 1881
[82] p31, *Planning, assuring and delivering service change for patients*, NHS England 2018

6.4 **Changed proposals and further consultation**

Based on the output of a public consultation, an NHS body may wish to adapt its published proposals to an extent that warrants consideration of further consultation. There should be further consultation if there is “a fundamental difference between the proposals consulted on and those which the consulting party subsequently wishes to adopt.”[83]

[83] 45, R(Smith) v East Kent Hospital NHS Trust [2002] EWHC 2640

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7 Decision-making

The culmination of a process to develop, discuss and consider proposals for changes to services is a formal decision. This section focuses on legal requirements that relate to decision-making on proposals for change. It covers:

- The types of decision to be made
- Decision-making arrangements
- Decision-making papers
- Local authority scrutiny decision

7.1 Types of decision to be made

It is likely in any substantial service change that there will be a series of decisions to be made:

1. First, commissioners will consider the evidence base and make decisions on:
    a. the future service model (service change decision); and
    b. the identity of the provider they wish to appoint (procurement decision).
2. Then, chosen providers will consider the evidence base as they make plans to implement the commissioning decisions.

Working in partnership at Integrated Care System (ICS) and Sustainability and Transformation Partnership (STP) level does not automatically ensure arrangements are in place to discharge legal responsibilities in decision-making.

7.2 Decision-making arrangements

Decision-makers should satisfy themselves that sufficient evidence is in place to enable them to discharge each of their legal duties in the process. For commissioners this is a wide range of duties set out at Annex A. Care should be taken that each decision to be made is considered by a body that has the legal authority to make that decision.

The commissioners' decision is to be based on the best balance of evidence, including evidence gained through public engagement and consultation. A clear audit trail of how the decision was reached and the considerations taken into account should be captured.[84]

7.3 Decision-making documents

The prescribed approach to meeting this requirement is to build a decision-making business case (DMBC), which can be built from the pre-consultation business case (PCBC) and should include: information on the sustainability and affordability of the proposals; analysis of output from public consultation and consultation with local

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[84] p32, *Planning, assuring and delivering service change for patients*, NHS England 2018

authorities and other stakeholders, and show how that output has been taken into account. A DMBC may form the basis for an additional assurance check where required by NHSEI.

The elements needed for a decision-making business case are covered in *Planning assuring and delivering service change for patients*. Whether or not it is required as part of the assurance process, a DMBC should be organised in a way that supports decision-making and the entirety of the documentation that builds the case should be made available to decision-makers for consideration.

Clinical Commissioning Groups must make decisions in accordance with the arrangements for securing transparency around decision-making each has set out in its constitution[85]. NHS trusts and NHSEI are required to conduct meetings in public[86]. Decision-making should take place in line with normal organisational governance processes. An extraordinary meeting with a single agenda item may be organised to consider the issue. The decision-making body should address conflict of interest in the appropriate way. Decision-making in the NHS is complex and multi-factorial and must take into account a series of statutory duties that do not all pull in the same direction. To balance the competing factors decision-makers have to exercise substantial discretion, judgement or assessment.[87] The chair of the meeting may find it useful to consider each of the applicable considerations in turn to make sure legal duties set out at Annex A are demonstrably discharged.

It is helpful to video-record the meeting, particularly if it is being broadcast or webcast.

Decision-makers should again be mindful of their procurement duties at this stage.[88] There are occasions when the process of discussing service change proposals leads to a change in the proposals being considered to such an extent that further consultation might be required.[89]

7.4 Local authority referral consideration

In practice local authorities (normally through their Health Overview and Scrutiny Committee or Joint Committee) will often reserve their considerations on referring a proposal for substantial service change to the Secretary of State for review[90] until after a commissioning decision has been made. The authority must inform the relevant NHS bodies of its decision.[91]

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[85] para 4(2), Schedule 1A, National Health Service Act 2006
[86] Public Bodies (Admission to Meetings) Act 1960
[87] 75, Farbey J in R(A and Keppel) v South Kent Coast CCG and others [2020] EWHC 372 (Admin)
[88] The Public Contracts Regulations (2015); and The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013
[89] See Section 6.4
[90] Regulation 23(9) of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
[91] s23(7 & 8), The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013; see Section 5.2

Further reading and resources (links embedded)

- *The NHS Long Term Plan* (NHS England, 2019)
- *Planning, assuring and delivering service change for patients* (NHS England, 2018),
- *Effective Service Change – A support and guidance toolkit* (available from NHSEI regional teams)
- *Patient and public participation in commissioning health and care: Statutory guidance* (NHS England, 2018)
- *Guidance for NHS commissioners on equality and health inequalities legal duties* (NHSE, 2015)
- *Guidance on capital regime, investment and business case approval* (NHS Improvement, 2016)
- *Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners* (DoH, 2014)
- *Joint Working Protocol: When a hospital, services or facility closes at short notice* (NHS England, 2017)
- *Equality Act 2010: Summary Guidance on Services, Public Functions and Associations* (EHRC 2014)

The Independent Reconfiguration Panel is available to offer generic advice and support to NHS and other interested bodies on the development of local proposals for service change, and publishes the advice it gives to the Secretary of State on each matter referred to it at https://www.gov.uk/government/collections/irp-initial-assessment-advice

NHSEI **regional leads for reconfiguration** can help guide you through national or regional assurance requirements, support you with understanding the broader service reconfiguration process including understanding public consultation duties, and signpost you to relevant support.

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South West	Christina Button	christina.button@nhs.net
London	David Mallett	davidmallett@nhs.net

You can access further support, examples, case study and resources at the national reconfiguration futureNHS workspace:
https://future.nhs.uk/reconfiguration/grouphome

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Annex A - Legislation giving rise to relevant duties

National Health Service Act 2006 as amended by the Health and Social Care Act 2012

- 1I(2) – function of arranging provision of services for the purposes of the health service in England
- 3(1) – arranging for provision to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility
- 3(1)(f) – CCGs must act in a manner which is consistent with the duties of NHS England and the Secretary of State
- 14P – Duty to promote the NHS Constitution
- 14Q – Duty as to effectiveness and efficiency
- 14R – Duty as to the improvement in quality of services
- 14T – Duty as to reducing health inequalities
- 14V – Duty as to patient choice
- 14X – Duty to promote innovation
- 14Y – Duty in respect of research
- 14Z1 – Duty to promote integration
- 14Z2 – Duty as to public involvement and consultation
- 14Z8 – Duty to have regard to commissioning guidance published by NHSE
- 14Z11 – Duty to prepare and publish a commissioning plan
- 14Z13 – Duty to consult about commissioning plan, publish a summary of views expressed, and explain how the views have been taken into account

S2 Health Act 2009 Duty to have regard to the NHS constitution
The Public Contracts Regulations (PCR 2015)
NHS (Procurement Patient Choice and Competition) (No,2) Regulations 2013
Local Government and Public Involvement in Health Act 2007
The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

Section 149 Equality Act 2010 – Public Sector Equality Duty.

See also provisions in:

- The Public Services (Social Value) Act 2012
- The Autism Act 2009
- The Children's Act 2004
- Freedom of Information Act 2000