Reconfiguration of NHS Services, Patient Engagement Duties on CCGs and NHS Trusts and the Role of Local Authorities

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Introduction

1. The provision of healthcare is continually changing: the needs of patients change; new technologies develop and become available; populations of settlements increase; older hospital or clinic buildings may deteriorate and become unsuitable; and pressures on funding change. The amount of money allocated to the NHS is essentially a political decision, and the division of those resources between primary and secondary care, between routine and specialist conditions and between treatment and research all involve value judgements and are ultimately political decisions - though that maybe "political" with a small P. However it is inevitable that there will never be enough money to go around, that compromises will need to be made between different priorities and that the powerful "sectional interests" within the NHS will cry foul at any decision which does not treat their sectional interest as having the highest priority for funding.

2. Dealing with changes to NHS services can require balancing incommensurable factors and controversial decision-making. In the tensions between commissioners, providers and regulators of care which may arise when NHS services are to be reconsidered, it can be easy for the patient voice to be lost. However, it is crucial that this patient voice is not lost, given that the NHS exists for the sake of its patients (present and future) and - a factor frequently overlooked by those operating NHS bodies - patients from the NHS through their taxes and vote for politicians who pledge continuing support for the NHS.

3. As will be well-known, the structural changes made to the National Health Service by the Health and Social Care Act 2012 were deeply controversial. One means of rendering the changes more palatable was that new guarantees were given that there would be a greater level of patient involvement in decision-making by the new NHS bodies.

[1] With thanks to David Lock QC for his helpful comments and suggestions. Chapter 5 of his website www.gplaw.co.uk provides further information on this topic.

4. These public involvement duties are significant, and are mandatory. However, there has been far from universal compliance with them. This paper is relevant to three types of person:

   (a) NHS bodies who are bound by patient involvement duties;
   (b) Individuals who are disappointed by a decision of an NHS body, and have not been involved in that decision;
   (c) Lawyers advising either of (a) or (b).

5. This paper will conclude by considering the important role of local authorities in the NHS commissioning process.

The Significance of Patient Involvement

6. There are various high-level statements concerning the importance of patient involvement in NHS decision-making.

7. Principle 4 of the NHS Constitution states:[2]

> *The NHS aspires to put patients at the heart of everything it does*
>
> *It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. Patients, with their families and carers where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services.*

8. NHS England's Guidance 'Transforming Participation in Health and Care: The NHS belongs to us all' begins:

> *"The NHS is a cherished national institution. Its founding principle is to provide healthcare which is free at the point of delivery, to anyone who needs it, regardless of their circumstances. The NHS must be more responsive to the needs and wishes of the public, all of whom will use its services at some point in their lives.*

[2] http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx, accessed 20 February 2016.

> *NHS England will ensure that public, patient and carer voices are at the centre of our healthcare services, from planning to delivery. Every level of our commissioning system will be informed by insightful methods of listening to those who use and care about our services."*

9. The Guidance goes on to say at p.7:

> *"Participation is not only about legal requirements. It underpins everything that the NHS in England does."*

10. On p.27, the Guidance quotes Tim Kelsey, National Director of Patients and Information at NHS England:

> *"We must put citizen and patient voice absolutely at the heart of every decision we take in purchasing, commissioning and providing services."*

11. There are clear references to the importance of patient involvement in the Parliamentary debates considering the Health and Social Care Bill 2012.[3] Andrew Lansley, then Secretary of State for Health, said:

> *"Under the Bill, patients will come first and will be involved in every decision about when, where, by whom, and even how, they are treated-"there must be no decision about me, without me." The 2002 Wanless report called for patient engagement, but that did not happen. Now it will. Because patients cannot be empowered without transparent information, an information revolution will give them more detailed information than ever before, showing them and their doctors the consultants who deliver the best care, giving them control over their own care records and enabling everyone to access the care they need at the right place and at the right time. Patients and their doctors and nurses will be able to see clearly which provider of health care offers the best outcomes and to make their decisions accordingly." [Hansard 31 January 2012, Col 608]*

12. At Col 609, he said:

> *"The general aims of reform are sound-greater role for clinicians in commissioning care, more involvement of patients, less bureaucracy and greater priority on improving health outcomes-and are common ground between patients, health professions and political parties."*

13. However, the inquiry commissioned by the King's Fund *Improving the Quality of Care in General Practice* found as one of its Key Messages:[4]

[3] With thanks to Adam Squibbs for these references.

> *"**Engagement and involvement of patients** Patients report high levels of confidence and trust in general practice, but patients' experiences of involvement in decisions about their care and treatment vary. Overall, patients and carers remain poorly engaged in making decisions about their own health. More effort and attention in general practice needs to be placed on enabling patients to be engaged in decisionmaking, and in supporting people to care for themselves."*

14. There is no doubt that there is considerable commitment at the top of the NHS to involving patients in decision-making. Further, there is clear research evidence that patient involvement leads to better decisions (with the evidence cited repeatedly in various Guidance documents). However there may be something of a gap between political commitment to patient involvement and the reality of patients both being involved and feeling as if they are involved in decisions made about their health services. Further, different patient groups have different experiences of the NHS. At the time of the King's Fund's Inquiry, ethnically white patients had a better perception of involvement in decisions about their care than patients from other ethnic backgrounds. Likewise, older patients felt more involved in decisions about their care and treatment than younger patients.[5]

The Statutory Duties of Patient Involvement

15. The National Health Service Act 2006 imposes a duty to make arrangements to involve patients in decision-making on three bodies:
    i) NHS Trusts/NHS Foundation Trusts (s.242)
    ii) Clinical Commissioning Groups (s.14Z2)
    iii) NHS England (s.13Q).

16. In ***R (Lewisham Borough Council) v Secretary of State for Health*** [2014] 1 WLR 514, Sullivan LJ described the statutory schemes which ensured public involvement in decisions to close hospitals as being within a statutory scheme which "sets great store by consultation" (para. 17).

17. Whilst the duties imposed by these sections are similar, there are significant differences between them.

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[4] http://www.kingsfund.org.uk/sites/files/kf/improving-quality-of-care-general-practice-independent-inquiry-report-kings-fund-march-2011_0.pdf, accessed 20 February 2016, p.

[5] *Improving the Quality of Care in General Practice*, p. 88.

Section 242

18. By s.242(1B), each NHS trust and NHS foundation trust must:

> *"make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in–*
>
> *(a) the planning of the provision of those services,*
>
> *(b) the development and consideration of proposals for changes in the way those services are provided, and*
>
> *(c) decisions to be made by that body affecting the operation of those services."*

19. It is well-established that s.242 does not impose a duty upon the Secretary of State: ***R (Fudge) v South West Strategic Health Authority*** [2007] EWCA Civ 803; ***R (Unison) v Secretary of State for Health*** [2010] EWHC 2655 (Admin), paragraph 33.

20. In ***R (LB Ealing) v NHS England*** [2013] EWHC 3255 (Admin), it was common ground that Primary Care Trusts [16]:

> *"… were obliged to secure that "users" of health services for which they were responsible were "involved" in the development of the proposals for change set out in the consultation document and not merely consulted about them after they had been formulated."*

21. The duty under s.242 is therefore not primarily one of consultation, but involvement: see the decision of HHJ Keyser QC, sitting as a Judge of the High Court, in ***R (on the application of Copson) v Dorset Healthcare University NHS Foundation Trust*** [2013] EWHC 732 (Admin), para. 41. Consultation is one of the ways in which this duty can be satisfied, but the duty can also be satisfied through the provision of information. It was found, with reference to s.11 of the Health and Social Care Act 2001 (the predecessor to s.242) that consultation was not required in every instance: ***R (Fudge) v South West Strategic Health Authority*** [2007] EWCA Civ 803, paragraph 51. In ***R (Lewisham London Borough Council); R (Save Lewisham Hospital Campaign Ltd) v Secretary of State for Health*** [2014] 1 WLR 514, Sullivan LJ held at paragraph 16:

> *"It is a striking feature of the 2006 Act that it makes provision for an elaborate and lengthy process of public involvement and consultation in respect of proposals to reconfigure hospital services: see section 242 of the Act."*

22. No obligation arises with respect to s.242 under proposals which are considered to be non-viable. Some possibilities can therefore be considered and discounted on clinical, financial or other grounds without consultation: ***R (Enfield Borough Council) v Secretary of State for Health*** [2009] EWHC 743 (Admin), [17] (a decision on permission by Geraldine Andrews QC (as she then was), sitting as a Deputy High Court Judge – although this matter was not in dispute between the parties).

23. It is also notable that the section 242 duty can be satisfied through the involvement of representatives. Therefore, an NHS trust or foundation trust can engage patients through a focus group or patient representative group. This is different to the position of CCGs or NHS England, which cannot satisfy the legislative requirements upon them concerning patient involvement by representatives[6]. The arrangements must relate to "users" of the services. In ***R (Royal Brompton and Harefield NHS Foundation Trust) v Joint Committee of Primary Care Trusts*** [2012] EWCA Civ 472, the Court of Appeal held at paragraph 7 that users of paediatric cardiac surgical services included the parents of the children to whom the services would be provided.

24. The patient involvement requirements under s.242 are excluded where the Secretary of State makes a direction under Part 2, Chapter 5A of the 2006 Act, to appoint a Trust Special Administrator. In those circumstances, the requirements of consultation are more limited: ***R (Lewisham Borough Council) v Secretary of State for Health*** [2014] 1 WLR 514, paragraph 16, *per* Sullivan LJ:

> *"It is a striking feature of the 2006 Act that it makes provision for an elaborate and lengthy process of public involvement and consultation in respect of proposals to reconfigure hospital services: see section 242 of the Act. If the Secretary of State invokes the Chapter 5A regime those arrangements are excluded, and Chapter 5A itself makes provision for a more limited process of consultation."*

[6] The NHS England Guidance which has been recently published at https://www.england.nhs.uk/wp-content/uploads/2015/11/ppp-policy-statement.pdf which suggests at page 17 that the section 13Q duty on NHS England can be discharged through involving representatives appears to arise from a misreading of the legislation.

25. The Trust special administration scheme has now been changed to allow local commissioners to define the services that must be retained as part of the administration and, to some extent, to reverse the effect of the Lewisham judgment, with commissioners now able to specify services that they require to be retained at the hospital trust which is in administration. The special administration powers had not been used at any time since they were used for Lewisham and Stafford. It seems highly unlikely that the Department of Health will use the powers again the future in their present form.

Section 14Z2

26. The equivalent of s.242 in imposed upon Clinical Commissioning Groups is s.14Z2. Section 14Z2(2) provides:

> *"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."*

27. As with s.242, there is no general duty to consult patients: the arrangements to be made for the involvement of patients may, in certain circumstances, involve patients by other means, including by providing them with information.

28. The scope of s.14Z2 is broad: the requirement for patient involvement will be triggered in a wide range of circumstances.

29. Unlike s.242, it is not possible for CCGs to involve patients through representatives. This wording is specifically excluded from the formulation of s.14Z2(2). The most plausible interpretation is that this different wording is intentional. Therefore, the use of focus groups

will not satisfy s.14Z2, and neither will the use of patient feedback groups, at least not where the membership of the feedback group is exclusive.

30. Consultation is one of the ways in which patients can be involved. Although if there is a major change after a consultation, this may give rise to a requirement to re-consult, this threshold was not met in the first case to consider s.14Z2 after an extension in proposed catchment: ***Keep Wythenshawe Special Ltd v University Hospital of South Manchester NHS Foundation Trust*** [2016] EWHC 17 (Admin), para. 90.

31. Pursuant to s.14Z2(5), CCGs must have regard to NHS England's Guidance, 'Transforming Participation in Health and Care: The NHS belongs to us all'. The Guidance includes the following advice to CCGs:[7]

> *"NHS Commissioners should:*
> - *Make arrangements for and promote individual participation in care and treatment through commissioning activity.*
> - *Make arrangements for the public to be engaged in governance arrangements by ensuring that the CCG governing body includes at least two lay people.*
> - *Listen and act upon patient and carer feedback at all stages of the commissioning cycle – from needs assessment to contract management.*
> - *Publish evidence of what 'patient and public voice' activity has been conducted, its impact and the difference it has made.*
> - *Engage with patients, carers and the public when redesigning or reconfiguring healthcare services, demonstrating how this has informed decisions.*
> - *CCGs will publish the feedback they receive from local Healthwatch about health and care services in their locality.*

32. The Guidance refers to a 'Ladder of Engagement and Participation':
    - Devolving
    - Collaborating
    - Involving
    - Consulting
    - Informing

33. The Guidance also stresses the importance of engaging early.[8]

[7] At p.5.

[8] Page 32.

34. A CCG is under a statutory duty to prepare an Annual Commissioning Plan, although many CCGs do not appear to do so. The Annual Commissioning Plan is required to state what steps the CCG proposes to take to comply with s.14Z2.[9] there is an express statutory duty on CCGs to consult patients about the content of a draft of the Annual Commission Plan before it is adopted by the CCG Governing Body: see section 14Z13(2). The legal consequences of failing to consult Annual Commissioning Plan had not yet been considered by the court.

35. Section 14Z2(3) imposes requirements upon a CCG's constitution: it must have a description of the arrangements made under s.14Z2(2), and a statement of the principles which will be followed in implementing those arrangements. The standard form CCG constitution which was approved by NHS England simply contained a recital of the words of section 14Z(2) but did not describe the arrangements that the CCG had made or intended to make to comply with the statutory requirement. This means that a large number of CCGs have constitutions which failed to comply with the legal requirements. CCGs are gradually making changes as and when challenges are raised.

Section 13Q

36. There is an equivalent requirement upon NHS England, under s.13Q. Section 13Q(2) provides:

> *"The Board 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 Board,*
> *(b) in the development and consideration of proposals by the Board 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 Board affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact."*

37. There is no statutory requirement for NHS England to take into account its own Guidance, although the Guidance itself say that NHS England will take it into account:[10]

> *"The guidance highlights a range of ways in which NHS commissioners can fulfil their statutory responsibilities and seize the opportunity to deliver personalised and*

[9] Section 14Z11(3)(a).

[10] Page 6.

responsive care to all. It applies equally to clinical commissioning groups and to NHS England's own directly commissioned services."

38. Despite the fact that NHS England came into existence in 2013, it had no document described as its arrangements under s.13Q until November 2015. In November 2014 NHS England was held by the High Court to be acting unlawfully in failing to have arrangements in *R (Curry) v National Health Service Commissioning Board*[11]. A paper was considered by the Board of NHS England at their meeting in November 2015 and a document which purported to be a set of "arrangements" was adopted[12]. However, it is doubtful that this document of itself complies with the statutory obligations on NHS England because it sets up some admirable principles but leaves the detail to be worked out in a series of framework agreements relating to the different areas of commissioning activity by NHS England.

39. There are well developed engagement processes for a large number of specialist services where NHS England has a good track record of engaging with patients and patient representatives when developing commissioning policies in specialised services. It may not be a coincidence that the NHS England overspend on specialist services has arisen in the area of its business where it most engages with patient interests.

40. In contrast, there is virtually no system for engaging with patients in other areas of its commissioning activity, and in particular in areas such as primary care - which affects virtually everybody - and offender health where there are serious logistical challenges in engaging with the prison population. NHS England is presently pursuing a policy of "reviewing" Primary Medical Services contracts to reduce funding to General Medical Services contract levels. The reductions in funding for primary care practices have not yet been implemented and there are a series of challenges raised by patients of primary care practices who object to reductions in funding for their local practice under a policy which was developed without any patient involvement whatsoever.

A Common Theme: The Requirements of a Lawful Consultation

[11] There is no judgment in this case because the Declaration was made as a result of concessions made by NHS England in its Summary Grounds of Defence.

[12] See https://www.england.nhs.uk/wp-content/uploads/2015/11/ppp-policy-statement.pdf

41. NHS bodies, especially when making major changes, often wish to involve patients by means of consultation. There is no general duty at common law to consult. As said above, the statutory involvement duties do not necessarily extend as far as a duty to consult. However, if a public body does decide to engage in consultation, then it must do so lawfully.

42. This paper does not set out exhaustively the entire of the law of consultation.[13] However, the key requirements were set out in ***R v Brent London Borough Council, ex p Gunning*** (1985) 84 LGR 168:
    (1) The consultation must be at a point at which the proposals are at a formative stage. Consulting once the decision has effectively been made will be unlawful.
    (2) The public body must provide sufficient reasons such that permit of intelligent consideration and response.
    (3) Adequate time must be given for consultees to consider the information and respond.
    (4) The product of consultation must conscientiously be taken into account in the eventual decision reached.

43. These four questions were accepted by Lord Wilson in the Supreme Court in ***R (Moseley) v Haringey London Borough Council*** [2014] 1 WLR 3947, para. 25. In ***Moseley***, the consultation was unlawful for a failure to adequately inform consultees of possible alternatives to the proposed form of reduction of council tax benefit. In ***R (West Berkshire District Council and Reading Borough Council) v Secretary of State for Communities and Local Government*** [2016] JPL 35, the Secretary of State was found to have failed to comply with the second of the Gunning criteria:[14]

> *"LPAs did not have the opportunity to make representations on material which was known to the defendant and central to the formulation and adoption of his new national policy, where that policy was going to have a substantial effect on the discharge of LPA's planning functions. The process followed by the defendant was plainly unfair."*

A Common Question: The Meaning of 'Arrangements'

[13] See 'An Update on Consultation' – Alistair Mills (2015) 20(3) JR 160.

[14] Para. 155.

44. Sections 242, 14Z2 and 13Q all impose a requirement upon NHS bodies to "make arrangements" for patient involvement. The meaning of this phrase in this context is yet to be judicially considered.

45. However, in the context of special education needs, Mummery LJ held that a duty to make arrangements had the following characteristics:[15]

> *"In the interests of fairness, consistency and administrative efficiency a local education authority is entitled to formulate a policy setting norms, standards and criteria to be applied in the consideration of the circumstances of individual children. Such a policy is lawful if it promotes the specified statutory purpose and is sufficiently flexible not to fetter the decision-making process in individual cases. Further, once a policy has been formulated, it is permissible (and advisable) to review it from time to time in the light of experience and of changing circumstances"*

46. In ***Tandy***, Lord Browne-Wilkinson said: "That duty will not be fulfilled unless the arrangements do in fact provide suitable education for each child".

47. Likewise, in a permission decision, Underhill LJ held in ***R (Nash) v Barnet London Borough Council*** [2013] EWHC 1067 (Admin):

> *"… the reference to 'making arrangements' would make it clear that the duty was concerned with intentions rather than outcome. It may also be that the draftsman wanted to emphasise the need to build the fulfilment of the best value duty into authorities' plans and procedures. Or perhaps it is just circumlocution. But, whatever the explanation, the important point for present purposes is what the arrangements are aimed at, namely securing improvements in the way in which authorities perform their functions"*

48. A requirement for a landlord to make arrangements to consult its tenants under s.105 of the Housing Act 1985 was considered by Laing J in ***Bokrosova v London Borough of Lambeth*** [2015] EWHC 3386 (Admin), para. 67:

> *"The obligation to make arrangements appears to be a general one, but the drafting contemplates relatively detailed arrangements: the arrangements must enable tenants to make their views known 'within a specified period'; and the authority must publish 'details' of the arrangements which it does make. Section 105 imposes obligations to make arrangements which enable tenants to be informed about an authority's proposals and to make their views (on such proposals) known to the authority. An important specific obligation section 105 imposes is to consider any*

[15] ***Tandy v East Sussex CC*** [1998] AC 714.

> *representations made to it 'in accordance with those arrangements before making any decision on the matter'."*

49. I suggest that the duty to make arrangements in the context of the National Health Service Act 2006 contemplates that the NHS body must have a policy that:

    a) Enables patients (or 'users' of health services) to be aware of how they are likely to be involved in decision concerning proposed changes;
    b) (Relatedly) is clearly promulgated and publicly available,
    c) Applies generally to how the body will make its decisions, rather than leaving this down to *ad hoc* decisions on a case-by-case basis;
    d) In fact has an impact upon the way the NHS body engages with patients.

A Common Question: Is Patient Involvement Required in Urgent Cases?

50. There is a widespread myth in the NHS that there is an exemption to the statutory obligations to involve patients if there are patient safety issues or a decision needs to be taken urgently. Like most "myths" the origin of this belief is obscure but the supposed exemption does not exist in the wording of the statutory duties. The questions to whether the statutory duty to involve patients is avoided where there are patient safety issues was addressed in ***R (Morris) v Trafford Healthcare NHS Trust*** [2006] EWHC 2334 (Admin). In that case the Trust "says it took an urgent decision to close the wards because they were not clinically safe": see para.44. It therefore contended that there was no duty to engage patients before the decision was taken. That argument was specifically rejected by Mr Justice Hodge who said:

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

51. This judgment therefore indicates that the patient involvement duty will still be engaged in urgent decisions but, as these are public law duties, the court retains a discretion as to whether to enforce the duty. A seriously urgent clinical decision can obviously be taken

without full consultation because otherwise patients would be at risk in the meantime. However, the duty to involve the public in decision-making is continuous therefore the views of the public should be sought as soon as possible after any such urgent decisions taken, and the views should be taken into consideration in deciding how to respond to the clinical emergency.

52. However in the ***Trafford*** case, perhaps predictably, the Judge did not order the Trust to reopen the wards whilst it went through a process patient engagement to determine the long-term future for the relevant facility.

53. In my view the most sensible approach would seem to be that an NHS body's arrangements should have a specific policy dealing with situations of urgency. Such a policy may well provide that, in situations of extreme urgency, the involvement of patients may be fairly attenuated (such as by ensuring that patients are provided with detailed information by the NHS body's website). This approach is similar to that in NHS England's November 2015 Guidance, at p.20-21:

> *"For example…*
>
> *NHS England has the contractual right to terminate a general dental services contract on patient safety grounds. Unless a new provider is immediately available and able to use the premises, it is inevitable that patients will have to go to another location for consultations and treatment, at least for a temporary period. NHS England's public involvement duty would be engaged in this scenario, but carrying out a detailed public involvement exercise before closing the practice could place patients at risk. It would therefore be sufficient for NHS England to notify all patients of the situation in this case, even though a more detailed level of public involvement would usually be required for the closure of a dental practice"*

54. This would have the advantage of satisfying the explicit requirements of the statute, whilst not preventing urgent decisions being taken.

The Role of Local Authorities

55. The role of Local Authorities in the scrutiny of major changes to the provision of services is set out in Part 4 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

56. Under Regulation 21(1), local authorities have a wide power to review and scrutinise matters relating to the planning, provision and operation of health services in their area. In carrying out a review, the local authority must invite representations from interested parties, and take into account relevant information, including information from a local Healthwatch forum (Regulation 21(2)).

57. Other than acknowledgement of receipt of a reference, and keeping informed the person who made the reference, the procedure for scrutiny is in the hands of the local authority (Regulation 21(3)-(4)).

58. Where a local authority does engage in review and scrutiny, it may prepare a report and recommendations to the responsible health body (Regulation 22(1)). Such a report and recommendations must include (Regulation 22(6)):

> *(a) an explanation of the matter reviewed or scrutinised;*
> *(b) a summary of the evidence considered;*
> *(c) a list of the participants involved in the review or scrutiny; and*
> *(d) an explanation of any recommendations on the matter reviewed or scrutinised.*

59. If the local authority issuing the report and recommendations requests a response from the responsible person,[16] it must do so within 28 days (Regulation 22(7)).

60. A responsible person, proposing a substantial development of the health service in an area of a local authority, must (Regulation 23(1)):

> *(a) consult the authority;*
> *(b) when consulting, provide the authority with—*
> *(i) the proposed date by which R intends to make a decision as to whether to proceed with the proposal; and*
> *(ii) the date by which R requires the authority to provide any comments under paragraph (4);*
> *(c) inform the authority of any change to the dates provided under paragraph (b); and*
> *(d) publish those dates, including any change to those dates.*

61. If, however, the relevant person is satisfied that such a decision has to be made without allowing a time for consultation due to a risk to the safety or welfare of patients or staff, then the duty to consult does not arise (Regulation 23(2)). The relevant person must however

[16] i.e. "a relevant NHS body or a relevant health service provider" (Regulation 20(1)).

inform the authority that the decision has been taken, and why no consultation has taken place (Regulation 23(3)). The local authority may make recommendations to the relevant health body (unless a joint health overview and scrutiny committee has been appointed due to cross-authority implications, or in case of a direction by the Secretary of State).

62. If a local authority makes a recommendation in the context of a substantial development, and the health body does not agree with the recommendation, then it must give reasons for its disagreement and attempt (with the local authority) to take steps to reach agreement (Regulation 23(5)). There is a long-stop of a complaint to the Secretary of State in a case of a failure to consult or a failure by the local authority and the responsible person to reach agreement. The Secretary of State may make a final decision or make a direction to NHS England, which may make a direction to a CCG (Regulation 25).

63. There is a duty upon responsible persons to provide such information as is requested to local authorities in relation to the planning, provision and operation of health services in the area of that authority (Regulation 26(1)). Confidential information is subject to a requirement of redaction or consent of the individual in question (Regulation 26(4)).

64. A local authority has the power to summon members or employees of a responsible person to answer relevant questions (Regulation 27(1)).

65. The local authority may arrange for these functions to be carried out by an overview and scrutiny committee.[17] It may arrange for this to be the overview and scrutiny committee of another authority, where that authority agrees and it is better placed to undertake the relevant functions (Regulation 28). The Secretary of State may also direct that this take place (Regulation 32(1)).

66. Local authorities may appoint a joint overview and scrutiny committee (Regulation 30(1)). Indeed a joint overview and scrutiny committee must be formed where a responsible person consults more than one local authority (Regulation 30(5)).

[17] Indeed a local authority's executive arrangements must include provision for the appointment of an overview and scrutiny committee.