PUBLIC CONSULTATION IN THE NHS 2014

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*Encouraging the maximum level of minimal participation*

Colin Crouch *Post Democracy, 2004*

**INTRODUCTION**

Over the last thirty years free market ideologues have worked behind the scenes to dismantle the NHS (ref 1 ; ref 2). Thanks to their efforts, the NHS in England is now a full blown market, free to flourish unfettered by political interference and public scrutiny. Under the 2012 Health and Social Care Act, the Secretary of State no longer has the fundamental duty to provide or secure a comprehensive health service. Clinical commissioning groups (CCGs) are responsible for commissioning and (rationing) services instead. And their duty is to commission services to ‘meet all reasonable requirements’ for their patients, not to provide communities with a comprehensive range of services (Ref 3).

Accountability arrangements that allow the ability of citizens and their representatives to hold their governments to account, by rewarding or punishing them, have the ability to constrain abuse of political power, as well as the potential to improve service delivery (ref 4). But under the Act, commissioners as well as providers of NHS funded services no longer answer to the Secretary of State. Instead, they are accountable to unelected, independent regulators[[1]](#footnote-1). And their role is to deregulate the NHS, to promote competition and private sector involvement. As a result, market forces, not the Secretary of State, now determine which organisations provide NHS funded services, which providers survive and which providers fail and have to close. In this way, the 2012 Act detaches the government from responsibility - and blame – and, by removing the ability of citizens to hold the Secretary of State to account, radically reduces democratic accountablility in the NHS.

Less well recognised but similarly significant is how the Act and related legislation removes the accountability of NHS organisations downwards, to local communities and their representatives. The NHS Plan in 2000 included a concordat welcoming the private sector into the NHS, Since then, successive health ministers have acted (i) to weaken accountability to local communities and their representatives (ii) to promote, instead, engagement with individual patients or ‘consumers’ and (iii) to limit the public scrutiny of NHS funded health care premises. Such tactics are required to smooth the way for privatisation. Private firms are accountable to shareholders, not to local communities. And to safeguard shareholder profits, firms require protection from undue scrutiny. Weak accountability mechanisms, with no means of redress for citizens, are desired because they are not a threat to corporate interests. In fact, privatisation would not have succeeded without the loss of accountability to local communities and their representatives.

Between 1974 and 2003, Community Health Councils (CHCs) represented the interests of NHS patients in each district health authority. Their performance varied from district to district. But, importantly, all had the statutory powers and independence necessary, if they so wished, to keep their residents fully informed and to hold the local health service properly to account.

Many deserved the accolade:

“*CHCs are a jewel - that is not well understood….There is nothing like it in the rest of Europe, where it is the administrators and doctors who decide*” Mikko Vienone, World Health Organisation European regional advisor (HSJ 23rd July 1998) .

CHCs were independent of health service management, free to keep the public fully informed and supported by officers who were accountable to them and not to the Regional Health Authorities, their paymasters. CHCs’ wide range of statutory duties and rights allowed them to form an overview of the whole of the health service in their area and to understand how patients might be affected, directly or indirectly, by proposals for change. Their statutory powers included (i) the right to information (ii) the right to visit and inspect health service premises (iii) the right to be consulted on any proposals for substantial variation or development of the health service in their area (iv) the right to refer disagreements with the health authority or concerns about the conduct of a consultation to the Secretary of State. Their statutory duties were to (i) monitor the operation of health services across the health authority (ii) provide the public with information (iii) advise and support patients with complaints (iv) make recommendations for service improvements (v) hold meetings in public and publish an annual public report.

It was the ability of CHCs to keep patients and the public fully in touch with what was happening to local health services that contributed to their downfall. For example, the monitoring exercise ‘Casualty Watch’ whereby CHCs across England simultaneously recorded waiting times in the A & E departments of their local hospitals, and then published their findings, greatly annoyed health authorities and hospitals with the longest waiting times. In the late 1990s, a public row broke out when a Birmingham CHC informed its residents why it had decided to oppose plans for a new PFI hospital. The Regional Health Authority told CHC members to either work within government policy or resign. And in Parliament, a Birmingham MP led the first call for CHCs to be abolished. In response, the CHC proposed a motion calling for PFI to be abandoned in the NHS at the 1999 AGM of the Association of Community Health Councils for England and Wales (ACHCEW). It became CHC national policy, with overwhelming support. The last straw, according to historian Charles Webster (ref 1) was probably the demand from ACHCEW that CHCs should play a central role in primary care and act as a bridge between the public and the New Primary Care Trusts. In retrospect, it was not surprising when, in July 2000, the NHS Plan was published and CHCs learnt from a single sentence that they were to be abolished. Nor was it a co-incidence when shortly afterwards, in October 2000, the Department of Health (DH) announced plans for a concordat with the private sector. The removal of effective public scrutiny, had opened the door for the DH to encourage the private sector to play a central role in the NHS.

CHCs were finally abolished in 2003 (National Health Service Reform and Health Care Professions Act 2002 s.22). Their functions were broken up and divided between new statutory bodies – overview and scrutiny committees (OSCs), patients forums (PFs) , patients’ advice and liaison service (PALS), an independent complaints service and the commission for patient, public involvement in health (CPPIH) - none of which retained the CHCs’ ability to acquire and develop an overview of health services in their area. Only one, OSCs, had the right to be formally consulted on proposals for substantial changes to health services and the power to refer disputes to the Secretary of State.

OSCs are cross-party committees of elected councillors set up by Local Authorities with social services responsiblities (Local Government Act 2000 s. 21, as amended by s.7 of Health and Social Care Act 2001). OSCs did not and still do not have the right to visit premises and inspect health services for themselves. Patient Forums were small committees based in NHS hospital and primary care trusts (NHS Reform and Health Care Professions Act 2002 s.15(1)). They had a range of statutory rights including the right to information and the right to visit NHS and private sector premises. But their powers were restricted to the trusts in which they were based. The CPPIH represented the views of Patient Forums to government. After three years Patient Forums and the CPPIH were abolished and replaced by Local Involvement Networks (LINks) (Government and Public Involvement in Health Act 2007) . These were replaced, in turn, by local Healthwatch and Healthwatch England, under the 2012 Act.

During the years of upheaval, patient representatives lost their collective voice as citizens with wide ranging statutory rights. Instead, they metamorphosed into consumers or rather, ‘consumer champions’ tasked with collecting information about patients’ experiences and reporting these to commissioners and providers in the expectation they would improve services and hence patient satisfaction with the services on offer. Local Healthwatch organisations inherited the power held by LINks to visit and inspect health service premises. But, their independence and freedom to speak out has been curtailed, culminating in the establishment of Healthwatch England as a subcommittee of the Care Quality Commission.

Running parallel with the above changes was a new duty placed on all health service bodies to involve and consult in an on-going way with health service users or potential users on (a) the planning and provision of services (b) changes in the way services are provided and (c) decisions affecting the operation of services (Health and Social Care Act 2001 s.11(1)). Since then, the duty to involve individual ‘users’ has had greater emphasis in official documents than the duty to consult with democratically elected OSCs. This is probably because individual patients lack statutory rights and so cannot pose a threat to health service planners or to private sector interests. Health service managers dictate the terms of the engagements and individual patients have no means of redress, apart from judicial review, if they are refused information or if their views are disregarded.

The following paper reviews the current law regarding public consultation in the NHS in England and describes how the loss of political accountability and public scrutiny has gone hand in hand with privatisation.

**1. PUBLIC CONSULTATION -TWO LEGAL DUTIES**

NHS bodies have two legal duties to consult when proposing changes to the way local health services are provided, operated or developed. They are:

(A) The duty to consult with local authorities (LAs) on proposals for substantial development of or substantial variation in the provision of local health services.

(B) The duty to consult and involve patients and the public in an ongoing way, not just when major changes are proposed.

The duties apply to all relevant NHS bodies i.e.:

* The NHS Commissioning Board (NHS England)
* Clinical commissioning groups (CCGs)
* Providers of health services commissioned by the Board, CCGs and the LA, including NHS trusts, NHS foundation trusts (FTs) and providers from the voluntary and private sectors.

NHS England and CCGs are responsible for conducting public consultation when they fund the services under consideration.

Consultations, according to case-law, must must be carried out properly, whether statutory or not i.e.

* Be undertaken when plans are at a formative stage.
* Include sufficient reasons / information to allow for an intelligent response.
* Allow adequate time for an intelligent response.
* Public responses must be conscientiously taken into account when the final decision is made (Ref: R v Brent ex parte Gunning (1985); (see also 5.1)

**2. CONSULTATION WITH LOCAL AUTHORITIES**

**2.1 Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013: Part 4: Health Scrutiny by Local Authorities**

**2.11 Key Points**

The regulations should be read in conjunction with statutory guidance, published in June 2014 (ref 6).

Local Authority Overview and Health Scrutiny Regulations 2002 and 2004 are no longer in force .

Under the 2013 regulations, OSCs when appointed can carry out a wide range of roles (regulation 28). The latter are called relevant functions (regulation 20(1)) and include:

* The review and scrutiny of any matter relating to the planning, provision and operation of the health service in its area (regulation 21).
* The making of reports and recommendations to NHS bodies responsible for the services under scrutiny or to other interested parties e.g. local healthwatch (regulation 22). Recipients must respond within 28 days when the OSC requires a response.
* Responding to consultations on any proposal for a substantial development or substantial variation of the health service in the LA area (regulation 23)
* Requiring members or employees of NHS bodies to attend LA meetings and answer questions (regulation 27).
* Under regulation 26, ‘responsible persons’ (i.e. relevant bodies (see above) plus GPs, and providers of other primary care services) have a duty to provide a local authority “*with such information about the planning, provision and operation of local health services as it may require to discharge its health scrutiny functions*”.

Information requests may include:

* Financial information about the operation of a trust or CCG, for example budget allocations for the care of certain groups of patients or certain conditions.
* Capital allocations for infrastructure projects, such as community facilities.
* Management information such as commissioning plans for a particular type of service.
* Operational information such as information about performance against targets or quality

Although local authorities have the right to request such information, they have no enforcement powers outside the formal consultation process and no power of veto over health service plans (see below).

**2.12 Consultation Process (Regulation 23)**

Regulation 23 dictates that :

* NHS bodies must consult with LAs on proposals for substantial development of or substantial variation in the provision of local services. Substantial is not defined but is expected to encompass reconfigurations, involving a final set of proposals; any configuration options within those proposals, as well as specific changes to individual services (Ref 7).
* NHS bodies are not required to consult where a decision has to be taken quickly to avoid a risk to the safety or welfare of patients or staff NB: *not* for financial reasons. Consulting bodies must inform the LA immediately and give the reasons why they have decided not to consult.
* A LA must inform the NHS commissioner or provider concerned, if it chooses not to respond to a consultation or make a recommendation.
* A LA must submit its response and any recommendations it may make by a date specified by the NHS commisioner or provider.
* NHS bodies and LAs that do not agree about a recommendation, must take all reasonable steps to try to reach agreement.

The 2013 regulations affect the process of consultation in several important respects:

* The regulations apply to LAs themselves as opposed to overview and scrutiny committees (OSCs), as previously.
* A local authority is not required to appoint an OSC. They may choose to do so, however, or make other arrangements e.g. appointIng committees involving members of the public.
* In consultations on substantial changes, a local authority will be allowed (under regulation 23) to delegate the power to refer objections to the Secretary of State, both to (a) OSCs, or (b) to joint scrutiny committees (where proposals affect services operating across LA boundaries}, but not to other committees.
* The local authority as a whole has the power to make a referral when it has not delegated that power to an OSC or joint scrutiny committee. Many LAs fear this will lead to the politicisation of the referral process, if council members vote along party lines. However, other LAs already follow this procedure without encountering problems (Ref. 5).
* The referral process is much more exacting than before. As a result, LAs or OSCs may be deterred from going down this route (see 2.13).
* The 2014 Guidance stipulates that NHS organisations and Health and Wellbeing Boards[[2]](#footnote-2) should engage with LAs or OSCs at an early stage, before plans are well developed. It argues that LAs or OSCs are, then, less likely to refer objections to the Secretary of State when consulted on a final proposal.

The aim of the guidance is to reduce the number of LA referrals to the Secretary of State and thereby the number of delays. However, LAs seem to be making the same number of referrals as before. Between February 2013 and May 2014, the SoS transferred 13 LA referrals to the Independent Reconfiguration Panel (see 2.14) compared with 10 transfers between January 2010 and January 2011([www.irpanel.org.uk](http://www.irpanel.org.uk)). It is a tribute to LAs that they continue to exercise their right of referral, despite of the exacting regulations.

**2.13 Referral Process Regulation 23 (9)**

Where all attempts to reach a local resolution have been exhausted, a LA or OSC may refer a disputed proposal to the Secretary of State (SoS) for a decision. Formerly, in consultations between LAs and NHS Foundation trusts (NHS FT ) disputes were referred to Monitor, the FT regulator. Now all disputes are referred to the SoS.

Under regulation 23(9) a LA can make referrals to the Secretary of State where:

* Consultation has been been inadequate in terms of content (information provided) or time allowed.
* The reasons given by a NHS body for not consulting (see above) are inadequate
* Where the LA considers the proposal would not be in the interests of the local health service.

Referrals reports must now include:

* An explanation of the proposal to which the referral report relates.
* An explanation of the reasons for making the referral
* Evidence in support of these reasons.
* Where the proposal is referred because of inadequate consultation , the reasons why the LA or OSC is not satisfied of its adequacy.
* Where the proposal is referred because there was no consultation for reasons relating to the safety or welfare of patients or staff, reasons why the LA or OSC is not satisfied that the reasons given for lack of consultation are adequate.
* Where the LA or OSC believes that proposals are not in the interests of the health service in its area, a summary of the evidence considered, including any evidence of the effect or potential effect of the proposals on the sustainability or otherwise of the health service in the area.
* An explanation of any steps the LA has taken to try to reach agreement with the relevant NHS body or health service provider.
* Evidence that the LA has complied with the requirements which apply where a recommendation has been made.
* Evidence that the LA has complied with the requirements which apply where a recommendation has not been made, or where no comments have been provided.

According to the 2013 guidance (Ref. 6), referrals to the Secretary of State should follow the terms of reference of the Independent Reconfiguration Panel (IRP, see below) i.e. whether a proposal would provide safe, sustainable and accessible services for the local population. However, the regulation that specifically requires a LA to consider financial sustainability (e.g. looking at opportunities a proposal offers to save money for use elsewhere in the health service) could become an obstacle for LAs or OSCs wishing to object to plans when the latter are based, primarily, on the need to save money.

**2.14 The Secretary of State’s decision (Reg 25)**

On receiving a LA referral the Secretary of State may, where appropriate:

* Make a decision relating to the subject matter of the referral, where the LA considers consultation has been inadequate.
* Make a final decision on a proposal, where the LA considers a proposal is not in the interests of the lthe local health service.
* After making a decision, give directions to the Board (NHS England) as to how it should exercise its power to direct a CCG in relation to the proposal.

The Board may direct a CCG to:

* Consult (or consult further ) with the LA in relation to the proposal
* Determine the matter in a particular way.
* Take or not to take any other steps in relation to the matter.

The above directions conflict with the duty of NHS England to undertake formal assurance of proposals put forward by CCGs. In the formal assurance process, area teams help CCGs from an early stage to develop ‘robust, evidence–based plans that are underpinned by effective patient and public engagement ‘(Ref 7). However, under regulation 25, it seems NHS England could be compelled to instruct CCGs to alter plans which it has already assessed and approved.

**The Independent Reconfiguration Panel (IRP)**

The IRP is an advisory public body set up in 2003 by the DoH to review proposals for change on behalf of the Secretary of State (Ref 8). On receiving a referral from a LA and before making a decision, the Secretary of State may ask the IRP to review the matter and provide him with advice. After the IRP has made an initial assessment, the Secretary of State will decide which referrals the IRP should review in full. The IRP also offers pre consultation advice and support to NHS bodies on the development of local proposals for reconfiguration or significant service changes – including advice and support for public engagement and formal public consulation.

In 2010, the IRP published a paper, based on its own reviews, setting out seven main reasons why LAs make referrals to the Secretary of State (Ref 9)**.** These include:

* Inadequate community and stakeholder engagement in the early stages of planning change.
* The clinical case has not been convincingly described or promoted.
* Clinical integration across sites and a broader vision of integration into the whole health community has been weak
* Proposals that emphasize what cannot be done and underplay the benefits of change and plans for additional services
* Important content is missing from reconfiguration plans and limited methods of conveying information.
* Health agencies caught on the back foot about the three issues most likely to excite local opinion – money, transport, and emergency care
* Inadequate attention given to the responses during and after the consultation

NHS bodies must provide LAs with enough information to enable them to make an informed response to a consultation. If the information they require is refused, they have the right to refer the matter to the SoS. In 2010 two strategic health authorities, London and Humber and North Yorkshire, based on DoH guidance, set out in detail what constitutes ‘necessary information’ in a consultation. (Ref 10&11). LAs should be aware they have the right to such information before responding to a consultation.

**2.15 Exemptions from duty to consult (Reg 24)**

Regulation 23 , the duty to consult with LAs, does not apply to:

* Any proposal to establish or dissolve an NHS trust or clinical commissioning group or to vary the constitution of such a group (unless they involve a substantial development or variation, as set out in reg 23(1)).
* Any proposals contained in a trust special administrator’s report or draft report (NHS Act 2006 s. 65F or 65I)
* Recommendations by a health special administrator on the action which should be taken in relation to a health special administration order (NHS Act 2012 s.128).

**Special administrators**

The 2012 Act provides for two special administration regimes (a) health special administration, applying to companies providing NHS funded services and (b) trust special admistration, applying to NHS FTs. The latter regime will eventually replace the special administration regime run by the DoH for NHS trusts, as the latter are expected to be licensed as FTs or merged with existing NHS FTs sometime this year.

Trust special administrators (TSAs), are called in by Monitor to manage insolvent foundation trusts.Their role is to draw up plans to enable trusts to clear their debts and to ensure the continued provision of ‘commissioner requested services’ i.e. essential services, which commissioners and providers have previously agreed must continue to be provided locally to protect the patients of a failing provider. However, when a trust is under administration, it is the administrators, not commissioners, who are formally responsible for defining which services should continue to be provided (designated location specific services at this stage). They are expected to do this in consultation with commissioners (ref 12). However, when commissioners do not agree with a TSA’s recommendation but the NHS Board does, the TSA can submit its recommendation to Monitor over the heads of commissioners (Health and Social Care Act 2012 s.176 (1076)). The same process for identifying location specific services will eventually apply to private sector health special administrators.

The TSA must reach its decision rapidly. It has 100 working days in which to publish a final recommendation, with only 30 working days in that period allowed for consultation. (Ref 13).

**Statutory Timescale for TSAs**

Stage 1. Monitor lays order before parliamen for the FT concerned to be placed into trust

special administration. Monitor appoints TSA (insolvency practitioner)

­­---------🡪 Within 5 working days

Stage 2. TSA begins. Takes over the role of FT governors, chairman and board of directors

----------🡪 Within 45 working days

Stage 3. TSA has to agree draft recommendations with CCGs and NHS England; publish and provide Monitor with draft report containing recommendations for his action. Monitor lays draft report before parliament.

---------🡪 Within 5 working days

Stage 4. TSA must start 30 day consultation on draft report, including holding a meeting with staff or their representatives and a separate meeting with other parties wishing to attend. TSA requests written responses from NHS England; CCGs; LAs and LA scrutiny functions e.g. OSCs; IRP; Local Healthwatch; Health and Wellbeing board and local MPs. TSA must hold separate meeting with NHS England and CCGs.

-------🡪 Within 15 working days of consultation ending

Stage 5. TSA agrees final recommendation with CCGs and /or with NHS England and presents final report to Monitor. Monitor lays report before parliament .

---------🡪 Within 20 working days

Stage 6. Monitor decides what action it plans to take and notifies SoS

Stage 7. SoS vetoes action plan in exceptional circumstances

Stage 8. Monitor publishes notice of decision and lays it before parliament. Monitor implements proposal.

TSA’s recommendations are designed to enable trusts to clear their debts. The are not designed to meet the needs of patients. Reconfigurations outside the special administration process (and not subject to a statutory timetable) commonly take several years to formulate and implement (Ref 14). According to NHS England (ref 7):

*“Developing, explaining and implementing proposals takes time, collective effort and energy…..*

*The stronger proposals are those developed collaboratively by commissioners, providers, local authorities and patients and the public. This will ensure that proposals are sound, evidence based, in the best interests of patients, will improve the quality and sustainability of care and that people affected will be involved and their feedback will be listened to and acted upon’.*

The freedom of TSAs to ignore the needs of patients in this way has serious implications, not only for the care of patients, but for the wider health economy. It could also leave the SoS open to legal challenge if he/she approves a TSA’s plan that demonstrably increases health inequalities (2012 Act s.4) or is not supported by evidence (2012 Act s.6).

**Clause 118 of the Care Bill**

Clause 118 in the Care Bill gives TSAs new powers to reconfigure, close or transfer services from a neighbouring trust in order to balance the books of a failing trust (Ref 14). The new clause follows the failure of the SoS to win high court approval for his decision to support a TSA plan to close the A&E department of Lewisham Hospital in order to balance the books of South London Healthcare Trust . Clause 118 was approved in parliament on March 11th 2014.

Before the vote on March 11th, the government agreed to publish new guidance to the effect that TSA plans *should* have the approval of local CCGs before they are implemented. The amendment is very likely to have won votes for clause 118, especially as it could also bring back the likelihood of public engagement. However, publishing guidance, rather than amending the law, still leaves the door open for TSAs and NHS England to continue as before. All NHS organisations (including NHS England) must have regard to statutory guidance. But, ‘having regard too’ does not mean they are bound to follow the guidance in every case. Rather they must have good reasons for not following it.

On May 7th, following a campaign by the pressure group ’38 Degrees’, the government finally introduced an amendment to the Care Bill, during its passage through the House of Lords (<http://www.publications.parliament.uk/pa/bills/lbill/2013-2014/0093/amend/ml093-I.htm>). The amendment to clause 118, submitted originally by Baroness Finlay, gives the CCGs of any affected trust, as well as the CCGs of the trust under administration, the right to engage with the TSA and respond to its draft proposals. It also gives the CCGs of an affected trust 20 days in which to consult the public, if they so wish, when the final TSA report recommends changes to the services at their hospitals. The amendment does not cover the possibility that the TSA and CCGs may not be able to reach agreement. If they cannot, NHS England will have the final say, as before.

**2.2 Duty of NHS FTs to consult with local authorities**

The coalition government has decided that all NHS trusts should achieve foundation trust status in 2014 (Ref 13). The following information will then apply to all trusts in the public sector.

Prior to the 2012 Act, regulations required foundation trusts to consult with OSCs when:

* They proposed to make an application to Monitor, the independent FT regulator, to vary the terms of their authorisation and
* Where the application, if successful, would result in a substantial variation in the provision of “protected goods and services” i.e those a FT must provide under the terms of its authorisation (Communities Health and Standards Act 2003( NHS Foundation Trusts Order 2004).

Under the 2013 scrutiny regulations, commissioners, i.e. CCGs or NHS England, are responsible for carrying out consultations when they fund the services under consideration. When a provider has a development or variation “under consideration”, therefore, it will need to inform commissioners at a very early stage so that they can begin to consult as soon as possible.

In April 2013, following the 2012 Act, Monitor became the economic regulator for all providers of NHS funded care, including those from the private sector. Now foundation trusts, along with all other providers of NHS care, apart from NHS Trusts, are issued with a licence that sets out the terms under which they must operate. NHS FTs authorised before 2013 were automatically issued with a licence and their ’protected goods and services’ designated ‘commissioner requested services’ (CRS). Commissioner requested services are those commissioners define as being essential i.e. services that should continue to be provided locally if any individual provider is at risk of failing financially (Ref 12).

There is no formal requirement for CCGs to involve the public in deciding whether a service should be classified as a CRS or not. However, if a service is designated a non-CRS, it does not mean that patients do not need or value the service. Rather, commissioners believe suitable alternatives exist if the current provider stopped providing that service. Moreover, commissioners can change the designation of a service as circumstances change. For example, not all ‘protected goods and services’ are expected to retain their CRS status beyond the initial stage (Ref 12). The number of services categorised as ‘non-essential’ will also grow as new providers are encouraged to enter the market .

The licence requires NHS FTs to continue to provide ‘commissioner requested services’ and not to make material changes to the way in which they are provided *without the agreement of commissioners*. It follows that providers could change or stop providing non-commissioner requested services without the agreement of commissioners and, also, without public consultation. This is because changes to non-essential services, by definition, would not qualify as substantial and, therefore, would not trigger a requirement for providers or CCGs to consult with LAs/OSCs. As more private companies enter the NHS, more and more services could be defined as non-essential and, therefore, subject to change or closure over the heads of elected councillors and local people.

**2.21 Role of NHS FT Governors**

Boards of FT governors are responsible for holding non-executive directors to account individually and collectively for the performance of the Board of Directors. They must act in the best interests of their NHS Foundation Trusts and represent the members of the trust as a whole and the public. (Ref 16).

The 2012 Act provides FT governors with new duties and powers to approve significant transactions, mergers and acquisitions etc . For example:

* Significant transactions must be approved by the majority of governors as well as the Board of Directors. Approval means that at least half of the governors *voting* agree with the transaction. The FT may include a description of ‘significant transactions’ in it’s constitution. They could include contract changes above a certain value (2012 Act s.167).
* The council of governors must approve an application by the trust to enter into a merger, acquisition, separation or dissolution. In this case approval means at least half of *all* governors agree with the application.
* The governors must decide whether or not the trust’s non-NHS activity interferes with its principal purpose, namely to provide goods and services for the health service in England. The council of governors must inform the Board of Directors of its decision.
* Governors must approve any proposed increases in private patient income of 5% or more in any financial year. Approval means at least half of the governors *voting* agree with the increase. Governors must feel confident that the board has reached its decision effectively and with due regard to the interests of trust members and the public before giving their agreement. Governors are not expected to withold their consent on unreasonable grounds. When the final decision has been taken and once the chair has confirmed the decision is not confidential, the council of governors should inform the trust members and the public that the trust has decided to increase the intake of private patients.
* Governors have a general duty to represent members of the trust and the public. But, unlike LAs, they have neither the power nor the means to do so. Governors are either chosen by a very small electorate of members, after putting their own names forward, or are staff representatives or stakeholders appointed by the FT. How they seek the views of their members and the public, in addition, is left up to them. Guidance from Monitor suggests this could include sharing information on the website, surveying their members, holding ‘drop in days’ or working alongside representatives of Healthwatch. Such methods could, perhaps, enable governors to act as ‘consumer champions’ for patients undergoing treatment at their hospital. They would not allow governors to determine how the policies of their FT are affecting the viability of other hospitals in the area. And the duties on FT governors do not increase public scrutiny. Governors do not have the right to inspect the premises of their own FT or the services it provides or a duty to meet patients and conduct quality reviews

Democraticically elected Local Authorities or OSCs do not have a formal role in the approval of significant transactions, mergers, acquisitions, dissolutions or, joint ventures of a FT with the private sector. Yet all of these can have a significant impact on trusts operating and risk profiles, according to Monitor ([www.monitor.gov.uk](http://www.monitor.gov.uk)) . Between 2009 and 2012 the NHS Co-operation and Competition Panel reviewed 12 potential large scale mergers on behalf of Monitor and found that none would breach the trust’s authorisation, if implemented ([www.monitor-nhsft-gov.uk/information-nhs-foundation-trusts/transactions](http://www.monitor-nhsft-gov.uk/information-nhs-foundation-trusts/transactions)).

**3 CONSULTATION WITH PATIENTS AND THE PUBLIC**

**3.1 Duty on providers and commissioners**

Section 242(1B) of the NHS Act 2006, as amended by the Local Government and Public Involvement in Health Act 2007 (LGPIH Act) came into force on 3rd November 2008. It provides that :

*Each relevant English body must make arrangements, as respects to 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-*

1. *The planning of the provision of those services.*
2. *The development and consideration of proposals for changes in the way those services are provided.*
3. *Decisions to be made by that body affecting the operation of those services.*

*Subsections (b) and (c) need only be observed if the proposals would have an impact on:*

1. *The manner in which the services are delivered to users of those services or the range of health services available to those users.*
2. *The reference to the delivery of services is to their delivery at the point when they are received by users.*

Formerly, 242(1B) applied to Primary Care trusts and to Strategic Health Authorities before they were abolished. The legal duty under s.242(1B) now applies only to providers of NHS funded services i.e NHS FTs, NHS trusts and all independent sector providers.

The 2006 Act, as amended by the 2012 Act, makes similar provisions for public involvement and consultation by the Board (s. 23(13Q)) and by CCGs (s.26 (14Z2)). For example, s. 23(13Q ):

*(1) Applies to any health services which are or are to be provided pursuant to commissioning arrangements made by the Board (NHS England).*

*(2) The Board must make arrangements to secure that individuals to whom the services are being provided or maybe provided are involved (whether by being consulted or provided with information or in other ways)-*

1. *In the planning of the commissioning arrangements by the Board.*
2. *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 individuals or the range of health services available to them.*
3. *In decisions of the Board affecting the operation of the commisioning arrangements where the implementaion of the decisions would (if made) have such an impact.*

*The references in subsection (2)(b) is to the delivery of services is a reference to their delivery at the point when they are received by users.*

Section 26 (14Z2) has identical wording to s. 23 (13Q,) but replaces ‘Board’ with ‘Clinical Commissioning Group’. CCGs are required to include in their constitution the principles and arrangements they will make under subsection 2.

A key difference between the two pieces of legislation is that, under the 2006 Act s.242(B), the duty to consult can be met by involving patients directly or through their representatives whereas under s.13Q and s.14 Z2 the duty to consult applies only to involvement with service users or potential users. The difference is not yet reflected in guidance on public involvement published by NHS England in 2013 which continues to refer to carers and representatives alongside users (Ref 7). But it could potentially be used to prevent pressure groups or charities taking part in decision making or collective legal action such as judicial reviews (see 6.2).

**3.12 Duty on commissioners to report**

Under section s 26 (14Z15) of the Act, each CCG is required to publish an annual report on how it has discharged its duties, in particular, how it has involved users under s.14Z2 (see above). Each CCG must consult with its relevant Health and Well Being Board in preparing the report and hold a meeting to present the report to members of the public. NHS England will provide guidance for CCGs in time for reporting on the year 2015/16.

NHS England must also produce an annual report at the end of each financial year, including a report on how it has involved users under s. 23 (13Q) (see above). The annual report will be laid before parliament and sent to the SoS. The SoS will respond to this with an assessment of the Board’s performance during the year.

**3.2 Patient / Public involvement in Practice**

The duty to involve users or potential users under 242(1B), 13Q and 14Z2 is a legal requirement whether a LA is consulted or not. It covers a whole range of activities, from providing information, to seeking the views and experiences of users about specific services or conducting large public consultations on major changes. Managers are advised in guidance (see below) to involve users from an early stage and choose methods proportionate to the impact plans would have if implemented .

In planning reconfiguration strategies, commissioners also are expected to engage with staff, patients and the public in a continuous way. After completion of a consultation on the strategy, commissioners can decide to consult again on specific configuration options. The latter process could include 12 weeks of formal consultation, although under the Cabinet Office principles, a range of approaches could be employed ( Ref 15).

Public/patient involvement is not a democratic process. Managers decide:

* When to involve users
* What level of involvement to use
* Which users should be involved
* What they should be told
* How their views will be used
* How feedback will be provided

Unlike elected councillors, patients are not accountable to the wider community. They do not have a statutory right to information, other than through the Freedom of Information Act (see 5.22) and do not have the right to refer objections to the SoS if consultation has been inadequate or the proposals are against the interests of the local community. Their only right of appeal, if they have been directly affected by an unlawful act or decision of an NHS body, is to seek a judicial review through the courts (see section 6, below) . Despite the above, it is important for campaigners to engage with NHS planners whenever the opportunity arises, not just to give their views as consumers but to find out and publicise what changes are being planned for the future.

**3.21 Public involvement in Procurement**

**3.22 DH Statutory Guidance October 2008 (Ref 13)**

Nothing in legislation explicitly directs commissioners **not** to involve patients and the public in the procurement stage of commissiong. However, under s.242 (1B), s.14Z2 and s.13Q, above, NHS providers and commissioners are not required to involve the public, where a proposal does not affect the way a service is delivered or the range of services available at the point of delivery. Guidance (Ref 17) published in October 2008 states, with respect to 242 (1B):

*‘There is no requirement to involve users where proposals for change or a decision to be made by an NHS organisation, for example a change of provider, does not result in changes to the service that affect the way in which that service is delivered or the range of services available’*

Thus NHS organisations are free not to involve or consult the public when putting existing services or reconfigured services (following formal consultations) out to tender. As a result, when competition law was imposed on the NHS in April 2012 (NHS Act 2012 s.75) a period of unprecedented fast track NHS privatisations occured, over the heads of patients and local communities. For example:

“*On March 27 the Health and Social Care Bill received Royal Assent and became law. With the ink barely dry on Her Majesty’s signature, the carving up of the NHS has begun. Virgin Care has won a £500 million contract to provide community services across Surrey …. and began running these sevices on 1st. April. What real choice did the people of Surrey have in who provided their community health services? The answer is none…. The choice was made by unelected, unaccountable bureaucrats who use “public consultation” as a fig leaf for fundamentally changing the nature of how* *healthcare is delivered.”* (Max Pemberton, The Telegraph, 9th April 2012 ‘Healthy competition in the NHS is a sick joke).[[3]](#footnote-3)

*In 2012, in just seven days, community services worth £262m were put out to tender and privatised under the new ‘any qualified provider” policy, without the public having a say. In a quarter of the cases, PCTs stated they had no plans to tender before the government instructed them to do so* (Guardian 4th October 2012).

By September 2013, services across the board, from maternity services to end of life care, including whole hospitals were in the hands of private firms. (Ref 18).

More recently NHS England turned its attention to privatising local enhanced services (LES) provided by GP practices. On 1st January 2014, CCGs were instructed to put all their LES out to tender or procure them under any qualified provider (AQP) by April 2014, unless they could prove the services could only be offered by a single commissioner. Figures suggest contracts worth a total of £18.6 m could be opened up to the markets with some GP practices losing as much as 10-15% of their income. Services such anticoagulant clinics, minor surgery and dementia support are all under offer without patients having a say (Ref 19).

**3.23 NHS England Guidance 2013**

The 2012 NHS Act did not amend or remove the duty on NHS trusts and NHS funded providers to consult with patients or their representatives under s.242(1B) of the 2006 Act. Instead, it has amended the 2006 Act to impose similar duties on NHS England and CCGs (see 3.1). So it seems reasonable to assume that the 2008 guidance would still apply, including the freedom it gives NHS organisations not to consult when offering existing services up to different providers. However in September 2013, NHS England published new statutory guidance[[4]](#footnote-4) for CCGs, which included their duty to involve patients and the public in the various stages of commissioning, including procurement (Ref 20).

The 2013 guidance ‘Transforming Participation in Healthcare’ includes a diagram or ‘Engagment Cycle’ which describes key stages in the commissioning process for public participation. These are:

* Community engagement to identify needs and aspirations
* Public engagement to develop priorities strategies and plans
* Patient and carer engagement to improve services
* Patient and carer engagement to monitor services and
* Patient, carer and public engagement to procure services (see overleaf)

The Engagement Cycle was originally developed 6 years ago by InHealth Associates on behalf of the DoH and Croyden PCT. Ironically (see below), it was designed to be used by CCGs wishing to move “beyond ‘tick box’ engagement.”



The above diagram and text was downloaded from the internet in January 2014. By March 2014, the text had been re-drafted, apart from the points under ‘Contracts should specify’, which remained unchanged. Significantly, it no longer states that people should be directly involved in decisions about who provides services. Instead it refers to the need for clarity about patient representation on panels – their roles, terms of reference and support and training. The Cambridgeshire consultation, described below, illustrates how this guidance works in practice.

At the beginning of 2014, Cambridgeshire and Peterborough CCG was facing a judicial review for refusing, on the grounds of commercial confidentiality, to release tender documents relating to a £800 million contract for community, mental health and hospital based services (Ref 21).

Law firm Leigh Day, acting for the campaign group ‘ Stop the NHS Sell Off’, claimed the CCG had acted unlawfully by preventing ‘proper patient involvement’ when it refused to publish the tender documents. The letter before action identified four areas where the CCG had failed to meet its obligations, including failure to take into account the 2013 guidance.The four areas were:

* It has breached its duty to have a patient involvement strategy.
* It has breached its duty to have a procurement strategy.
* Its constitution did not fully reflect the extent of its requirements around engagement.
* It has not taken into account NHS England’s guidance ‘ Transforming participation in health and care’.

The CCG, in response to the letter before action, denied it had acted unlawfully but nevertheless released the tender documents in January 2014, without going to court. The tender documents and service specifications issued at the invitation to tender stage were found by campaigners to be so lacking in detail that they effectively gave bidders the freedom to do what they wanted.

The CCG later published the Memorandom of Information (MoI) for bidders on its website,([www.cambridgeshireandpeterboroughccg.nhs.uk](http://www.cambridgeshireandpeterboroughccg.nhs.uk)) In it the CCG stated that it did not intend to specify in detail how its desired outcomes should be achieved, preferring instead for its ‘vision’ to be realised through the procurement process, by encouraging bidders to develop ‘innovative delivery models’. Thus, the CCG abdicated responsibility for specifying how to meet the needs of its patients. Instead, bidders were asked to design services that would deliver the outcomes required by the CCG. Improved outcomes would then be aligned with financial incentives for the successful bidder.

Strangely, bidders were expected to comply with NICE guidance on safe staffing levels but this is not due to be published until the end of 2014.

**3.24 Cambridgeshire and Peterborough CCG Consultation**

On March 17th 2014, Cambridgeshire and Peterborough CCG began a three month public consultation on the procurement of a provider for its multimillion pound contract. (Ref 22). The CCG’s aim was to seek the views of users and residents on initial proposals put forward by four shortlisted bidders. The bidders would take the views of the public into account in drawing up their final proposals. And a team of CCG assessors would use the public feedback to evaluate each bid before selecting a preferred bidder. The assessors included: GPs, patient representatives, LAs, and specialists in areas such as information technology. The patient ‘representatives” were members of the Patient Reference Group, a subcommittee of the CCG governing body previously involved in the short listing process. The wider community was not involved.

The list of shortlisted bidders was published only on the CCG’s website, not in the consultation document.They included:

* Accord Health (Interserve with Provide, formerly Central Essex Community Services and North Essex Partnership NHS FT as mental health lead)
* Care for Life ( Care UK with Lincolnshire Community Health Services NHS Trust and Norfolk Community Health and Care NHS Trust)
* Uniting Care Partnership ( Cambridgeshire and Peterborough NHS FT with Cambridge University Hospitals NHS FT).
* Virgin Care Ltd

According to the Memorandum of Information, available on the CCG website alongside other technical documents, the preferred bidder or ‘lead provider’ will be awarded a 5 year contract with the option to extend it for a further 2 years. It will be responsible for planning and providing community services for adults and older adults and for holding the budget for buying unplanned hospital services and mental health services for older adults and palliative care. It will be responsible for 20,000 staff transferred from Cambridgeshire Community Services NHS Trust (CCS) which may be dissolved.[[5]](#footnote-5) The CCS currently delivers services from 50 properties, including 5 community hospitals, with a total of 102 beds. The MoI states that bidders will not be compelled to continue to use the buildings.

**The consultation document**

In the consultation document, the CCG’s stated its ‘vision’ was for ‘older people’s health care and adult community services to be better organised around the needs of patients’. It wanted to see:

* More joined up care
* Better planning and communication between patients, carers and professionals
* More patients to be supported to remain independent
* Fewer emergency hospital admissions and long stays in hospital

The public were invited to give their views by ticking boxes in a questionnaire drawn up by a market research firm, mruk research which was also responsible for analysing the responses. For example, residents were asked to say to what extent they thought the CCG’s ‘vision’ would be successful in achieving the four outcomes listed above. They then had the choice of ticking 5 boxes labelled: strongly agree, agree, neither agree or disagree,strongly disagree or don’t know. They were also asked to give their views on annonymised proposals, put forward by each of the bidders and listed in categories, by ticking boxes in each section to indicate which was the most and least important proposal to them.

Few would disagree with the desirability of the above outcomes. But the consultation document was virtually devoid of facts or planning information and, in any case the questionnaire did not provide respondents with the opportunity to express an informed opinion. Missing information included: needs and activity analyses; a financial analysis and a risk analysis; issues around accessibility and transport; the future availability of geriatricians; current and proposed staffing levels; implications for the 20,000 community staff who would be transferred to a new provider; pay and conditions for new staff; drawbacks of having a single lead provider (in contrast to large number of drawbacks listed for the current provision); the impact the proposals could have on the sustainabiltiy of hospital services in the area; the future of Cambridgeshire Community Services NHS trust, and, if this was dissolved, which organisation would take responsibility for its buildings and 102 rehabilitation and intermediate care beds; the fact that neither Cambridgeshire County Council nor Peterborough City Council wished to include social care funds in any new pooling arrangement or to integrate social care staff with health provision; Respondents, instead, were directed to detailed technical information on-line, designed to be read by experts, not the general public

The consultation document said services would not be cut or delivered in different locations. Yet, according to the Memorandum of Information, a lead provider would not be compelled to use any of the existing buildings. The consultation document highlighted current difficulties of trying to achieve service integration with multiple block contracts. It did not mention that the lead provider would also be required to subcontract in turn. It did not disclose the identity of the four bidders or reveal that the process could leave responsibility for buying unplanned hospital care, mental health services and palliative care in the hands of a profit-driven private firm.

In 2010, the coalition government introduced four clear tests new reconfigurations must demonstrate before being approved (Ref 36). These are:

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

In the Cambridgeshire consultation, the CCG said it had no choice but to put the contract out to tender as it was legally obliged to do so. Then it cited financial and demographic pressures but only one piece of research – from the Kings Fund - as the reasons for change. The CCG consultation document, as discussed, did not facilitate strong, public and patient engagement. Yet strangely, NHS England would have approved the consultation document with all of its inadequacies, as part of its duty to assure CCG proposals for change (see 2.14).

The group ‘Stop the NHS sell-off’ continued to campaign during the consultation period, attending public meetings and collecting 5,500 signatures on a petition opposing NHS privatisation. It was vindicated at the end of September when the CCG awarded the contract to the NHS bidder ‘Uniting Care Partnerships’. The exercise cost the CCG £1million. Campaigners are calling for a public enquiry into why the CCG embarked on such a process in the first place. They are also demanding to know why it refused to allow Cambridgeshire Community Services Trust to bid for the contract when it was in line for a ‘Trust Provider of the Year’ award and judged one of the best NHS employers in the country (Ref 23).

**3.3 Public involvement in Tendering**

In December 2013, NHS England issued further guidance for CCGs on the planning of major service changes and reconfigurations. (Ref 7)**.** The document, like most official documents, stresses the importance of patient and public involvement in the planning process. It then states:

*“ It is for commissioners to decide how best to secure services that meet patients needs and improve the quality and effectiveness, including whether to use choice and competition. Commissioners need to make a balanced judgement on a mix of factors ….such as whether there are a range of providers.However, patients and their interests should always come first and nothing in legislation requires commissioners to take a decision in respect of competition issues that conflict with this*

Thus CCGs, alone, decide whether or not to put services out to tender. Patients and the public do not have a say even though their interests are supposed to come first.

Commissioners have a duty to put contracts out to tender when not to do so would be against the interests of patients (Procurement, Patient Choice and Competition Regulations 2013). But CCGs (including Cambridgeshire and Peterborough CCG) say they are legally obliged to put all service contracts out to tender whether they wish to do so or not (Ref 24). Their assertion runs counter to the guidance from NHS England and to the regulations, which suggest CCGs have a choice. In fact, there is little evidence, either nationally or internationally, to support the premise underlying the 2012 Act, namely that choice and competition benefits patients.

* A review by the Parliamentary Labour Party Health Committeee ‘An Inquiry Into The Effectiveness of International Health Systems ‘ (HSJ 20 May 2014) concluded that markets in healthcare increase inequalities and that competition can “impede quality, including increasing hospitalisation rates and mortality”. As a result the report called for the repeal of the H&SCAct 2012 .
* An attempt between NHS England and Monitor to draw up a new Choice and Competition Framework was put on hold in September 2013 because they could not find enough evidence to show how competition benefited patients (Ref. 25**).** At a board meeting of NHS England in September 2013, the policy director, Bill McCarthy said:

*“We’re committed to being a system that works on evidence and in this area, even taking from international evidence, the direct evidence of where best competition and choice works to improve outcomes is fairly limited”*

Chairman Malcolm Grant added:

*“It is so important that we get away from ideological preconceptions and take a much more pragmatic focus around the needs of patients”*

The dispute remained unresolved in March 2014, suggesting the future of the project may be uncertain. According to the HSJ, new policy owners in Monitor consider *their* guidance should be the key resource for commissioners to understand choice and competition, not the framework with NHS England (Ref. 26).

The lack of evidence for the view that competition benefits patients robs the coalition of the official fig leaf for its ideological agenda. The SoS, himself, stripped the phrase ‘putting patients first’ of its significance by rejecting the main recommendation of the Francis report into failures at Stafford hospital. The Francis recommendation was to rewrite the NHS Constitution to make it explicit that ‘patients come first’. A government appointed panel, chaired by health minister Norman Lamb, helped the SoS to reject the recommendation. Alongside Norman Lamb, the panel included Monitor chair Stephen Thorton and representatives of Virgin Care (Ref 27). Thus competition and private interests appear to carry more weight with the government than the interests of patients, despite its protestations to the contrary.

**4. HEALTHWATCH ENGLAND (NHS Act s.181) & LOCAL HEALTHWATCH (2012 NHS Act s.182-189)**

**4.1 Background**

The NHS Act 2012 established (i) Healthwatch England, a national body and (ii) Local Healthwatch organisations, (to replace Local Involvement Networks ) as the new “consumer champions” for patients, service users and the public.

* Healthwatch England began operating on October 1st 2012, as a subcommittee of the Care Quality Commission (CQC) – the body responsible for inspecting hospitals, care homes and care services. Healthwatch England operates on behalf of the CQC but must not have a majority of CQC members on its committee.
* Local Healthwatch organisations started in April 2013. They are not statutory bodies but have statutory duties and powers similar to those of Local Involvement Networks (LINks). Local Healthwatch organisations are commissioned by upper tier and unitary local authorities. They are accountable to the local authority but funded nationally.

Various bodies can bid to provide Healthwatch organisations e.g. community interest companies, charities or social enterprises. Unlike OSCs, local Healthwatch committees can “enter and view” public or private sector premises providing health and social care services [[6]](#footnote-6).

**4.2 Healthwatch England (H&SCA 2012 s.181)**

The functions of Healthwatch England are:

* To provide leadership, support and set standards for Local Healthwatch organisations.
* To highlight national issues and trends in order to influence national policy. It will collate and provide information to the Secretary of State for Health, the Care Quality Commission, NHS England, Monitor and local authorities about (a) the views of people regarding their need for and experiences of health and social care services and (b) the views of Local Healthwatch organisations and of other persons on the standard of provision of health and social care services and on whether or how the standards could or should be improved.
* In performing their functions, Healthwatch England must have regard to such aspects of government policy as the Secretary of State many direct.
* The Secretary of State can give a direction to Healthwatch England or to the CQC if he/she considers they are significantly failing to fulfill their duties.

**4.3 Local Healthwatch Organisations (H&SC Act 2012 s. 182)**

The functions of Local Healthwatch organisations are:

* Providing advice and information to users and the public about access to services and support for making informed choices.
* Providing NHS complaints advocacy (LAs will continue to manage complaints about social care).
* Gathering views and understanding the experiences of people who use services, carers and the wider community.
* Making people’s views known to Healthwatch England and providing a steer to help it in carrying out its role as national champion
* Recommending investigation and special review of services via Healthwatch England or directly to the Care Quality Commission.
* Promoting and supporting the involvement of people in the commissioning and provision of local services and how they are scrutinised.
* Enabling people to monitor/review the commissioning and provision of local care services
* Obtaining the views of people about their needs for and experiences of local care services and make those views known to those responsible for the commissioning and provision of local care services.
* Making reports and recommendations about how those services could or ought to be improved to ‘responsible bodies’ : i.e. NHS trusts; NHS foundation trusts; NHS England; CCGs; LAs; or a person prescribed in regulations (i.e. primary care providers).

**4.4 Healthwatch Regulations**

Regulations laid in December 2012 (The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations part 6 2012) make provision about:

* The criteria that bodies will need to meet in order to be contracted as local Healthwatch organisations
* The contractual arrangements between (a) the Local Authority and local Healthwatch and (b) local Healthwatch and its contractors.
* The duties on commissioners and providers to respond to reports, recommendations and information requests and their duty to justify their decision if they do not intend to act on recommemndations or provide information.
* Referrals to local authorities or scruntiny committees (OSCs) and the duty on them to acknowledge referrals from local Healthwatch..
* The duties on service providers to allow entry to local Healthwatch representatives

The regulations lay out in detail what Healtwatch committees can and cannot do.

**4.41 Key Points**

**Regulation 36** requires local Heathwatch committees to act independently of political parties, think tanks and campaigns. They must not:

* Promote or oppose changes in any law applicable in the UK in the EU or elsewhere or

the policy adopted by any governmental or public authority in relation to any matter (36 (1a)).

* Provide or affect support for a political party or political campaign or influence voters in relation to any election or referendum (36 (1c).
* Undertake campaigning and policy work unless it is based on evidence and incidental to its core activities (Reg. 36 (2).

**Regulation 38** stipulates that local `Healthwatch organisations must include provision for the involvement of lay persons and volunteers in their governance bodies.

**Regulation** 42 allows only authorised representatives of a local Healthwatch to enter and view and observe the activities on premises owned or controlled by a service provider.

**Regulation 44** requires a recipient of a Healthwatch report or recommendation to respond within 22 days or, in certain circumstances, in 30 working days to explain what action it proposes to take or why it does not intend to take any action in respect of the report or recommendation

**Regulation 46** requires a local Healthwatch to refer reports of social care matters to the LA or OSC . The latter must respond within 20 working days.

**4.42 Limitations of local Healthwatch Committees**

* A prime role of local Healthwatch committees is togather evidence from the views and experiences of patients and members of the public and to feed the evidence in written reports back to commissioners and providers. A Healthwatch committee has no means of direct redress if its reports or recommendations are not acted upon. But it can recommend investigation and special review of services via Healthwatch England or directly to the Care Quality Commission.
* Healthwatch committees are gagged from speaking out against any law in the UK or the policy adopted by any governmental or public authority. Governmental authority includes any national, regional or local government in the UK or the EU or any of its institutions or agencies. They can conduct campaigns but *only* when they have collected sufficient evidence and they are a minor activity. It is doubtful Healthwatch England would, even then, advise a local healthwatch committee to speak out against government policy, given the Secretary of State is responsible for overseeing the performance of it and the CQC.
* Healthwatch organisations, unlike scrutiny committees, do not have a statutory right to be involved in consultations. Their primary role, instead, is (a) to promote the involvement of individual patients and members of the public in consultations and (b) gather evidence from the views and experiences of patients, users and the public to feedback to commissioners and providers.
* A local Healthwatch must appoint one person to represent it on the LA’s Health and Wellbeing Board (NHS Act 2012 s.194 (6)[[7]](#footnote-7). Healthwatch would then become jointly responsible with the other members of the Health and Wellbeing Board for the JSNA and JHWB, despite the fact a lay representative could struggle to retain independence surrounded by persuasive NHS and Local Authority executives.
* Section 224 (1a) of the Local Government and Public Involvement in Health Act 2007 allows the Secretary of State to impose a duty on service providers[[8]](#footnote-8) to respond to requests for information. But following consultation on Local Healthwatch regulations, the Department of Health has decided service providers should **not** have a duty to provide local Healthwatch committees with information. A local Healthwatch committee must use the FoIA to obtain information when a service provider refuses to collaborate. In a letter to the Secretary of State, the Chair of Healthwatch England, Anna Bradley, has protested:

*“The local Healthwatch may struggle to get information using the FOIA. This is because when a LA or health provider outsources provision of services to a private company then the information held by the private provider may not be accessible using the FOIA. The public authority would need to have complied with its own statutory duty to put contractual mechanisms in place to ensure the activities set out in s. 221 (2) can be carried on …. .. but commercial contracts between private companies and public bodies try to limit any FOIA disclosures as far as is possible. This is achieved by placing an obligation on the public body to try and rely on exemptions, for example the commercial interests exemptions and confidential information exemptions, or by using third party rights exclusion clauses and the rules of privity of contract (Ref:28).*

Her concerns echo those of Christopher Newdick of Reading University (Ref 29). In 2006 he wrote:

*“ If an NHS body enters into a contract with a private commissioner (or provider) although the NHS body is subject to the (FOI) act, the act specifically excludes disclosure of information that is confidential or likely to prejudice commercial interests. Private sector companies are entitled to seek the protection of this exclusion, as their obligations are primarily to their shareholders”.*

* Clinical commissionng groups and CCG committees in common are currently not mandated to have local Healthwatch representatives on their decision making committees.

In a recent letter to the Secretary of State Anna Bradley expressed concern that under a Draft Legislative Reform (Clinical Commissioning Groups) Order 2014, CCGs would be allowed to form joint committeess with each other or with NHS England but would not be mandated, at the same time, to allow local Healthwatch representatives to attend joint meetings as observers (Ref. 30 &31 www.healthwatch.co.uk). The letter pointed out that In areas such as Manchester where joint CCG committees already existed, local Healthwatch organisations found that CCG decision-making lacked transparency and accountability, a situation that impaired their abiity to carry out their Healthwatch functions. They reported :

* Disengagement of CCGs with local acountability mechanisms.
* Poor public engagement by CCGs and committees in common.
* Major decision-making items such as models for service reconfiguraion being discussed in closed sessions.
* Insufficient planning for public engagement

The letter from Healthwatch England called on the SoS to issue statutory guidance that would address these problems (Ref 30). But the Secretary of State replied he had no plans to introduce further legislative change to amend the LRO or to introduce a mandatory non-votong seat for local Healthwatch on CCG or joint CCG committees (Ref.31). This, he said, would be contrary to *the ‘permissive and flexible nature of legislation in relation to CCGs’* and the duty to involve and consult the public would still apply to CCGs. Short and accessible resources might be found to enable local Healthwatch committees to work together ito monitor the decisions of CCG joint committees. Minimising the obligations placed upon CCGs is, thus, a greater priority for the SoS than ensuring CCGs have access to the views and experiences of patients.

The Chair of Healthwatch England has pledged *“The Healthwatch network will hold all organisations to account for how they involve consumers and users in their decision-making. Healthwatch will challenge organisations to do better and remind them of their responsibilities.”* (Ref 28). This admirable aim might be difficult to achieve, given the response, above, from the Secretary of State.

**5. COMMON LAW AND CONSULTATION**

Common law is the body of law (case law) which has been made by judges. It is binding unless it conflicts with statute (Acts of Parliament) or regulations and takes precedence over government guidance and local policies.

5.1 **Rules defining ‘proper consultation’**

The common law, below, defines what is meant by the term consultation and what constitutes a ‘proper consultation’.

Consultation is ‘the communication of a genuine invitation to give advice and a genuine receipt of that advice’

(*R v Sec of State for Social Services ex parte AMA (1986*)

Consultation with patients and the public, whether statutory or not, must be carried out properly i.e.

* Be undertaken when plans are at a formative stage
* Include sufficient reasons/ information to allow for an intelligent consideration
* Allow adequate time (usually 12 weeks) for an intelligent response
* Public responses must be conscientiously taken into account when the final decision is taken

(*R v Brent LBC ex parte Gunning (1985)).*

A recent ruling by the court of appeal states:

* The consulting bodies obligation is to let those who have potential interest in the subject matter know in clear terms what the proposal is and why exactly it is under consideration, telling them enough (which may be a good deal) to enable them to make an intelligent response.
* The duty (on the public body) to provide sufficient information does not in general extend to providing options or information about proposals which it is not making unless there are very specific reasons for doing so.

*R (on the application of United Company RusalP Plc v The London Metal Exchange (2014) EWCA Civ 1271 (\*th October 2014*

In other words, a “one-option’ consultation is lawful given it is undertaken with an open mind i.e. before a decision is taken.

**5.12 Central procurement of new services**

A court of appeal ruling clarifies when NHS commissioners need to consult during the planning and procurement of new services (R(Fudge) v South West Strategic Health Authority and Others (2007)):

* If new services are planned and procured centrally by the DH and an NHS organisation is not responsible for the services, it will not have to involve users or consult with the OSC.
* Where services are planned centrally and procured locally, the NHS organisation responsible for the procurement must involve users and consult with the OSC where necessary.
* In addition, an NHS body may have a duty to involve in relation to proposals and decisions which it has not itself generated: the issue is whether the proposal affects the services for which the NHS body is responsible. A local NHS body may need to involve users if a national decision to procure a treatment centre has an impact on other services for which the body is responsible.

**5.2 Common Law v. Government Policies**

**5.21 Consultation Principles (Cabinet Office 2012)**

In 2008, the common law principles in 4.1 above, were codified in the ‘Code of Practice on Consultation for Government Departments’ (*Dept Business, Enterprise and Regulatory Reform July 2008*). The Code set out criteria to be reproduced in formal consultation documents on substantial changes.

In July 2012, new guidance or ’Consultation Principles’ published by ther Cabinet Office (Ref 15) replaced the former ‘Code of Practice’. The emphasis is now on the use of on-going consultation with patients and their representatives (NHS Act 2006 s242(1B)) in preference, where possible, to formal, written consultations with OSCs (NHS Act 2006, s.244). It states:

* NHS bodies proposing changes to local health services should identify key stakeholder groups and embark on earlier engagment with those groups, in preference, to conducting more formal, written consultations.
* Formal consultations may still be appropriate for ‘contentious’ changes (formerly known as ‘substantial’). And, longer and more detailed consultation will be needed in situations where smaller, vulnerable organisations, such as small charities could be affected.
* Consultation needs to be digital by default, but other methods should be used where these are needed to reach all groups affected by the policy. Consideration should be given to more informal ways of engagement if more appropriate e.g. e-mail, web-based forums, public meetings, working groups, focus groups,surveys – rather than always reverting to a written consultation. Information should be easy to understand and clarify the main issues and be sufficient to enable stakeholders to make an informed response.

The Consultation Principles, above, do not have legal force. However, their emphasis on informal engagement with individual patients rather than formal written consultations with LAs is in keeping with the 2006 legislation which gives NHS managers leeway to decide how, when and who to consult. The 2013 LA regulations preserve the right of LAs to demand enough time and information to enable them to make an informed response to a consultation, in accordance with case law. But LA statutory powers are in danger from other stipulations that may limit, for example, their ability to refer objections to the SoS.

**5.22 Common Law and the Freedom of Information Act**

Commercial confidentiality takes precedence over the public’s right to information. Under The Freedom of Information Act (FoI), 2005, the public has the right to request official information from public bodies. But the Act carries 23 exemptions preventing disclosure. Section 43 of the Act specifically excludes public bodies from disclosing information likely to prejudice the commercial interests of any person (a person maybe an individual, a company, the public body itself, or any other legal entity). It even provides an exemption from the requirement to inform the public whether or not such information is held. Consequently, contracts between NHS bodies and private firms e.g. PFI contracts, contracts with commercial providers or commissioners are shrouded in secrecy.

Professor Allyson Pollock describes in an article her attempts to obtain a copy of the contract that allowed Circle Healthcare to run Hitchingbroke NHS Hospital and how the DH and Treasury refused to disclose it on the grounds of commercial confidentiality. She comments, *“In future, healthcare will be arranged through tens of thousands of commercial contracts. It will become increasingly difficult to know what exactly is being done with public money* ( www.opendemocracy.net/author/allyson-pollock )

Christopher Newdick of Reading University has warned, *“where contracts are between private commissioners and private providers, it will be very difficult to get useful information because the private organisations would often wish to prevent disclosure in their own commercial interests* (Ref. 29).

His warning has come to pass. The Information Commissioner recently refused a Freedom of Information Request about the staff and dispensary of a GP practice. The Commissioner said he was aware that *“primary care health services contracts are currently being granted to private companies…..and that the disclosure of information would be likely to prejudice (the GP practice’s ) commercial interests. And may result in the closure of the practice”.* (Ref 32).

Hundreds of general practices and commissioning functions are now operated and managed by profit making firms and many more are under threat (Ref: 3). NHS England recently announced a short list of companies and organisations competing to be on the approved list of firms able to compete for £1 billion worth of contracts offering advice and support on commissioning to CCGs. The sucessful firms will be involved in patient care reforms, drug purchasing, negotiating hospital contracts and crucially, outsourcing services to the private sector. A largely unknown commissioning support industry group (CSIG) has now turned its attention on the NHS. United Health, the giant US health insurer (and former employer of NHS England’s chief executive Simon Stevens), chairs the group. It has been taking part in regular meetings with Bob Ricketts, director of commissioning support services and other senior staff from NHS England. And recently it paid for senior NHS managers to visit its care centres in the US on a five day fact finding mission. (Ref 33). Thus NHS commissioning has become the target for unaccountable, profit-hungry, giant health care firms whose decisions are shrouded in secrecy, far from the realm of public scrutiny. The Cambridgshire and Peterborough consultation, with its meaningless questionnaire, shows planners are adapting to the fact that the public no longer has enough information to respond intelligently to consultations or to hold NHS organisations to account. Nevertheless they continue, compelled by law, with the (expensive) charade of giving people a say.

**6. PATIENTS’ LEGAL CHALLENGES - JUDICIAL REVIEWS**

Judicial review is a mechanism that allows the Courts to hold public bodies [[9]](#footnote-9) to account if they abuse their power by acting:

* Illegally – where a public body makes decisions inconsistent with its statutory powers or duties.
* Irrationally – where a public body makes decisions which are irrational or illogical
* With procedural impropriety – where a public body does not act impartially e.g. makes a decison that discriminates against individual patients.

It is an essential mechanism for upholding the statutory rights of the public and individual citizens .

The NHS Constitution gives patients and the public the right to make a claim for judicial review if they think they have been directly affected by an unlawful act or decision of an NHS body. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of the Constitution in their decisions and actions.

Judicial review is not a form of appeal against a decision, as such, but against how decisions are made. Failure of CCGs, for example, to observe *any* *one* of their statutory duties in commissioning decisions i.e.not only the duty to consult, could expose them to challenge in the courts. Their duties include:

* Duty to promote the NHS Constitution.
* Duty to secure continuous improvement in (i) the quality of services provided and (ii) the quality of outcomes that are achieved.
* Duty to secure continuous improvement in the quality of primary medical services.
* Duty to promote patient involvement in their own care ‘no decision about me without me’.
* Duty to reduce inequalities between patients with respect to their ability to access health services and the outcomes achieved.
* Duty to enable patient choice.
* Duty to secure public involvement & consultation as laid down in NHS Act 2006 s. 242 (1B)).
* Duty to promote the integration of health services with health related social care services.

The ‘right’ to seek a judicial review is not an easy option. Legal costs are high (although legal aid is still available for the poorest claimants living on means tested benefits). And a ruling in the Court of Appeal makes it clear that very little can be achieved by bringing proceedings for judicial review where the obligation (to consult) is limited (R (Fudge v South West Strategic Health Authority and Others (2007).

However, judicial reviews can have a successful outcome for campaigners, as shown by the ‘Save Lewisham Hospital’ campaign and the ‘Stop the NHS sell-off’ campaign in Cambridgshire. In 2012, NHS Gloucestershire PCT backed down over plans to move community services and 3,000 staff to a social enterprise on the day it was due to face a challenge in the high court from Michael Lloyd, a 75 year old resident (Ref 34). The DH later gave the PCT permission to consider the option of establishing a new NHS community trust. The PCT bowed down to public pressure and decided to do so, keeping community services in the NHS.

**6.1 How to seek a judicial review**

The following advice on how to seek a judicial review is taken from the 2006 briefing “Patients’ legal challenges to NHS cuts /closures” by Leigh Day solicitors Richard Stein and Ross Curling (see KONP website). The procedure is still largely relevant but see, also, an excellent, up-dated briefing by Richard Stein ‘Quick and Easy Guide to Judicial Review’, available on-line.

* Find patients affected by the service changes who would be willing to take legal action. If they are in receipt of any means tested social security benefits such as income support, pension guarantee credit, family credit, housing benefit or council tax benefit they are likely to be eligible for Legal Aid (now called Public Funding).
* Collect all of the available documentation available from the relevant NHS bodies (reports, public consultation documents, press releases, press cuttings, correspondence etc).
* Obtain legal advice/help to write a letter before claim to the relevant NHS bodies reminding them of their duties to consult before making changes to health services, threatening judicial review if they do not agree to reverse the decision. Our contact details are below.
* Do not delay! Cases must be brought promptly (within weeks of the decision being made).
* Once a lawyer’s letter has been received in cases where no real consultation has been carried out the decisions are usually put on hold pending consultation. If not, commencing legal proceedings will need to be considered immediately.
* The case will be heard in the High Court in London (or one of the regional Administrative Courts).
* There is no oral evidence so the Claimant does not have to go to court. He or she can play as large or small a part as he or she wants to.
* If the implementation of the decision is imminent proceedings can move very quickly, suspending a decision in a matter of days or a few weeks. Otherwise it can take up to a year.
* Carry on campaigning! A judicial review about the lack of consultation will only delay the implementation of a decision. To prevent it the political argument needs to be won. You have to make it too difficult politically for the NHS body to confirm their proposed changes.

**6.2 Restrictions on Judicial Review** (Ref 35)

Plans to make it harder to challenge government decisions via judicial review, introduced in the criminal justice and courts bill, were approved by the House of Commons in 2014. These included :

* Reducing the time limit for bringing judicial review for certain cases .

In planning cases the time limit was reduced from 3 months to 6 weeks; in procurement cases from 3 months to 4 weeks.

* Removing the right to a hearing in some cases. If a judge after considering the case on paper, concludes that a case is ‘totally without merit’ claimants now lose the right to seek a short hearing before the court, a move which frequently led to a full hearing in the past.

However, in October 2014 the House of Lords voted against the plans on the grounds that they would mean governments could not be brought to account in the courts if they acted illegally. The three main legal professions in England and Wales also condemned a move to prevent charities and non-governmental organisations from intervening in judicial review cases which contained matters of public interests (Guardian 28 October 2014; see also 3.1).

The government is considering further changes:

* A significant increase in court fees, to meet the actual costs of the courts in handling a judicial review
* No payment from legal aid unless a case is expressly granted permission to proceed to a full hearing. As the majority of judicial review cases are settled (usually) favourably before the permission stage is reached, this proposal would threaten the financial viability of law firms which act for claimants.
* Removal of legal aid from foreigners and prisoners

Jamie Beagent from openDemocracy concludes:

*“ The government has repeatedly sought to justify these changes through unevidenced assertions that judicial review is a hindrance to economic growth and that right to judicial review is ‘abused’. …..*

*Make no mistake , these changes are not about saving money or addressing ‘abuse ‘of the judicial review process. They are an ideological attack on the ability of citizens to hold our government to account which threatens lasting damage to the rule of law in this country”.*

CONCLUSION

The type of public engagement preferred by NHS organisations and the Cabinet Office is the involvement of individual patients or individual members of the public - in marginal decision making and on management terms. A more democratic approach seemed possible in 2013 when NHS England published guidance stating people should be directly involved in decisions about who should provide services. However, that guidance was soon altered. It now refers to patient representation on panels and their need for support and training, not consultation with the general public. Individual participants, as discussed, have no means of redress when their views are ignored. So engagement with them allows managers to operate unhindered while, paying lip service to public accountability and consultation. The NHS Constitution, meanwhile, gives individual patients or members of the public the right to claim judicial review if they are personally affected by an illegal or discriminatory decision. But recent moves by the government to limit the number of judicial reviews make it increasingly difficult for them to do so.

Opposing policies such as the above, where statutory rights are given by one hand and removed or weakened by the other, are now widespread. Local authorities or OSCs, the last remnants of democracy in the NHS, have the right to require NHS Foundation trusts, private sector providers and CCGs to provide them with information but they have no enforcement powers, outside the formal consultation process, or visiting rights to enable them to seek information for themselves. They have the right to be consulted on proposals for substantial changes but it is becoming more onerous for them to refer objections to the Secretary of State. Moreover, the duty on NHS organisations to consult with OSCs is shrinking. There is no formal requirement for commissioners to involve LAs/OSCs in deciding whether to classify services as commissioner requested services or not. Changes to or closures of services deemed ‘non-commissioner requested’ or ‘non–essential’, by definition, would not trigger a requirement for consultation even though such services may be valued or needed by patients. OSCs do not have a right to be consulted on Foundation Trust plans to increase private patient income or make significant transactions or mergers, acquisitions and separations or to form joint businesses with the private sector, all of which could pose a significant risk to local services. Foundation Trust governors, alone have the power to approve them. Yet OSCs are far better placed than FT governors to assess the implications of such decisions for the wider health economy. The duty to consult LAs or OSCs does not apply when Trusts go bankrupt and are taken into special administration. The amendment to clause 118 of the Care Bill was rightly viewed as a triumph by campaigners. It requires administrators to consult with every CCG likely to be affected by their recommendations, not just the CCGs attached to the failing trust, and provides some scope for public consultation. However, the amendment leaves a basic loophole intact, namely, when administrators and CCGs cannot agree, NHS England, not the CCGs or public opinion, has the final say.

Local Healthwatch organisations – the official ‘consumer champions’ - are constrained similarly. Healthwatch members have the sole right to visit and inspect health service premises on behalf of local residents. They can report their findings to Healthwatch England and NHS organisations but are forbidden by law to use the information to oppose government policies or engage in policy work. They may campaign if they have enough evidence but only if it is kept as a minor activity. Equally odd, is the Secretary of State’s refusal to provide Healthwatch members with the right to information or the right to attend CCG board meetings as observers. Healthwatch members have a duty to provide the public with information and help patients exercise choice. Yet they may have to use the Freedom of Information Act to obtain official information for themselves. Another key role for Healthwatch organisations is to gather the views and experiences of patients and feed these back to Healthwatch England, the Local Authority, OSCs and NHS organisations. Yet Healthwatch members cannot make use of their own knowledge in public consultations as they do not have a statutory right to be consulted. Instead, Healthwatch committees have been subsumed into the planning process by virtue of their single seat on Health and Wellbeing Boards. In practice, far from being ‘consumer champions’, Healthwatch organisations are the equivalent of a government smoke screen, engaging the public in a minor way, while fundamental changes to the NHS, including privatisation and its consequences, remain hidden from view.

A prerequisite for accountability to operate is a free flow of information to ensure citizens have the knowledge to scrutinise and challenge the decisions and acts of those in power (Ref 4). However, under the Freedom of Information Act , information can be withheld on the grounds of commercial confidentiality. Contracts between NHS bodies and commercial firms are shrouded in secrecy. As a result, consultation documents are bereft of essential information, so that consultees cannot make an informed response even if they wish to.

Moreover, contracts with private firms leave patients with less information to choose where to be treated. This irony and the fact many patients may be too ill to choose fosters not only spurious competition but health inequalities, as shown in the recent Labour Party Parliamentary health committee review. An absurdity at the heart of government policy is the ideological belief that privatisation and competition promote choice, improve services and reduce health inequalities.

Ominously, profit hungry commissioning support firms are coming together in groups to bid for lucrative NHS contracts. One shadowy commissioning support group, chaired by United Health, the giant US health insurer, is currently lobbying NHS England strongly for a contract worth £1 billion, even to the extent of taking NHS officials on a fact finding trip to the US. When so much tax payers money is at stake, it is, perhaps, not surprising that CCGs are taking major decisions in closed sessions and disengaging from local accountability mechanisms, as reported by Healthwatch organisations. The decision of the SoS to refuse Healthwatch representatives an observer seat on CCG committees reinforces the view that deals with private firms are being struck in secret. The prescient words of historian Charles Webster spring to mind “local communities and their representatives are likely to count for little when it comes to appeasing corporate interests” (Guardian May 8th 2002).

There may still be time to save the NHS and restore democractic accountability. People of all political persuasions, in England, as well as Scotland, support the health service and do not want it handed over to profit driven private firms. And irrespective of how hard the government works behind the scenes to curtail statutory rights, it cannot remove the power of the public to vote politicians out of office at the ballot box. That power, above all, explains the policitians fear of exposure, their drive to hide information and to privatise by stealth. Thanks to the persistence and direct action of campaigners, however, news of NHS privatisation is getting out, hopefully in time to influence public opinion and galvanise grassroot support before the general election in 2015. Effective grassroot campaigners have shown they have the power to jolt and influence politicians out of their complacency. The survival of the NHS rests in their hands.

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1. NHS regulators include:

   * Monitor - responsible for (i) issuing licences to providers of NHS funded services registered with the Care Quality Commission (ii) overseeing the performance of all providers (iiI) promoting competition between providers, with the power to impose fines for infringements of competition law (iv) minimising the obligations placed upon both commissioners and providers.
   * The NHS Commissioning Board (NHS England) - responsible for (i) setting up and offering support to CCGs (ii) ensuring patients can exercise choice and (iii) ensuring that any organisation providing functions or services on behalf of the NHS can operate freely with the minimum of interference.
   * The Care Quality Commission (CQC) – responsible for (i) registering and inspecting all care providers that meet its standards of quality and safety (ii) publishing reports, thus, enabling patient choice (ii) providing NHS and private sector organisations with a common inspectorate that allows them to compete on a level playing field.

   [↑](#footnote-ref-1)
2. Health and Wellbeing Boards (H&WBBs) are joint forums in which health and social care senior managers, local commissioners, at least one elected representative and one healthwatch representative work together to draw up joint strategic needs assessments (JSNAs) and Joint Health and Wellbeing strategies (JHWSs).. The H&WBBs are expected to drive the local commissioning of health care, social care and public health services, including reconfiguration plans, through their JSNA process (Ref 7). H&WBBs must involve local Healthwatch and the local community in a continuous way

   throughout the JSNA and JHWS processes (Ref 20). [↑](#footnote-ref-2)
3. Local MP Jeremy Hunt, now Health Secretary, personally intervened behind the scenes to encourage the Virgin takeover, according to Daniel Boffey in The Observer, 9th September 2012. [↑](#footnote-ref-3)
4. NHS organisations must have to regard to guidance but courts will not require them to follow it if they have good reasons not to do so or where it conflicts with primary legislation. [↑](#footnote-ref-4)
5. In 2012, the CCG did not support the Community Services Trust’s bid to become a foundation trust on the grounds that it provided the CCG with flexibility to plan in the face of increasing demand and funding cuts [↑](#footnote-ref-5)
6. Recent guidance for LAs recommends that when a health scrutiny body (LA or OSC) is planning to review a certain service, it would be useful if the local Healthwatch arranged to visit the service at the same time to inform the review (Ref 6`). [↑](#footnote-ref-6)
7. The regulator Monitor considers that the 2012 Act: ‘*strengthens local democratic involvement by ensuring that there is at least one locally elected representative and one representative of Healthwatch on every HWB, to influence and challenge commissioning decisions and promote integrated working’* (Ref 16). [↑](#footnote-ref-7)
8. in this context service providers include NHS trusts, Foundation trusts, CCGs, LAs and persosn prescribed by regulations made by the SoS [↑](#footnote-ref-8)
9. or private companies undertaking public functions [↑](#footnote-ref-9)