The history of current legislation in England, enabling the public to influence the planning and commissioning of health services.

In 1974, following a serious break down in care in the Ely hospital (Hansard 1969), parliament created statutory Community Health Councils (CHCs), run by local people with powers to monitor and influence local health care. These bodies had powers to inspect services and to veto proposals for substantial changes to health services (including hospital closures) made by Area Health Authorities. We have an archive site about the Association of CHCs for England and Wales at http://www.achcew.org/ It also contains the legislation.
CHCs were abolished in England in 2003, and replaced by Patients' Forums, which were abolished in 2008 and replaced by Local Involvement Networks abolished in 2013 and replaced by non-statutory Healthwatch (Health and Social Act 2012). Each abolition reduced the community power to directly influence local services. The power to challenge substantial variations to services was transferred to local authority, Overview and Scrutiny Committees (OSC) in 2003 (Department of Communities and Local Government 2000).

The Health and Social Care Act (HSCA) 2012 (s182-189), established local Healthwatch as local authority based social enterprises, able to perform statutory activities, but accountable to and funded by local authorities they monitor.

The Health and Social Care Act 2012:

- Established Clinical Commissioning Groups (CCGs), run by local general practitioners (GPs), with budgets to commission health services on behalf of local communities (HSCA 2012:s10).

- Reduced Ministerial accountability by shifting some of their responsibilities to NHS England (HSCA 2012:s9);

- Transformed the role of Foundation Trusts regulator Monitor; giving it a mandate to investigate 'anti-competitive' practices, set prices for NHS-funded care and promote choice (HSCA 2012:s61/62).

- Transferred responsibility to appoint a Trust Special Administrator (TSA) from the Secretary of State for Health (SoS) to Monitor (HSCA 2012: s174). The TSA can to take over NHS trusts believed to be either financially or clinically unsustainable (Chapter 5A, NHS Act 2006 (amended by Health Act 2009:s16).

70% of local NHS services are now commissioned by CCGs, run by general practitioners (GPs) the quasi representatives of patients. Governors and lay members of Foundation Trust are endowed with 'powers' that give them virtually no influence. NHS England and CCGs must ensure "health services are provided in a way which promotes the NHS Constitution" (Health and Social Act 2012:s23 and s26, DH 2013).

Rights of communities to determine what service are provided in their area are limited to influence in relation to design, access, quality and safety of services (Health and Social Care Act 2012: s26, 14Z2):
(2) CCGs must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—

(a) in the planning of the commissioning arrangements

(b) in the development and consideration of proposals for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals

Local Health and Wellbeing Board (HWBB) were established to make strategic decisions in relation to health and social care. Its statutory membership includes Healthwatch, the local authority, CCG, acute providers and the local voluntary sector.

It is by negotiating with these bodies and campaigning for better services that communities and Healthwatch can influence local services. Local OSCs, run by borough councillors, can formally review local services, call NHS chief executives to account for

service quality and make recommendations for service improvement. They can refer a proposed reconfiguration to the Secretary of State (SoS) for Health. Guidance advises that:

Health scrutiny should be held in an open forum and local people should be allowed to attend and use any communication methods such as filming and tweeting to report the proceedings.

The SoS can request the statutory Independent Reconfiguration Panel (IRP), to review and advise whether proposals are in the best interests of the NHS. Major reconfigurations have been stopped following IRP reviews, e.g. the children's congenital heart services and the Horton Hospital proposals for maternity and paediatrics (IRP 2010).

Lewisham Hospital and other JRs

When these statutory rights have been exhausted judicial review (JR) may be used as a means of obtaining:

Assistance from the Administrative Court when citizens are oppressed by authority or are failing to receive the assistance which parliament has required authorities to afford them. *Donaldson LJ in Parr v Wyre BC [1982] HLR 71 at 80 (Public Law Project 2014)*

Thus, NHS decisions which a community believes not to be in their best interests can be overturned. The JR used to challenge attempts to downgrade services at Lewisham Hospital is an example of a community successfully challenging a reconfiguration.

Save Lewisham Hospital Campaign (the Campaign) and Lewisham Council

brought a JR against the SoS and the Trust Special Administrator (TSA) (DH 2012) regarding removal of acute facilities from Lewisham Hospital (LH) (R (Lewisham Council) v SS for Health and the TSA 2013).

This case relates to: ..."a recommendation to reduce services at LH by the TSA, and secondly to an alternative decision made by the SoS to reduce services at LH.

A popular campaign working alongside the local council overturned the TSA/SoSs attempt to close acute services. The TSA, was appointed under s16 of the Health Act 2009, (amended 5A, 2006 NHS Act). He claimed the right to include LH in plans for service reorganization of the South London Healthcare Trust (SLHT). The JR concluded the TSA had acted outside his authority by failing to give due weight to views of GP commissioners (a Primary Care Trust (PCT) committee) (DH 2008). The TSA's plans were quashed.

The background was the SoS's decision that performance of the SLHT could not be improved through usual measures. The SLHT was bankrupt and saddled with unmanageable debt. Following minimal consultation, the TSA's Report was presented to the SoS on 7/1/13. Sir Bruce Keogh, the NHS Medical Director, reviewed the recommendations (NHS England 2013) and the SoS accepted the modified recommendations.

The SoS decided to dissolve the SLHT, move its hospitals to the control of adjoining trusts and also that the LH be subject to substantial changes to services:

(a) Replacing A&E with a non-admitting urgent care centre;
(b) Replacing the obstetrician-led maternity unit, with a "stand-alone midwife-led birthing centre";
(c) Closing the emergency and in-patient paediatric unit, so only urgent paediatric care would to be provided at LH;
(d) Developing LH into a centre for "non-complex procedures such as hip and knee replacements" for South East London.

TSA's decisions were not subject to the public consultation procedures under the s242 of the NHS Act 2006, because the he claimed these took two years. Section 242 requires health organisations to make arrangements to ensure that public, patients and staff are involved in the planning, development, consultation and decision making in respect of proposal.

The TSA adopted the short-cut 'Four Tests' procedure' introduced by the previous SoS 2010 (Nicholson 2010):

1. Support from GP commissioners will be essential;
2. Arrangements for public and patient engagement, including local authorities, should be further strengthened;
3. Greater clarity about the clinical evidence base underpinning proposals.
4. Proposals should take into account the need to develop patient choice.

The Campaign and Lewisham Council argued at the JD that:

· The TSA had no right to make recommendation for reconfiguring services outside the SLHT area
· The TSA had failed to meet the requirements of the 'Four Tests'.
· Rights of patients to influence decisions relating to their hospitals had been greatly reduced by the TSA
· The remedy of the last resort for non-performing hospitals, should not be used to downgrade the successful LH.
· GP commissioners had not been properly consulted about local change as required by the Chief Executive of NHSE (Nicholson 2010b)

and

· The Prime Minister had stated on (9/1/13):

"What the Government and I specifically promised was that there should be no closures or reorganisations unless they had support from the GP commissioners, unless there was proper public and patient engagement and unless there was an evidence base. Let me be

absolutely clear: unlike under the last Government when these closures and changes were imposed in a top-down way, if they do not meet those criteria, they will not happen." (Hansard 2013).

The SoS's argued the duty of the TSA was to make decisions benefitting the wider area, claimed he had fulfilled the 'Four Tests' and that he could take action he considered necessary, under Paragraph 28 of Schedule 4 to the 2006 NHS Act, and give directions to NHS bodies under section 8(1) of the Act.

Mr Justice Silber upheld the applicant's case on the grounds that:

· LH was not in the area of the South London Healthcare Trust over which the TSA had jurisdiction.
· The recommendations of the TSA and the decision of the Secretary of State to reduce facilities at LH, were a substantial variation and were not lawful because the Lewisham GP commissioners had not agreed to the closure.
· The SoS would have had to carry out a full public consultation if intended to dissolve the Trust under Section 8 of the 2006 Act. That consultation would have had to be consistent with the Gunning principles (R v Brent London BC ex parte Gunning [1985] 84 LGR 168). As the SoS had not done so his approach was not an alternative to the TSA decision.

The judge stated the TSA's regime was exceptional, had the power to remove the public's right to be consulted, and that the Four Tests' were partly met, even though most responses to the consultation had rejected the TSA proposals. Despite high profile campaigning by thousands of people, the judge did not consider their views had been ignored, whereas the irrationality of the TSA in failing to adequately consult GP commissioners caused the JR succeeded.

The judgement was a victory for an alliance of community and GP commissioners, but it was the specific status of the GPs, participating directly in civic life, that secured appropriate healthcare in Lewisham was won. Citizens were ignored by the TSA – until they stood up in the Court and proclaimed their voice.

Other relevant cases

Gunning v Brent Borough Council (1985) is most frequently cited, where it was agreed the decision-maker's discretion is not unbounded and cannot consult on a decision already made, because the outcome of the consultation is pre-determined and the process pointless (Sheldon 2012). The following 'Gunning principles' must be adhered to:

(i) consultation must take place when the proposal is at a formative stage;
(ii) sufficient reasons must be put forward for the proposal to allow for intelligent consideration and response;
(iii) adequate time must be given for consideration and response;
(iv) outcome of consultation must be conscientiously taken into account.

In Fudge v South West Strategic Health Authority (2007) it was held that the duty to consult the public in relation to the development of private treatment centres, arose even though the PCT was implementing a policy decision of behalf of the DH. The PCT, was still responsible for the provision of services and the duty to consult.

In Pam Smith v NE Derbyshire PCT (2006), the PCT awarded a contract to United Healthcare to run a GP practice without consulting patients. At Councillor Pam Smith's appeal, the court decided that patients should have been consulted before the contract was awarded, because there was a significant change to services. It was not adequate for the statutory Patients' Forum to have acted on behalf of the community, because it had no power to require the PCT to reverse its decision.

The range of powers available to influence decisions by local and national NHS bodies are extensive but weak. Legislation requires that individuals are involved by being consulted or given information but in reality the public is rarely involved in decisions about what is commissioned, and most would not know how or where decision are made. Hospitals invite governors to comment services, but their powers are negligible. A determined body of residents could engage their CCG and demand that decisions are taken to develop or change a service, but in practice such engagement usually results in minor alterations to service delivery or reconfigurations.

Healthwatch with it statutory powers to influence commissioners provides communities with the right to influence and commissioner a duty to respond. OSCs, now represents the most significant power in the England for communities to challenge major reconfiguration (Centre for Public Scrutiny 2011) and the Healthwatch seat on the HWBB a potentially powerful place to influence major decisions. The Prime Minister's public commitment to defending the NHS, galvanised government to produce the 'Four Tests', that ultimately fuelled victory for the community in Lewishm. Thus, the quasi-legal 'Four Tests' beat the carefully crafted statutory consultation framework in s242 of the NHS Act 2006, because the Prime Minister, previous SoS and the NHS chief executive, had joined forces, accidently undermining dual attempts by the new SoS, to close a popular and successful A&E department. Neither by front door nor back door could the SoS destroy acute services at LH. But his revenge was delivered in s120 of the new Care Act 2014, which he amended to enable the TSA to act outside his immediate area of jurisdiction (DH 2014).

I hope this is useful.

Malcolm Alexander , Chair, HAPIA