HEALTH NEWS BRIEFING

ASSOCIATION OF COMMUNITY HEALTH
COUNCILS FOR ENGLAND AND WALES

The Problem with Referrals

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July 1999

Contents

PREFACE

This briefing has been prepared from the experiences of Community Health Councils who have consulted ACHCEW's legal services about problems they have encountered which have led them to refer issues to the Secretary of State and from the results of a survey of all CHCs in England and Wales about their experiences of making a referral.

Although changes are likely to be made to Community Health Council regulations to reflect changes in the structure of the health service in both England and Wales, no details are yet available as to whether we can expect significant changes to CHCs rights to be consulted or to make a referral. This briefing has been prepared as a commentary on the existing system and is intended to be a positive contribution to discussions about changes in procedures that will increase transparency and improve local accountability.

Thanks are due to, all those CHC officers who have shared their experiences and expertise, all those who responded to the survey and to my assistant Antonia Ford who compiled all the responses received and assisted in other ways too numerous to mention.

I am grateful to the Chairs of Barnet and Oxford CHCs, Elizabeth Manero and Tom Fellows for their input into discussions about the problems CHCs experience in making representations to the Secretary of State and for their thoughtful comments. Likewise, thanks are due to Richard Stein a solicitor who has provided advice without charge, ACHCEW's policy officers and to Henrietta Bond for her suggestions about layout.

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AIMS

This briefing has been prepared in an attempt to clarify the process whereby Community Health Councils (CHCs) can ask the Secretary of State to intervene in disputes about local health services or the way they relate to other health service bodies.

The results of a survey of CHCs are analysed and problems with the process are identified. Suggestions for change made by CHCS and by ACHCEW are detailed. It is hoped that this information will assist those in the NHS Executive who are charged with reviewing accountability structures and practices in the health service.

The range of issues which can be the referred to the Secretary of State are explored, as are those which can be the subject of legal challenges.

The experience of CHCs, both in relation to the problems they have experienced and their successes, has been utilised to provide practical guidance about how to make a referral to the Secretary of State.

SECTION 1 – Understanding the Referral Process

1.1 What is a Referral?

In the course of carrying out their functions of representing the views of patients and their local communities in the health service, Community Health Councils (CHCs) will sometimes disagree with plans being considered for those services. NHS trusts and health authorities and in the future Primary Care Trusts, rely upon CHCs to provide the community's perspective on plans, but will not always be willing to modify them accordingly. One of the safeguards in the current system is the ability of CHCs to refer matters to the Secretary of State. Where local resolution cannot be achieved, an appeal to the authority of the Secretary of State can be made through the system of referral. The Secretary of State will have a broader overview and will be able to settle disputes in line with Government policy.

CHCs are required to advise their local health authorities and to report to the Secretary of State for Health (in England) and the Secretary of State for Wales (in Wales). Health Authorities and other NHS bodies also have obligations to their Secretary of State, who has overall responsibility for the National Health Service. The Secretary of State has the power to adjudicate and resolve disputes between health service bodies. In fact, Ministers may decide matters referred to the Secretary of State with the responsibility for the particular issue at stake.

1.2 What is the Legal Position?

Since they were first established, CHCs have referred disputed matters to the Secretary of State. Some referrals are specifically provided for in legislation, others are made on the basis that CHCS have a responsibility to let the Secretary of State know of their concerns about health authority decisions or because of strong local opposition to plans for local health services.

1.2.1 Statutory Right of Referral

These are provided for in the Community Health Regulations 1996[1], which make express provision for CHCs to refer matters to the Secretary of State for Health.

Consultation Exercises

Regulation 18(5) deals with inadequate consultation exercises and states:

'In any case where a Council is not satisfied that sufficient time has been allowed ....., or that consultation on any proposal ..... has been adequate, it shall notify the Secretary of State in writing who may require the Health Authority to carry out such further consultation with the council as he considers appropriate.'

[1] S.I. 1996 640.

Access to Information
Similar provision is made for CHCs to refer issues relating to their requirements for information rights to the Secretary of State at Regulation 19 which provides:

'In the event of a Health Authority refusing to disclose to a Council information ....., the Council may appeal to the Secretary of State and a decision of the Secretary of State as to whether the information is reasonably required by the Council in order to discharge its functions shall be final for the purpose of this regulation' [2]

Inspection Rights
Where a CHC and the relevant health body are unable to agree on arrangements for inspection of premises providing care to NHS patients, Regulation 20 makes provision for adjudication by the Secretary of State.

'Subject to paragraph (2), a Council or any member authorised by the Council for the purpose, may enter and inspect any premises controlled by a relevant Health Authority or relevant NHS trust at such times and subject to such conditions as may be agreed between the Council and the Health Authority or NHS Trust, or in default of such agreement, as may be determined by the Secretary of State.'[3]

It clear from the above that CHCs can refer these specific issues to the Secretary of State and that his decision will be binding on the bodies in question.

1.2.2 The Inherent Jurisdiction of the Secretary of State

CHCs have traditionally referred other matters to the Secretary of State for Health, including their concerns about health authority decisions about the provision of local health services. Such referrals have been made on the basis that the Secretary of State has overall responsibility for the health service and thus the inherent jurisdiction to resolve disputes between health service bodies.

Section 1 of the NHS Act 1977 gives the Secretary of State for Health overall responsibility for the provision and functioning of the National Health Service. Many of the Secretary of State's duties and powers are delegated to health authorities and NHS trusts. The Secretary of State acts through the various Regional Offices of the NHS Executive. In Wales, similar arrangements apply, such that the Secretary of State for Wales operates through the Welsh Office.

Section 2 of the National Health Service Act 1977 grants of the Secretary of State additional powers:

'(a) to provide such services as he considers appropriate for the purpose of discharging any duty imposed on him by this Act; and

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[2] Regulation 19(3) Community Health Council Regulations 1996 S.I. 1996 No. 640.

[3] Regulation 20(1) Community Health Council regulations 1996.

(b) to do any thing whatsoever which is calculated to facilitate, or is conducive to the discharge of such duty.'

Section 2(b), gives the Secretary of State the power to operate a referral or appeals procedure, whether or not the referral is specifically provided for in the CHC Regulations. For example, where a CHC wishes to contest a health authority decision, but the adequacy of the preceding consultation exercise is not at issue.

In practice, the Secretary of State does take referrals from CHCs on matters not specifically provided for in the CHC Regulations. Department of Health guidance on consultation in the health service,[4] while not explicitly detailing the referral process, states:

'Ministers wish to reserve to themselves decisions on contested closures. Where a CHC wishes to object formally to a proposal involving the closure or change of use of a health building.....the DHA (now health authority) shall refer it to the RHA (now regional Office of the NHS or the Welsh Office). If the RHA supports the DHA's proposal, it will refer the proposal to the Secretary of State for final decision.'[5]

1.3 Who Can Make a Referral?

CHC's can and do refer matters to the Secretary of State. It has recently been confirmed that referrals that members of the public or patient groups have no right of access this route of appeal.

It appears that referrals can be made not only by CHCs, but also by other health service bodies where they cannot agree. In theory, therefore, a dispute between a health authority and trust can be settled by the Secretary of State. No information is available to establish whether such referrals are made and if so, how often.

1.4 What Matters can be Referred?

As detailed above, CHCs have a wide remit for referring issues to the Secretary of State. The instances detailed below are not an exclusive list. As health services develop, new issues will arise which may need to be determined by the Secretary of State and Ministers.

1.4.1 Consultation

Health Authorities have an express duty to consult a community health council on any *'substantial development of health service'* or any *'substantial variation of the provision of such services'* [6]

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[4] Consultation and Involving the Consumer, issued under EL (90) 185.

[5] Similar guidance applies to Wales.

[6] Regulation 18(1) Community Health Council Regulations 1996 S.I. 1996 No. 640.

Referrals can be made:

- If changes are made without consultation or the consultation was inadequate.
- Where a health authority refuses to consult because it does not consider that the proposals it has under consideration are substantial in their nature, but the CHC believes that they will have a substantial impact.
- If a health authority denies that it has any proposals under consideration and thus refuses to consult, but the provider (NHS trust, GP, etc) is making changes to services.
- Where a health authority refuses to consult on the basis that emergency measures are necessary and that as a result there is no time to consult. Regulation 18(3) states that consultation requirements: *'shall not apply to any proposal on which the Health Authority is satisfied that, in the interest, of the Health Service, a decision has to be taken without allowing time for consultation.'* However, if the CHC believes that their health authority was remiss in failing to consult at an earlier date, or disputes the urgency, or the necessity of the action proposed, it may wish to ask the Secretary of State to intervene.

Examples of inadequate consultation which may lead to a referral, include:

- Failing to consult on all options under consideration.
- Too short a consultation period.
- Failure to provide relevant information, e.g. about PFI schemes or the impact of proposals on other health services in the locality.
- Misrepresentation of facts in public consultation documents.
- Where the health authority appear to have reached a decision before they have considered the views of those responding to the consultation.

1.4.2 Failure to Provide Information – Regulation 19

Health Authorities have a statutory duty to provide all information, which is relevant to the execution of a CHC's functions. Regulation 19 (1) states:

'It shall be the duty of each relevant health authority to provide a council with such information about the planning and operation of health services in its area as the Council may reasonably require in order to discharge its functions.'

This right is not utilised to its full extent by all CHCs. In part, this may be because there is no definition of what information a CHC needs to be able to discharge its functions. Some CHCs have agreements with their health authorities about what information shall generally be supplied. However, all CHCs can ask for specific information. For example, background information to clarify reports under consideration at health authority meetings, or to make a consultation proposal more easily understood. Particularly contentious information includes, PFI documentation, information concerning the financial basis for proposals under consultation and incident inquiry reports. A health authority's refusal to supply information on the specific request of a CHC can lead to a referral. However, it appears that few CHCs have asked the Secretary of State to instruct their health authority to provide information. CHCs may wish to consider making greater use of this right.

1.4.3 Inspection Rights – Regulation 20

Under regulation 20(1) the council or authorised CHC members may enter health authority or NHS trust premises for the purposes of inspection. Protocols can be agreed between the CHC and a health authority or trust, detailing the times and conditions for inspection. However, difficulties can still occur over the completion of spot checks or non-compliance with conditions.

If a dispute arises, it is open to the CHC, or the health authority, or trust to ask the Secretary of State to adjudicate. Referrals under this head are rare, but not unknown.

1.4.4 Others

A referral can be made where the consultation procedure is legitimate but the CHC objects to the decision reached at the conclusion of a consultation process. Department of Health guidance[7] only addresses disputes over contested closures, but in practice any conflict can be the subject of referral. Examples include:

- Dispute over implementation of agreed strategy.
- Disputes with health authorities about purchasing decisions, e.g. refusals to fund a particular treatment.
- Disputes over changes to a CHC's area.
- Land and building sales by NHS trusts and occasionally by health authorities.
- PFI plans.

1.5 Does the CHC have to Refer?

In general, CHCs have discretion about whether to refer a matter to the Secretary of State. They will consider the importance of the issue to local people and whether other means of resolving a conflict can be utilised. However, it appears that CHCs are obliged to inform the Secretary of State of inadequate consultation exercises. Regulation 18(5) provides that a CHC shall make a written notification to the Secretary of State in such cases. Clearly this duty will only apply once the CHC has decided that a consultation is defective.

[7] EL (90) 185

SECTION 2 - The Stages of the Referral Process

2.1 Effect of Changes in the NHS

In recent years, the structure of the NHS has under gone considerable change. More is anticipated. In the past, Regional Health Authorities adjudicated in disagreements between health authorities and CHCs. Regional Health Authorities, like other health service bodies, were required to hold their meetings in public. Papers and decisions were open to scrutiny. A matter would only be passed to the Secretary of State for determination if the Regional Health Authority upheld a district health authority's decision against the views of a CHC. The papers forwarded to the Secretary of State by the Regional Health Authority were available for public scrutiny. The Regional Health Authority would take responsibility for notification of the Secretary of State's decision to all parties and sometimes took a role in ensuring that this decision was implemented.

In 1995, Regional Health Authorities were abolished and many of their functions including their role in relation to referrals, were allocated to regional offices of the NHS Executive in England and to the Welsh Office in Wales. These offices are, staffed by civil servants. Regional offices cover wider regions than did the Regional Health Authorities. The Welsh Office covers the whole of Wales. Regional officers act for and as agents to the Secretary of State for Health in their regions. On occasion the Welsh Office or regional offices of the NHS Executive may try to resolve a dispute before deciding whether to pass the referral onto the Secretary of State's office.

This structural reorganisation of the NHS has considerably changed the balance of power. The involvement of the regional office may mean that Secretary of State is unaware of local situations. The various duties that regional officers fulfil, including involvement in planning of local health services, as paymaster and as local adjudicator, can lead to the impression of a conflict of roles.

There is a lack of clarity in the procedural requirements for referral, not least because the relevant guidance[8] has not been updated to reflect the changing nature of the NHS.

[8] EL (90) 185.

2.2 The Process

There are no formal procedural requirements for a referral to the Secretary of State. The only guidance available[9] provides little advice and only really confirms that referrals on a range of issues can be considered. Published in 1990, this guidance is also out dated in both language and principle.

Where proposals are opposed by a CHC, it appears that the health authority in question should refer the matter to the Secretary of State through the local regional office of the NHS Executive or directly to the Secretary of State for Wales. In practice, the referral procedure involves CHCs voicing their objections by way of a formal letter addressed either to the Secretary of State or to the local regional office of the NHS Executive. Some English CHCs have discovered that their regional officers do not take referrals seriously unless the CHC has contacted the Secretary of State directly.

2.3 The Decision to Refer

Any decision to make a referral can only be taken once a full CHC has agreed that they are dissatisfied with the decision taken or failure on the part of the relevant health service body to meet its obligations. For the avoidance of any later difficulties, the decision to refer should also be taken by resolution of the CHC. If other steps are deemed to be necessary or advisable, before the referral is made, the CHC may want to resolve to alert the Secretary of State's office to the possibility of a forthcoming referral and instruct its officers to take the necessary action.

Once the CHC as a body has decided to refer a matter, it should be put in writing to the regional office of the NHS and/or the Secretary of State's Office. It is also advisable to provide written notification of the CHC's concerns or dissatisfaction to the relevant health authority or NHS trust.

2.4 The Referral Letter

The Secretary of State will require sufficient information to enable him to assess the CHC's objections, evaluate the possible options and reach an informed decision. It is therefore necessary to draft a formal letter that includes the following information.

- Details of the contested decision or alleged failure.
- The impact of the decision on local health services and/or the CHC's ability to carry out its functions.
- Detailed reasoning for the CHCs opposition or complaint.
- Details of the CHCs own preferred option (if any).

[9] as 9 above.

- What action the CHC would like the Secretary of State to take, e.g. overturn decision, instruct the health authority to consult, instruct the health authority to provide access to information, etc.
- Any time constraints that apply and why. The Secretary of State should be asked to make his determination within that time.

Additionally, all relevant documents such as consultation documents, the CHC's response and copy correspondence with summaries of the same should be enclosed where appropriate.

If there are suggestions or suspicions that proposals will be implemented by the trust or health authority during the period that the Secretary of State may be considering the matter, then the CHC should ask the Secretary of State to instruct the relevant body that they must not do this.

There is no requirement placed on CHCs to provide detailed alternative proposals when making a referral, but it probably helps, if CHCs can show that viable alternatives exist to their health authorities' proposals. However, CHC resources and expertise may not be adequate to enable CHCs to provide fully worked up and costed plans.

2.5 Strategy

Experience has shown that successful referrals are usually accompanied by proactive strategies from the CHC concerned. Press coverage, involvement of other interested organisations and the activities of high profile campaign groups, all lend weight to the CHC cause.

The following tactics can be utilised to publicise the community's reaction to the issue and help notify the Secretary of State of relevant developments.

- Persuade other interested groups to make representations to the Secretary of State. Organisations that may have an interest in health issues, include; local user groups, Leagues of Friends, national charities, staff associations and trade organisations.
- Lobby local MPs and ask them to make representations to or ask questions of the Secretary of State.
- Arrange Parliamentary questions.
- Issue press releases through CHC contacts, or by utilising the press networks of other organisations involved in the campaign.
- Initiate and actively participate in local campaigns. Strong public opinion is a useful tool.
- Keep the Secretary of State's office updated on any developments and regularly chase for a response/decision.

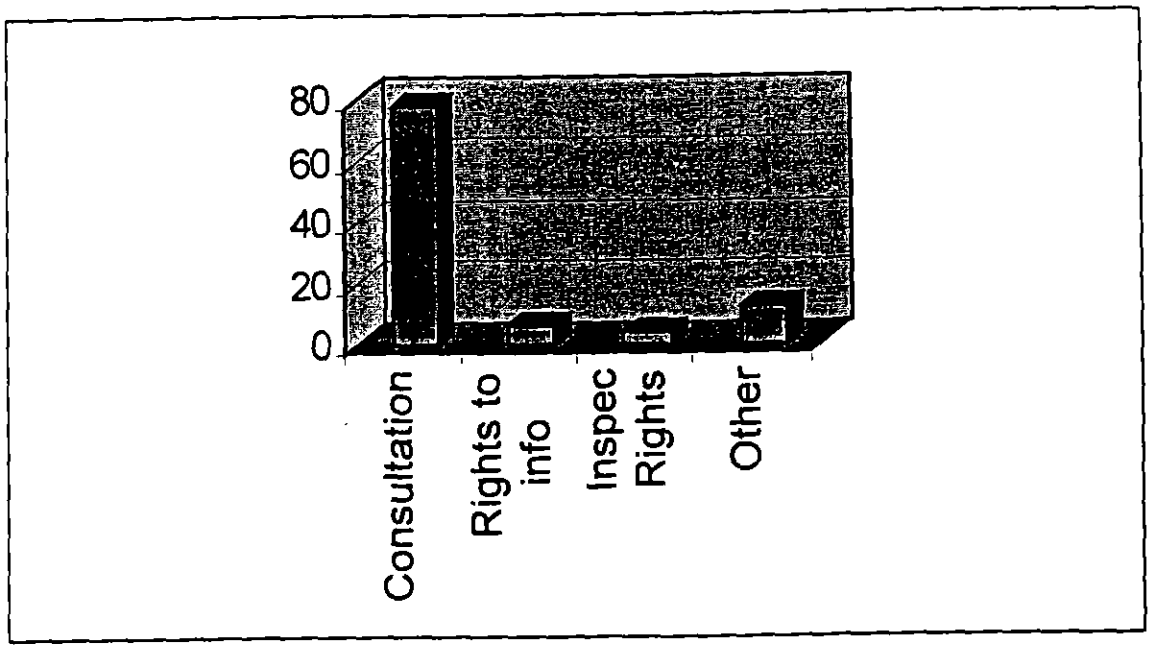
SECTION 3 - The Survey

CHCs have been reporting serious concerns about the referral process. In order to identify the extent of these problems, ACHCEW conducted a survey of CHCs to establish their experiences.

3.1 Results

One hundred and fifty seven (75%) CHCs responded. Of those, 43% indicated that they had made a referral to the Secretary of State. Not every CHC answered every question, so the results are given in percentages.

CHCs were asked to identify what dispute with their health authority, or other health service body initiated the referral. Consultation was found to be by far the most contentious issue. 78% of CHCs reported making referrals in response to inadequate consultation procedures. Interestingly, 12% reported that they had made a referral about issues not expressly provided for under the Community Health Regulations 1996.



CHCs were asked a series of questions about the referral process to develop a picture of their individual experiences and observations. The results are as follows.

	Yes	No
Was matter resolved by Secretary of State?	63	37
Was outcome acceptable?	36	64
Did Regional Office of the NHS Executive have prior involvement in the matter complained of?	62	38
Was the Regional Office impartial?	41	59
Were health authority submissions supplied to the CHC?	39	61
Were proposals implemented during the referral?	51	49
Were reasons given for the decision?	79	21
Is process open and accountable?	25	75

These figures show a general dissatisfaction with the referral system. It can be seen that a high proportion of CHCs have experienced problems with the way the referral process is operated.

- Three-quarters of those CHCs who had experience of the referral process concluded that the process was not open and accountable.

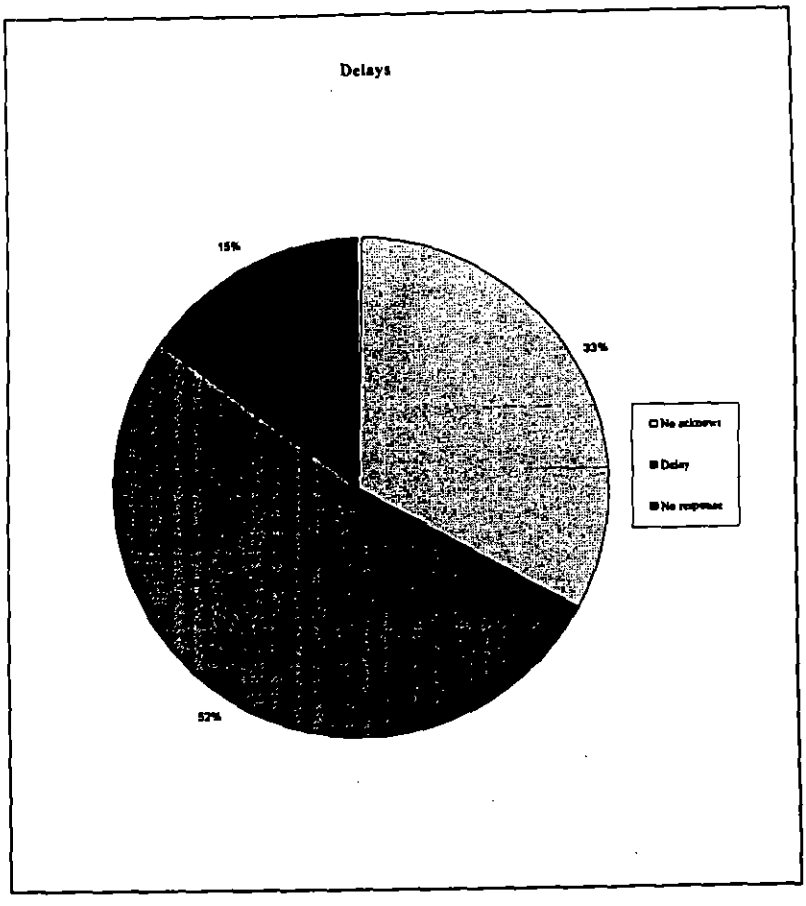
- Although 79% of CHCs were given reasons for the Secretary of State's decision in their case, it appears that the reasons given were often inadequate, leaving important questions unanswered.

- Sixty-one per cent of CHCs reported that they were not supplied with copies of the health authority's submissions to the Secretary of State.

- Fifty-one per cent reported that health authorities continued with their proposals while the matter was the subject of a referral. Ministers have confirmed that health authorities and other NHS bodies should not implement disputed proposals while they are the subject of an unresolved referral. However, in practice, many health authorities and trusts do continue with their plans while the matter is under consideration.

- Sixty four per cent (64%) of those CHCs that had made a referral, reported that the decision reached by the Secretary of State was unacceptable to their CHC.

The graph below depicts the extent of problems of delay reported by CHCs.



Fifty-two per cent of CHCs reported delays in the referral process. CHCs routinely wait three to months for a response. West Essex CHC had, at the time of survey, received no decision in a matter referred to the Secretary of State eleven months earlier. Subsequently, a decision was made some 15 months after the matter had been referred.

The Secretary of State's office regularly fails to acknowledge CHC referrals.

3.2 Problems Identified

CHC identified three main problems with the referral procedure. Each of these problems undermines the purpose of the referral process and cause consequential problems for all the health service bodies involved and to the local community.

3.2.1 Lack of Transparency

Once a Secretary of State referral has been initiated, health authorities and NHS trusts are given an opportunity to comment on any submissions made by the CHC. This is not a reciprocal arrangement. While CHC submissions are widely available, CHCs are not given the same opportunity to consider and comment on health authority responses.

As representatives of the public, CHCs do require sight of health authority submissions to the Secretary of State to permit them to sensibly make all the representations necessary to put forward the views of the communities they represent. A lack of openness can foster suspicions that there is bias and unfairness in the process. In seeking to obtain this information CHCs may wish to point out that in line with the Government's stated objectives of improving openness and accountability in the health service all such submissions should be made publicly available.

If a health authority refuses to provide copies of reports it has submitted in response to a referral, it may be useful to invoke Regulation 19 of the CHC Regulations 1996. This provides that CHCs are entitled to ask for information which the CHC may reasonably require in order to discharge its functions concerning the planning and operation of health services in its area. As detailed above, a right of referral exists in relation to any refusal by a health authority to provide such information[10].

3.2.2 Delay

Delay is obviously a serious and recurrent problem. Coupled with a lack of acknowledgement or complete failure to respond, it can totally undermine the purpose and benefit of seeking Secretary of State adjudication.

Delays can cause problems to all the parties concerned. Occasionally the Secretary of State's adjudication is pre-empted by implementation of disputed proposals. Inherent delays within the referral system produce consequential problems that reflect badly on the CHC and magnify financial and service implications for the health authority and other health service bodies concerned. Changes necessary to meet local needs may be suspended and growing uncertainty effect both staff and patient morale. Additionally, the CHC may be subject to allegations that any delay in implementing proposals or resultant deterioration in service, are a direct result of their actions.

Excessive delay also has a bearing on the judicial remedies available to CHCs. Courts often require applicants to adhere to strict deadlines and delay may therefore close these judicial avenues.

It is unclear what causes these delays. However, CHCs have found that if local MPs put pressure on the Secretary of State, resolution of the dispute can be considerably accelerated.

3.2.3 Bias/Unfairness

In England, the wide range of responsibilities undertaken by regional offices of the NHS appears to be causing problems within the referral process.

NHS Executive regional officers have responsibilities to ensure the smooth running of the NHS in their region. They are often the architects of the plans, which become the subject of complaint and referral. The impression of bias is thus given.

[10] Regulation 19(3) Community Health Council Regulations 1996

Regional officers of the NHS Executive are required to advise the Secretary of State for Health who will be guided by them, particularly in relation to local matters. Concerns referred by CHCs are almost invariably local issues.

Regional offices are not subject to the same requirements on openness that apply to other health service bodies. Briefings are treated as confidential and 'civil servant privilege' is said to apply to internal discussion and advice. Regional office briefings to Ministers are not made available to CHCs.

It is not clear in all cases whether matters are determined by the Secretary of State for Health, or by officers at the regional level. Civil servants' duties to Ministers make it difficult for them to act as impartial judges or advocates.

It is clear that problems also arise in the role that NHS Executive regional offices take in channelling public opinion through to the Government. CHCs representing the views of their local communities have reported instances where the regional office has been seen to take the side of the health authority. As a consequence, CHCs have had to rely upon local MPs to inform Ministers of the views of local people. Ministers need to be sure that the briefings they receive are not viewed as tainted in this way.

In situations where regional officers are expected to act as independent arbiters in disputes between health authorities and CHCs, or where they are required to present impartial briefings to Ministers, these factors can all lead to an impression of unfairness.

SECTION 4 – The Impact of a Referral on Legal Proceedings

4.1 Judicial Review

Some of the matters that form the subject of a referral to the Secretary of State could also form the grounds for legal challenge by way of an application for judicial review. Judicial review proceedings allow the court to review the lawfulness of actions and decisions taken by public bodies. The court will not appraise the merits of individual decisions restricting its investigation to the legal basis on which the decision was reached. CHCs are not usually able to contemplate a legal challenge of this nature, not least because the costs of an application for judicial review are so high. However, occasionally monies become available through public donations, or from another body sharing the CHC's concerns. A CHC may have to decide whether they wish to proceed with an application for judicial review as well as making a referral.

4.2 Issues for Review

The decisions and procedures of health authorities and trust are open to legal challenge through judicial review. Issues that may satisfy the strict judicial review criteria include:

- Complaints that a health authority has not consulted on a substantial variation or development in health services. This would amount to a breach of the statutory duty placed on health authorities in Regulation 18. At the same time a referral could be made under the provisions of Regulation 18(5).

- Objections to the way a consultation has been carried out. If a health authority does not conduct a proper consultation exercise, the courts might consider this a breach of statutory duty (as above) and a breach of the rules of natural justice. A referral could be made under the provisions of Regulation 18(5). Examples include; instances where the consultation period is insufficient, where there is a failure to provide all relevant information, or the authority appears to have made a decision in advance of considering the consultation responses.

- The decision reached is unreasonable or the health authority considered irrelevant factors or disregarded relevant factors in reaching its decision. Here the courts might consider an application for judicial review on the grounds of illegality or irrationality. It would be possible to refer these sorts of complaints to the Secretary of State under his inherent jurisdiction.

- A breach of a health authority or NHS trust's duty to facilitate inspections could be challenged through the courts as a breach of the statutory duty contained in Regulation 20. At the same time a referral could be made under the provisions of Regulation 20(1).

- Likewise, any failure to provide information that the CHC requires in order to carry out its functions, could be challenged as a breach of statutory duty contained in Regulation 19 and referred to the Secretary of State in line with the provisions of Regulation 19(3).

Other matters that could be the subject of judicial review include:

- Failure to comply with requirements of public access legislation. For example a breach of the statutory duty laid down in the Public Bodies (Admission to Meetings) Act 1960 which now applies to NHS Trusts as well as to health authorities. A complaint of this nature could form the basis of a referral under the Secretary of State's inherent jurisdiction to resolve disputes between health service bodies.

- Failure to provide services. This would amount to a breach of the statutory duty placed on the Secretary of State and health service bodies in the National Health Service Act 1977. A referral could be made relying upon the Secretary of State's inherent jurisdiction.

4.3 Practical Problems

Any application for leave for judicial review must be commenced without delay and in any event within **three months** of the decision complained of. All applicants are also required to have exhausted other avenues of complaint or appeal before seeking judicial intervention.

In a recent decision in the High Court, Mr Justice Collins held that a CHC complaining about the way a consultation exercise has been carried out, should have applied to the court without delay, and should not have waited for the health authority to reach its decision on the proposals under consideration. By default there would be no time to make a referral to the Secretary of State. The Court of Appeal overturned this part of the judge's ruling. Consequently, CHCs are entitled to wait for a decision from their health authority before embarking on costly legal proceedings. It is not clear whether the courts would be prepared to accept an application for judicial review if the CHC has waited some time for a decision from the Secretary of State on referral. For this reason, any CHC wishing to mount a legal challenge should ensure that they do not delay in making application to the court and if referring the matter to the Secretary of State, this too should be done as soon as possible after the decision or failure complained of.

If proceedings are commenced against the health authority or other health service body, it should be noted that an adverse decision from the Secretary of State might sway the court, which will almost certainly have regard to it.

If CHC submissions are rejected by the Secretary of State and the time limit for the original complaint has elapsed it may then become necessary to bring judicial review proceedings against the Secretary of State, rather than against the health authority or other health service body.

SECTION 5 - Challenging Failures in the Referral Process

5.1 Legal Challenge

It is probable that in any particular case the referral system itself could be challenged through the process of judicial review on the grounds that the rules of natural justice have been breached, in that the parties are not afforded equal treatment, the process is fundamentally unfair and there is an impression of bias. However, it is clear that CHCs do not have the desire to take this step or the resources to fund the costs of such an action. Further, CHCs share the concerns of other NHS bodies, that scarce resources should not be used in legal proceedings, where that can be avoided.

5.2 Complaints to the Parliamentary Ombudsman

The Parliamentary Ombudsman investigates complaints about the actions or failures of Government departments and public bodies.

The Ombudsman may investigate any allegation that maladministration within a government department or public body has resulted in injustice. The delays, which characterise the Secretary of State referral procedure and the appearance of bias in the process, could be investigated by the Parliamentary Ombudsman's office.

A complaint to the Parliamentary Ombudsman must be channelled through an MP. Usually this will be a local constituency MP. The matter complained of must have occurred within 12 months of the date of the complaint.

As no CHC appears to have made a complaint to the Parliamentary Ombudsman about the referral procedure, his willingness to investigate it has not been tested. However, a complaint could be used to publicise the problems that CHCs encounter. An adverse Ombudsman's report might trigger a review and improvements to the system.

SECTION 6 - Improving the Process

6.1 CHC Suggestions

In the survey undertaken, CHCs were asked to make suggestions about how the referral process could be improved. Several broad suggestions were identified as possible improvements:

1. All referrals should be put directly to the Secretaries of State for Health or Wales with a right on the part of CHCs to meet the Secretary of State or Minister adjudicating.

   Such a right of direct access may be impracticable as it would place an unmanageable burden on Minister. Any request for direct access rights is likely to be viewed unfavourably by the Government.

2. A two tier system whereby referrals be initially considered by a specialist inquiry/facilitation team (independent of regional offices or health authorities) and referral only be passed to the Secretary of State if agreement cannot be reached.

   This could have the advantage of permitting a more open process to be set up, but may exacerbate problems of delay in particularly contentious issues.

3. Initial consideration, or referral and facilitation between the parties, to be carried out by the Chair of the Regional Office.

   The chair is not a civil servant and thus his recommendations would not be subject to the rules protecting civil servants' briefings to Ministers. However, any system which is dependant upon an individual might be vulnerable to the impression of bias or poor judgement both at the initial stage and in any briefing to Ministers.

4. System as now, with changes made to comply with the Code of Practice on Openness in the NHS and the Code of Practice on Access to Government Information.

   Problems arising from the perceived conflicting roles of regional officers would not be resolved unless other organisation changes are made in an effort to combat this. However, if appropriate changes are made by the enactment of freedom of information legislation, regional office briefings to Ministers might become available for public scrutiny.

6.2 Recommendations for Change

ACHCEW's Standing Committee has considered reports on the survey. A working party met to identify the problems and possible solutions and to consider what steps should be taken. It has become clear that:

- Decisions (even adverse decisions), reached after a transparent process, are more likely to be accepted by the public.

- Difficult or sensitive issues that may arouse substantial public interest need to be brought to the attention of Ministers at the earliest possible opportunity. The current system does not provide an early warning system. Some issues that are determined by Regional Offices and do not reach the attention of the Secretary of State may result in public hostility to the Government.

- The delays involved in the present system are bad for morale within the NHS. Managers and staff may not know for many months whether plans will be implemented or not and therefore lack job security. Staff 'drift' often results. CHCs are often blamed unfairly.

- Delays in the referral process and the perception of unfairness lead community groups to consider legal challenges to health authority plans and to place pressure on CHCs to instigate these.

As a result, we are suggesting changes to the referral system which could have beneficial consequences for the health service as a whole.

1. The decision-making body should conduct consultation on substantial variations to health services.

2. CHCs should be consulted on proposals to dispose or acquire land or buildings.

3. Submissions to the Secretary of State made by the health authority/other health service bodies involved in the disputed proposals, should be made publicly available.

4. All referral letters should be acknowledged.

5. There should be a clear timetable for consideration of referrals. We suggest all referrals should be resolved within three months and urgent matters be considered under a fast-track procedure.

6. Any delays should be reported to all the parties.

7. The Secretary of State should supply detailed reasons for decisions reached.

The NHS Executive has been asked to consider these proposals and they are to be forwarded to the Welsh Office with a similar request.

SECTION 7 - Summary

CHCs with concerns about local health service initiatives, or who are experiencing problems representing the public's views to local decision-makers in the health service can refer their concerns to the Secretary of State. This route of appeal should be an important safeguard against poor or misguided decision-making in the health service.

A survey of Community Health Councils in England and Wales conducted by the Association of Community Health Councils, found general dissatisfaction with the referral procedure amongst those CHCs, which had used it. Complaints about the process and the outcome were widespread, with almost two thirds of respondents reporting dissatisfaction.

The survey identified three key areas of concern. These were unacceptable delays, total lack of transparency and the unfairness caused by an inherent bias in the system.

Despite the importance of issues under consideration, delays of over a year can elapse between the submission of a referral and notification of a decision. Such delays cause widespread dismay and insecurity and militate against the effective provision of local services. For example, delay can slow down the pace of necessary change and lead to staff drift from facilities whose future is uncertain. It interferes with trust and health authority budgeting and leaves the public anxious and uncertain about the future of local health services.

This report recommends that a clear timetable should be agreed and adhered to. It proposes that no referral should remain unresolved for longer than 3 months. It is vital that all parties to the process have a clear expectation of when decisions will be made. There is currently no fast-track procedure for issues of particular urgency. This must be remedied if the health needs of local communities are to be protected.

There is an in-built lack of transparency in the process. Since the abolition of Regional Health Authorities in 1995, the system is widely seen by participants to be unfair and unaccountable. In England, regional offices of the NHS Executive now act as, the local arm of the Secretary of State in resolving disputes and as advisers to Ministers, as well as having a key role in planning of local health services. This has lead to widespread suspicions that they may not always provide unbiased advice to Ministers and that Ministers may not always be made fully aware of public opinion in some areas. Furthermore, regional office, briefings to Ministers are not open to public scrutiny.

CHCs have reported that the decisions of Ministers do not always contain reasons and frequently make no mention of the substantive objections raised by CHCs. Occasionally, the reasons given by Ministers amount to no more than a re-iteration of health authority or NHS trust rationales for their proposals. This has led many to believe that their referral has not received full consideration.

The current operation of the system also freezes out the CHC once the referral has been made. Although the text of a CHC's referral is provided to those health authorities and NHS trusts involved in the proposals in question, CHCs are not given the opportunity to comment on any submissions made by those health bodies.

There have been cases where the referring CHC has received no direct response from the Secretary of State; instead they discovered the outcome of their referral from health authority or NHS trust press releases. This lack of respect for the people who represent the public interest in the health service undermines the legitimacy of the process.

ACHCEW has proposed improvements this appeal mechanism with the aim of ensuring that local communities, through their statutory representatives, are treated as equal partners in the process.

Published by:

ASSOCIATION OF
COMMUNITY HEALTH COUNCILS
FOR ENGLAND & WALES
30 DRAYTON PARK LONDON N5 1PB

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Price: £10.00 (inc. p&p)