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Consultation

- The Legal Requirements

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PREFACE

This report is based upon information from Community Health Councils about their experiences of, and problems with, consultation exercises over the period September 1996 to December 1997.

Thanks are due to; Martyn Smith Chief Officer of West Birmingham CHC, Cherry Hunter, Chief Officer at Huddersfield CHC, the Information Officers at ACHCEW, all those CHC Chief Officers and others for bringing problems and best practice in consultation to my attention, Richard Stein and Richard Gordon QC, for steering the case of R v North East Devon Health Authority ex parte Pow and others through the courts, Graham Girvan, Elizabeth Manero, Tom Fellows and others who made helpful comments on drafts of the document, Amina Hussein for proof reading it, and all the members of ACHCEW's Standing Committee for their support.

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INTRODUCTION

Consultation has increasingly become a signifier of a democratic society. The British public expect to be listened to more than once every five years, when parties seek election to government. People expect to be able to have their say through a variety of mechanisms, including; local elections, the media, local and national planning processes and inquiries and through their representatives on local groups, such as school governing bodies and community health councils.

The right to be consulted on issues which have a direct impact on the community and the individuals within it has become enshrined in both statute and common-law. Within the National Health Service many groups have an expectation of being heard. Health service users have the right to be consulted and to have their views conscientiously taken into account by those making decisions about services and the way in which they will be delivered. Those rights are accessed through local community health councils (CHCs), who are required to represent the views and interests of their local community and to advise the local health authority accordingly .

Consultation has been defined as: *'the communication of a genuine invitation to give advice and a genuine receipt of that advice.'*[1]

Parliament has provided CHCs with the right to be consulted in Regulations. In addition to the formal consultation requirements laid out in the legislation, health authorities and CHCs are expected to engage in an ongoing dialogue about the provision of health services to the community. There are many examples of good practice in this respect. While it is probable that most health authorities do meet their statutory obligations to consult CHCs, many CHCs have experienced problems in attempting to put forward the views of their communities. For obvious reasons, the cases which have come to my attention, fall into the latter category.

Some CHCs have found that their health authorities place no value on consultation. There have been instances where CHCs have complained that their local health authority has refused to consult with them, or if it does, officers of the health authority have referred to it as a 'paper exercise', and have acted as if in no doubt of the outcome by implementing their preferred plans.

[1] R v Sec of State for Social Services ex parte AMA [1986].

Some health authorities consult in a rather half-hearted manner, failing to give the CHC adequate time in which to canvass local opinion, or to provide CHCs with sufficient information to permit sensible consideration of proposals put out to consultation. Some have attempted to consult only on general principles and not on detailed plans. These complaints have frequently arisen when health authorities have sought to limit consultation to the contents of their annual purchasing plans, or on Private Finance Initiative (PFI) schemes, when relevant and necessary information has been withheld on the grounds of commercial sensitivity.

There have been many instances where CHCs have suspected that an authority has failed to properly take into account the submissions made by to it, or where there are indications that the decision is a foregone conclusion.

Occasionally, after completing a successful consultation exercise, health authorities decide unilaterally to change their plans and attempt to implement changes which were not laid out in the consultation document. This problem has typically arisen in connection with PFI schemes.

Other CHCs have found that health authorities interpret their statutory duty very narrowly and refuse to consult over changes to primary care services, or proposed cuts in funding to local support services and voluntary groups providing health services.

Further problems can arise with the way the appeal procedure operates. CHCs are expected to refer complaints about consultation to the Secretary of State. However, in some cases, a referral to the Secretary of State for Health, is not given proper (or any) consideration by the Secretary of State. Occasionally health authorities fail to pay due regard to the referral process and actually implement contested proposals, while the matter is being considered by the Secretary of State.

Before their abolition, Regional Health Authorities carried out the dual role, of advising in relation to consultation requirements and arbitrating in disputes between CHCs and health authorities. Advice is currently provided by ACHCEW under the Legal Services Service Level Agreement, while the arbitration role has nominally been taken on by the Regional Offices of the NHS Executive. There appears to have been an increase in both, the number of disputes and the number of referrals made to the Secretary of State.

The law governing the duty do consult and how it should be conducted, is useful to CHCs in situations where consultation is not going well.

The actual practice of consultation carried out by some health authorities indicates that they are unaware of requirements placed upon them by caselaw and that some are woefully ignorant about some aspects of government guidance. Further, the guidance itself, is inadequate in many respects and needs to be brought up to date and expanded and clarified.

CHC CONSULTATION RIGHTS

Legislation provides for two distinct consultation processes.

1. There is a legal obligation placed on health authorities to consult with CHCs, which applies where a health authority is considering proposals for substantial changes in health services.[2]

2. The Secretary of State for Health is required to consult CHCs over proposals to establish, dissolve, or merge NHS Trusts or to grant them extended powers - S5 of the National Health Service and Community Care Act 1990. Such consultations will usually be conducted by the relevant Regional Office of the NHS Executive.[3]

As the majority of CHCs will be more concerned about the conduct of consultation on proposed variations in health services, this publication concentrates particularly on the law relating to these types of consultation, although many of the same principles will apply to consultation by the Secretary of State on NHS Trusts.

[2] Community Health Council Regulations 1996 S.I. 1996 No. 640.
[3] National Health Service Trusts (Consultation on Establishment and Dissolution) Regulations 1996 (S.I. 1996 No. 653).

THE LEGISLATION

Schedule 7 of the National Health Service Act 1977, gives the Secretary of State for Health, the power to make Regulations providing for consultation with CHCs by health authorities. The relevant Regulations are The *Community Health Council Regulations* 1996 (S.I. 1996 No. 640). These apply in England and Wales. Regulation 18 details CHCs' rights to be consulted and Regulation 19 gives equally important rights in relation to the provision of information. These rights were previously laid out in the Community Health Council Regulations 1985, which are now superseded.

S5 of the National Health Service and Community Care Act 1990, allowed for the setting up of NHS Trusts. It also provides a safeguard, requiring consultation by the Secretary of State with the relevant CHC, before he can make an order to establish, or dissolve (or merge) NHS Trusts, or before their powers can be extended. Such changes can only be made by an order of the Secretary of State. NHS Trusts are all set up by Establishing Orders, and any changes must be by way of amending or dissolution orders. S5(2) as amended requires the Secretary of State for Health (through the relevant Regional Office of the NHS Executive) to consult with English CHCs before establishing new NHS Trusts in England. S5(3) requires the Secretary of State for Wales to consult (through the Welsh Office) with Welsh CHCs before establishing new NHS Trusts in Wales.

In England, Regulations[4] also provide for consultation with CHCs when other changes to NHS trusts are contemplated, including dissolution, and changes to trust powers. The Welsh Office have indicated that they will follow the same line as the NHS Executive, with regard to consulting CHCs over such proposals.

Government Guidance

Government guidance - Consultation and Involving the Consumer, was put out under cover of EL (90)185. This document, further details the duty to consult and the procedure to be followed, but has significant shortcomings. Although minor alterations were introduced in subsequent guidances[5], there have been no significant changes in content. As it was issued by the NHS Executive, it applies in England only. However, there is no reason to assume that the principles contained in it should not pertain to consultations carried out in Wales. It is likely that the courts would expect Welsh authorities to have regard to the contents of this guidance.

[4] See footnote 3.
[5] EL (95) 142 and EL (96) 17.

The Relationship between Legislation and Guidances

Parliament-made law is made up of primary legislation, in the form of statutes (Acts) and secondary legislation, in the form of regulations (statutory instruments). Legislation is binding on the bodies at which it is directed and will be enforced by the courts. Regulations are usually introduced to facilitate and give effect to statutory provisions. Regulations can only be introduced if the relevant primary legislation makes provision for them. So for example, Schedule 7 of the National Health Service Act 1977 at paragraph 2 provides for the introduction of regulations detailing CHC rights and mode of operation.

Interpreting the effect of legislation is done by looking first at the Act and then at any regulations. They should not be in conflict. If there is any ambiguity in the statute, then when possible, regulations can be used for clarification. If they do not provide clarification, then the courts will turn to Hansard to try to establish the intention of Parliament at the time the legislation was being debated. On those occasions when regulations do appear to conflict with, or detract from, the primary legislation, then the court will give weight to the contents of the Act in preference to the regulations.

Other documents which may be relevant are Secretary of State Directions and government guidances. Generally, directions do not have the same weight as Acts and regulations, because they do not have to go through Parliament before they come into force. However, they are generally taken as being binding on the bodies to which they are directed. If Secretary of State Directions are made under sections 13-17 of the 1977 National Health Service Act, they will be interpreted as having the full force of law The courts will use Secretary of State Directions for the purpose of clarification, but these will be seen as secondary to legislation and the courts will not enforce them if they are in conflict with, or detract from, the provisions of Acts or regulations. The Secretary of State for Health has not issued any directions relating to CHC consultation rights.

Government guidance, is just that, unless it has been issued under sections 13-17 of the National Health Service Act 1977, in which case it will have the force of law and must be obeyed. Otherwise, courts will expect authorities to have regard to the contents of any relevant guidance, but will not require them to follow it to the letter, particularly if the body in question has a reason for not adhering to guidance. Guidance can be used to try to clarify any omissions or ambiguities in legislation, but only to the extent that the guidance casts light on Parliament's intention. It will not be upheld where it conflicts with, or detracts from, the contents of legislation.

Health Authorities produce their own policies and procedures. There are of lesser import even than government guidance, although they can be an indication of good, or bad practice, on the part of the authority which has produced them. If an authority produces a policy which is in conflict with the

requirements placed upon it by legislation, it can be challenged through the courts.

The Relationship between Legislation and Common-law

Common-law is the body of law (caselaw), which has been made by judges, sometimes in relation to matters which are not governed by statute, and sometimes in relation to principles which apply in the interpretation of statute. Common-law is binding unless it conflicts with statute. However the position is not so clear where there is a conflict with Secretary of State Directions. The courts will attempt to interpret these in line with common-law. Common-law takes precedence over government guidance and health authority policies. Many of the principles governing consultation are to be found in caselaw, some from cases directly concerning consultation in the NHS and some arising from actions brought against public bodies with responsibilities for other public services, such as education and planning. The majority of the caselaw detailed within this document, arose from instances where health bodies were accused of failing to consult, or of failing to carry out adequate consultation.

CONSULTATION ON SUBSTANTIAL CHANGES IN HEALTH SERVICES

Regulation 18(1) of the Community Health Council Regulations 1996 provides;

'.....it shall be the duty of each relevant Health Authority to consult a Council (CHC) on any proposals which the Health Authority may have under consideration for any substantial development of the health service in the Council's district and on any proposals to make any substantial variation in the provision of such service.'

This duty has been re-iterated by the courts. For example in R v N.W. Thames Regional Health Authority ex parte Daniels [1993].

It is worth noting that CHCs do not have to request consultation. Health authorities, must approach CHCs with proposals when the duty to consult arises. However, there is nothing to prevent a CHC asking for consultation, if their health authority appears to have overlooked this duty.

Problems which have arisen in practice, make it necessary to consider the extent of and limits to, this duty.

NHS Trusts

Since the introduction of the internal market, divided responsibilities between NHS trusts and health authorities have caused some problems in the consultation process. The statutory duty to consult has remained solely with health authorities. Guidance[6] provides that;

'Consultation on substantial changes in the pattern of services provided by NHS Trusts as a result of major changes in contracts...will be the responsibility of the purchasing authority.'

The duty to consult is not restricted to proposals put forward by the health authority in question. Substantial variations or developments proposed by Trusts or other providers, should be considered by the health authority and at that point, the duty to consult arises. However, NHS Trusts frequently involve the local health authority at the stage when the decision-making process has already become crystallised and it is often the case that other options for service development, or delivery have already been discarded, or are no longer viable, because of steps already taken by the Trust.

[6] Consultation and Involving the Consumer EL (90) 185.

If it appears that an authority is unaware of substantial proposals which are under consideration by a provider, then it is open to the CHC or others, to trigger the duty to consult, by bringing those proposals to the authority's attention.

Presently, there is nothing to prevent service providers alerting CHCs of their plans. Where a CHC has good relationships with NHS trusts in their area, they are often aware of the details of proposed changes, before they are approached by the health authority. ACHCEW has long argued that the duty to consult CHCs, should be extended to those bodies which actually make decisions about service provision. In this way problems which currently arise because of the split responsibilities of NHS trusts and health authorities and delays which occur in communicating with the relevant health authority and then the CHC, could be avoided.

It is worth noting that in a recent case,[7] it was held that; the Health Authority was under a duty to consult with the CHC when the authority became aware of proposals for substantial changes to services and the fact that those proposals had not been considered by the Board of the authority, was not a good enough reason to delay the consultation.

Another useful pointer from the courts comes from the same case, when Mr Justice Moses referred to the period of time, during which there were discussions between the trust and health authority, as being the time when the health authority had an opportunity to consult the CHC.

Primary Care

There appears to be significant differences between health authorities around the country, as regards their willingness to consult CHCs over proposed changes in primary care services. This matter was raised in July 1996, by way of a Parliamentary question. The answer given by John Horam, the then Minister with responsibility for this area, was that,

'There is no explicit requirement for health authorities to consult CHCs about general medical services, which are the responsibility of general medical practitioners and governed by the National Health Service (General Medical Services) Regulations 1992.' [8]

This line cannot be sustained in the face of the very broad and clear terms of Regulation 18(1) of the Community Health Council Regulations 1996, which place on health authorities, a general duty to consult on any proposals they has under consideration, amounting to a substantial variation or development in the health service in the relevant district.

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[7] R v North and East Devon Health Authority ex parte Pow and others [1997].
[8] Hansard 18 July 1996.

In a letter dated 3 September 1997, the NHS Executive accept that where health authorities have proposals about substantial changes to local GP services before them, they have a duty to consult the relevant CHC. For example, where the authority is considering changes in the location of GP premises or hours of availablity. A Department of Health Circular put out in 1985[9], details the relationship between CHCs and FPCs (whose duties are now undertaken by health authorities) and provides further details of the sorts of changes which would attract the duty to consult. The same definition of substantial would apply as currently applies to changes in other health services.

Guidance put out in 1995,[10] details how GP fund-holders are accountable, principally through the provision of their purchasing plans and intentions to the local health authority. This guidance does not contain any specific requirement, or framework for consultation with patients and patient groups.

Government guidance appears to be needed to clarify this duty and to ensure that consultation is adequately carried out by health authorities considering variations or developments in primary health services, including changes in GP fund-holding practices and GP commissioning.

The corollary is that; under Regulation 17 of the Community Health Council Regulations 1996, the duty on CHCs to advise their local heath authority, includes a duty to consider the operation of GP services and to make recommendations for the improvement of that service. Consequently, there are likely to be resource implications for CHCs.

CHCs may wish to make representations for a further right to be directly consulted by GPs, before GPs make changes which may impact on patient services, particularly in view of the proposals contained within the Government's White Paper.

Substantial Variation

The Regulations do not define 'substantial' or 'variation'. The only reference in Consultation and Involving the Consumer, as to what amounts to a substantial variation or development in the health service, is under the section on closures where it is stated;

'We have no reason to dissent from the view that there will be few instances in which the closure of facilities on a scale sufficient to save material amounts of money, will not be a substantial variation.'

[9] HC (85) 11 Health Service Development Community Health Councils.
[10] EL (95) 54 An Accountability Framework for GP Fund-holding.

CHCs have complained that health authorities have used this lack of direction, to write their own rules about when a change is substantial enough to require consultation and have even, at times, refused to consult over closures.

Caselaw does not provide a definitive statement as to what constitutes a substantial variation or development in health services. It is notable that the idea of defining it numerically or as a percentage has been rejected by the courts[11]. However, Mr Justice Griffiths[12], while holding that an order requiring consultation was inappropriate in the particular case, because events had overtaken the application by the borough council, made a number of points, including;

- the movement of services from one part of a district to another may result in great inconvenience to the people of the district and certainly falls to be considered by those looking after their interests, and

- the argument, that services can be provided elsewhere, should not be given too much weight (when considering whether to consult or not).

It is likely that the courts would want to look at the impact of particular proposals for service changes, on the users of any that service.

At any one time, a number of proposals may be under consideration. Each on its own might not amount to a substantial change, but the combined effect could be said to be substantial. It may be that the total revenue savings contemplated, comprise a significant sum, or that the cumulative effect of service changes, would have an impact on the community. Further, a process of gradual erosion of services, may cumulatively amount to a substantial variation. In each case, the health authority should consult the CHC.

A referral to the Secretary of State can be invoked, when there is a dispute about whether a proposed change is substantial or not. If the authority refuses to consult, then arguably that amounts to inadequate consultation and comes within the terms of Regulation 18(5) - see below. In any event, the relationship between the Secretary of State, CHCs and health authorities is such that he has an inherent jurisdiction to arbitrate in disputes of this nature.

Substantial Development

This is an even more nebulous term. Again, it is not defined in the Regulations. However, it was clearly meant to denote something other than a

[11] R v Tunbridge Wells Health Authority ex parte Goodridge and others [1988].
[12] LB Lewisham v The Health Commissioners of the Lambeth Southwark and Lewisham Health Area [1979].

substantial variation. There is a possibility that it was meant to cover proposals for new services, which would not be said to amount to a variation in existing services.

In 1979 Mr Justice Griffiths[13] held that:

'A consideration that there would be no diminution in services (after reconfiguration) was not sufficient to allow an authority to decide that the proposals were not substantial.'

It is likely that a court considering this today, would want to look beyond the impact of a proposed change on the availability of services to the patient and would want to take into account other factors, which might include, the impact on long term planning, research capabilities, ownership of facilities, or employment of staff.

Who Decides?

Curiously, in Consultation and the Consumer, there is a statement that

'It is for the Health Authority to decide whether the change proposed, constitutes a 'substantial' development or variation.'

The CHC Regulations do not in fact, give to health authorities the power to decide what is and what is not, a substantial change. The test must be an objective one and CHCs have as much right to decide whether a variation or development, is a substantial one, or not. In the past, CHCs have received advice from a legal advisor to a Regional Health Authority,[14] that there is a duty on health authorities to consult on any proposal that is not manifestly temporary or trivial. Further, in 1985 there was a ministerial statement that health authorities would be expected to go along with CHCs' views in most cases.[15]

Rights to Information

Regulation 19[16] places a legal duty on health authorities to provide to CHCs;

'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.'

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[13] as 12 above.
[14] Letter from Mr A.P. Andrews, Head of Legal Services at South East Thames Regional Health Authority, dated 28 July 1986.
[15] Letter from John Patten MP to Jeff Rooker MP dated 5 February 1985
[16] See footnote 2.

Note that the CHC do not have to request this information, but should be provided with it automatically. However, when they do ask for specific information, so long as it is;

- to allow it to fulfil its functions (including; advising, inspecting facilities in which NHS services are provided and, of course, responding to consultation proposals),

- reasonably required by the CHC, and

- not information relating to, the diagnosis or treatment of a patient, or personnel matters, or any other information, the disclosure of which is prohibited by law

(Regulation 19(2)),
then the health authority are legally obliged to provide it.

Government guidance[17] states that a health authority,

'may also refuse to disclose to a CHC any other information which the (health authority) regards as confidential.'

This does not appear to accurately reflect the exemption detailed in Regulation 19. ACHCEW have written to the Department of Health's Solicitors seeking clarification.

The Regulations do not stipulate a timetable for the supply of information, but the implication is that it must be supplied within a reasonable period.

Regulation 19(3) provides that;

'In the event of a Health Authority refusing to disclose to a Council (CHC) *information to which paragraph (2) does not apply, 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 purposes of this regulation.'*

No mention is made of the situation where a health authority just fails to respond to the request, as opposed to actively refusing it. When making a request for information CHCs would be well advised to do so in writing and to stipulate the date by which they require its production. In this way, a health authority's failure to provide it by that date, without an explanation, is more likely to be seen as a refusal.

Frequently CHCs complain that consultation exercises are hampered by the failure of their health authority to provide adequate information. CHCs argue that without all the relevant information, they are unable to sensibly evaluate

[17] See footnote 6.

the proposals under consideration. This is typically the case where the proposals involve a PFI scheme, and the health authority has expressed concerns about commercial sensitivity. CHCs can find support in caselaw. Mr Justice Sedley found that for any consultation exercise to be adequate, a number of requirements have to be met, including; that the proposer must give sufficient reasons for any proposal so as to permit intelligent consideration and response[18].

[18] R v LB brent ex parte Gunning [1985].

THE PROCESS

What is Consultation?

The courts have laid down basic requirements for a valid consultation exercise. The most general of these is that, *'the essence of consultation is the communication of a genuine invitation to give advice and a genuine receipt of that advice.'*[19]

Some guidance on the process is to be found in Consultation and Involving the Consumer, which re-iterates the above, stating;

'The essence of consultation is the communication of a genuine invitation to give advice and a genuine receipt of that advice. In order that this might be achieved, a (health authority) must give sufficient information and allow sufficient time for a view to be taken and advice to be formulated.'

The same guidance goes on to say;

'It will be for each authority to decide on the form, content, extent and timing of a consultation. The Courts will decide, in the last resort, whether the exercise was conducted with sufficient clarity and to a time scale and an extent that satisfied the requirements of the Regulations. The principle should be to ensure a full degree of involvement by interested parties, including consumers, at all stages of strategic and operational change.'

The four necessary basic principles of an adequate consultation exercise by a public body, were described by Mr Justice Sedley,[20] as follows;

- Consultation must take place at a time when proposals are still at a formative stage,
- The proposer must give sufficient reasons for any proposal so as to permit intelligent consideration and response,
- Adequate time must be given for consideration and response, and
- The product of the consultation must be conscientiously taken into account in finalising any proposals.

Mr Justice Moses,[21] stated that consultation is a process whereby a health authority and CHC should jointly seek to reach a solution to a problem. In the same case it was held that North and East Devon Health Authority were at

[19] See footnote 1.
[20] See footnote 18.
[21] See footnote 7.

fault in failing to consider that the consultation process could produce alternative solutions to those which they had identified.

The overall test to be applied by the court is whether the consultation as a whole resulted in unfairness[22].

At What Stage in the Decision-Making Process?

The legislation does not lay down any indicators as to when consultation should take place, other than to refer to consultation on proposals under consideration. However some principles, based upon the need to ensure that consultation is meaningful, are laid down in caselaw. Health authorities are required to consult on proposals while they are still in a formative stage and before they become decisions or final solutions. In the Lynton case,[23] Mr Justice Moses attempted to identify the point at which a proposal becomes sufficiently crystallised so as to permit consultation. He held that a health authority must go out to consultation on proposals for a substantial change under consideration by them, whether or not the proposals have gone to the Board of the Authority.

In What Form?

Although there is no statutory duty placed on health authorities to consult on their purchasing plans, or in general upon plans to make contractual changes with service providers, many health authorities do consult with CHCs and other local groups about their purchasing intentions. Where proposed contractual changes amount to a significant variation, or development, in health services, it is clear that full consultation is required by virtue of Regulation 18(1) of the 1996 CHC Regulations.

Some health authorities have purported to consult on proposals to make cuts in services by asking for comments on their purchasing plans. However, purchasing plans usually do not contain sufficient information so as to allow the CHC, or indeed any other consultee, to form a clear view of what is proposed and then to make a reasoned response. Purchasing plans do not usually contain exact timetables for proposed changes. In some instances, the lack of clear information about when plans are to be implemented, may prevent full consideration of the impact of the changes.

[22] R v Warwickshire DC ex parte Bailey [1991].
[23] See footnote 7.

It may be reasonable to accept that consultation on purchasing intentions can, in some cases, take the place of statutory consultation, when certain criteria are satisfied, including that;

- the consultation is timely,
- sufficient detail is provided to the CHC on any proposals involving substantial variations or developments in the service, to facilitate a considered response, and
- the CHC is willing to accept consultation on the plan in place of specific consultation on the changes proposed. However, CHCs should note that they too have a duty to act reasonably and any decision to waive the right to a separate formal consultation on service changes should be a reasonable one, taken after consideration of all the facts.

In the event that a CHC is unhappy with the form of consultation when carried out on the health authority's purchasing plan, now known as the Service and Financial Framework (SFF), it is suggested that they;

- identify the substantial variations of developments contained in the plans,
- identify those aspects of the plans which are likely to prove controversial,
- detail the information the CHC thinks would be needed to allow proper consideration of the proposals,
- if there are alternatives to the course of action identified by the health authority, to identify them, and
- write to the health authority detailing the CHCs concerns.

Since EL(92)1, it has been accepted practice that health authorities consult when drawing up their purchasing plans. However, in an annex to EL(97)39[24], it is stated;

'There will no longer be a formal requirement to publish purchasing intentions.'

This guidance stresses the need to work with other service providers to produce SFFs. This guidance goes on to say that;

[24] NHS Priorities and Planning Guidance 1998/99.

'there should be wide informal consultation on the developing SFF' and that 'Health Authorities should publish the framework....to inform local interest groups and the public of the NHS service intentions....'
Health Authorities are reminded of the need to consult formally on major service changes.

It may be necessary to seek clarification of CHCs' rights in relation to the planning of services, from the NHS Executive, particularly bearing in mind that the process of planning can have a significant impact on provision and on the range of options which will be viable by the time formal consultation takes place on proposals for substantial changes.

How Long?

Regulation 18(4)[25] provides that;

'A Health Authority may specify the date by which comments on any proposals referred to in paragraph (1) are to be made by the Council.'

The courts have held that;

'adequate time must be given for consideration and response'[26]

Over time, CHCs have come to expect that they will be allowed a period of at least three months within which to respond, having established the views of their local community to the proposals under consultation. Previous guidance to the effect that three months is the norm HSC(IS)207, was superseded by 'Consultation and Involving the Consumer', which only states that the consulting authority must:

'allow sufficient time for a view to be taken and advice to be formulated.'

However, the significance of the requirement that sufficient time be allowed for consideration of the proposals and the formulation of a response is underlined by the grounds given for a referral to the Secretary of State for Health, as laid out in Regulation 18(5), which reads:

'In any case where a Council (CHC) *is not satisfied that sufficient time has been allowed under paragraph (4)....., 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.'*

[25] See footnote 2.
[26] See footnote 18.

There are a number of factors which will affect any consideration of the adequacy of the time period provided, including;

- the complexity of the proposals being made,
- whether these have already been considered in a previous consultation exercise, e.g. the strategy having been agreed, the authority are now consulting on the detail of implementation,
- whether the proposals affect a small or larger population, e.g. if proposals will have implications for the communities served by several health authorities, a longer period of consultation is likely to be necessary to ensure proper co-ordination,
- the time of year, and
- whether it is important to have an early decision.

CHCs are not in continuous session. The consulting authority should have regard to the CHCs cycle of meetings. CHCs may need to arrange extra council and sub-committee meetings to deal with the work involved in ascertaining the view of the community and preparing a response. While a shorterconsultation period that 3 months may be acceptable at some times of the year, Xmas and summer pose particular problems, as any public meetings which may need to be arranged to establish local views, will be poorly attended and CHC members themselves, are likely to take their holidays over these periods.

CHCs have limited staff resources and most would be unable to deal with two or more overlapping consultation exercises on major issues. Health authorities and CHCs may want to consider drawing up agreed protocols for the time-tabling of consultation exercises. If two or more concurrent exercises are unavoidable, then it may be appropriate to seek an extended period.

Recently a number of CHCs have complained that although their health authority announced that they would consult over a specific period, the consultation documents have not been made available until some time after the period has commenced. This is poor practice on the part of the consulter. If a challenge were to be mounted, it is highly likely that the courts would discount any period prior to the delivery of the details of the proposals.

The principle of legitimate expectation may be relevant here. If a health authority has always given a CHC three months within which to consider proposals and respond to them, but then imposes a shorter period, without good reason, the CHC might wish to seek to protect its right to an adequate response period, by pursing the argument that, in the absence of special factors, previous practice had set up a reasonable expectation, that three months is a necessary minimum period for a consultation exercise.

PARTICULAR PROBLEMS

Urgency

Regulation 18 (3) provides that the duty to consult;

'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; but in any such case, the Health Authority shall notify the Council immediately of the decision taken and the reason why no consultation has taken place.'

Consultation and Involving the Consumer confirms this exception, clarifying that only urgency permits closure without consultation, not considerations as to whether the proposals are of a temporary or permanent nature. It adds that in such cases the authority; *'should implement the decision with a speed consistent with their decision.'*

Clearly, the temporary closure of a ward to prevent the spread of MRSA, falls into this category. However, to comply with its legal obligations, a health authority is required to inform the CHC of the closure and the reason why there was no time to consult. Financial imperatives have been behind a spate of claims by health authorities that they do not have to consult CHCs before implementing closures and making other money saving service changes. NHS trusts are under a duty to balance their books.[27] Health Authorities are required to keep within their budgets. Urgent unforeseen financial considerations may occasionally arise, but some health authorities have attempted to rely on the provisions of Regulation 18(3) because they failed to plan ahead and others have been guilty of financial mismanagement.

In the Lynton case,[28] North and East Devon Health Authority decided to close two community hospitals without consulting the local CHC, claiming that the financial situation was so acute that they were unable to afford to keep the hospitals open for the period of time that would be required to carry out consultation. Mr Justice Moses found against the Authority, stating that;

'Regulation 18 read as a whole, is designed to ensure that consultation does take place with a Community Health Council. ..... It would seriously undermine the purpose of the Regulation if a Health Authority could allow time to pass to the point where matters were so urgent that there was no time left for consultation.'

[27] S10 National Health Service and Community Care Act 1990.
[28] See footnote 7.

CHCs have received advice[29] that;

'.....if the CHC itself anticipates that an urgent need to make financial savings will arise, they should quickly make use of their powers to get information about these matters and then to give advice or make recommendations themselves. They need not wait for the authority to initiate consultation. If they do that,.....the authority must take into account their advice and/or recommendation before deciding to make an urgent substantial variation, i.e. one where consultation is avoided. The authority would otherwise be acting in an unlawful way.'

If, under Regualtion 18(3), temporary measures are taken without consultation, the authority is required to consult with the CHC before taking any steps to confirm the changes as permanent.

Closures

Closures of hospitals and other facilities are not specifically mentioned in the legislation. Consultation and Involving the Consumer contains the following statements;

'We have no reason to dissent from the view that there will be few instances in which the closure of facilities on a scale sufficient to save material amounts of money will not be a substantial variation.'

and

'Ministers wish to continue to reserve to themselves decisions on contested closures.', which indicates that closures of facilities are seen to have particular significance.

In any event, closure of a facility which would involve the relocation of services will almost certainly amount to a substantial variation in health services and thus attract the duty to consult. If a building contains no services, it may be arguable that the closure amounts to a substantial development, particularly if it is to be disposed of, as it will then not be available should a future need for it arise.

Temporary Variations in Services

Government guidance[30] states that the Regulations *'do not distinguish between permanent and temporary closure'.*

The courts have confirmed that whether proposals involve a temporary or permanent solution does not alter their essential nature or remove the duty

[29] R. Allen, 2 June 1986. Legal opinion for Lewisham and North Southwark CHC.
[30] See footnote 6.

on the authority to consult[31]. Whether a variation is substantial will depend upon the proposal itself, although it is conceivable that, in some instances, the length of time a temporary change is likely to apply, might be a factor.

Overlapping Consultations

Health Authorities may carry out more than one consultation exercise at any time. For example, consultation on a strategy for services, may overlap with one concerning proposals to make specific substantial changes to services. The specific proposals may have implications for the long term strategy. Before taking decisions, the authority should consider all relevant representations, that they receive through both exercises. Failure to do so could lead to a challenge, although in the Lynton case, Mr Justice Moses commented that the fact that North and East Devon Health Authority had not concluded their public review of services, prior to reaching their decision to close hospitals, was not in itself grounds to overturn the decision for irregularity.

Another situation in which overlapping consultation exercises may arise, is where a health authority's consultation over one issue, coincides with a consultation exercise carried out by the Secretary of State through the NHS Executive. For example, on proposals to establish, dissolve, or vary NHS Trust powers. These consultations, while involving decisions to be taken by two separate bodies, often relate to the same substantial proposal. The authorities concerned, will need to co-ordinate the consultations. Depending upon the particular circumstances, the making of a decision by one authority without having taken into account the related issue, could give rise to grounds for a legal challenge.

PFI Proposals

CHCs have been hampered in their ability to make a useful contribution to debate and decision-making concerning individual PFI schemes in their localities, by the dearth of information which is available to them about the schemes. Many of those CHCs have requested further information under the provisions of Regulation 19, but have been informed that relevant reports are of a commercially sensitive nature and that confidentiality considerations prevent their release. Some of the questions which then remain unanswered are very important, and touch upon the underlying assumptions upon which bed numbers are based, and risks are allocated between the private partners and the NHS bodies involved.

Recent guidance,[32] instructs health authorities and NHS trusts to provide information about PFI schemes in line with the Code of Practice on Openness

[31] See footnote 7

in the NHS. ACHCEW has asked the DoH to issue further guidance to health authorities and NHS trusts, detailing specific reports and documentation which should be made available to CHCs when PFIs are under consideration.

Contractual Changes

CHCs often ask whether they should be consulted by their local health authority over the authority's plans to alter its contractual arrangements with health providers. Consultation and Involving the Consumer, advises that while health authorities are not expected to consult on the details of individual contracts, they should do so on the strategies underlying those contracts. Nonetheless, there are occasions when the contractual change proposed is so significant, that it cannot fail to have an effect on service delivery. Some contractual changes can have an effect on the viability of a particular provider. In which case, it is arguable that the proposal amounts to a substantial development. In these circumstances, there is a strong case that consultation is required under Regulation 18(1). As health authorities generally do not accept that they have a duty to consult in such cases, Government guidance to this effect may now be required.

The Single Proposal Consultation.

This may arise where service reductions proposed, which are not options but a complete package and no alternatives appear within the plans. If consultation is carried out only on one option, is arguable that the decision has already been made. In which case the body carrying out the consultation might be open to challenge for failing to consult at an appropriate stage in the decision-making process, i.e. at a stage when other options were still open to them. However, it may also be necessary to produce other evidence that the health authority in question had effectively closed its mind to any alternatives, e.g. evidence that it was implementing their plan prior to the end of the consultation period.

The courts have considered a number of cases where complaints have been made by CHCs and others about inadequate consultation by public bodies. Mr Justice Sedley has held that; *'the product of the consultation must be conscientiously taken into account in finalising any proposals.'* [33]

In other words, the decision-maker should not make up his or her mind before considering the responses to the consultation document. The same requirement applies such that an authority cannot reach a decision, before going out to consult.

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[32] EL (97) 35 Making Information Available About PFI Projects.
[33] See footnote 18.

CHALLENGES

The first step in pursuing an inadequate consultation exercise, should be to bring the problems to the attention of the consulting body. This should be done in writing, to ensure that the CHC's concerns are put on record.

Referral to Secretary of State

Regulation 18(5) of the CHC Regulations 1996, provides that;

'In any case where a Council (CHC) is not satisfied that sufficient time has been allowed under paragraph (4), or that consultation on any proposal referred to in paragraph (1) 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.'

Many CHCs have been unaware that this Regulation places them under an **obligation** to refer instances of inadequate consultation to the Secretary of State. In extreme cases, a CHC could itself face a legal challenge if it failed to make a reference when the health authority was obviously in breach of its obligations.

How to Make a Secretary of State Referral.

Where for any of the reasons identified in this document, a CHC considers that the consultation has been inadequate, it has the right to refer this to the Secretary of State. This right is additional to CHCs inherent right to refer matters to the Secretary of State, when the CHC disagrees with decisions reached by the health authority. Neither procedure requires the CHC to provide detailed alternatives, but clearly any referral made to the Secretary of State should provide sufficient detail of the CHC's complaint and the background to that complaint, so as to allow him to adjudicate.

NHS Executive Regional Offices are the local representatives of the Secretary of State for Health, and CHCs can either make the referral through the Regional Office, or direct to the Secretary of State at;

The Department of Health
Richmond House
79, Whitehall
London SW1A 2NS

The Secretary of State should be addressed as; 'The Right Honourable [Name] MP'

In cases where the CHC considers that the Regional Office is too closely associated with the proposals under consideration, or where they have failed to respond to initial overture from the CHC, it is sensible to direct the referral to the Secretary of State himself. In any event, CHCs should keep the NHS Executive Regional Office informed of problems and copy to them any correspondence including a copy of a referral made directly to the Secretary of State. The relevant health authority and NHS Trusts should also be sent copies, and where appropriate, they should be asked to confirm that they will take no steps to implement their proposals until the Secretary of State has adjudicated.

With any referral to Secretary of State, CHCs need to enclose copies of;

- the consultation documentation,
- the CHC's response,
- the relevant correspondence. For example any letters sent by the CHC seeking more information about the proposals, or complaining about the shortness of the consultation period,
- minutes of relevant health authority meetings, and
- any relevant background material, such as details of promises previously made, any consultation protocol which has been agreed or previously adhered to, etc.

The Procedure

The Secretary of State will need to satisfy himself of the facts of and background to the complaint. The NHS Executive Regional Office is usually asked to investigate and make recommendations. This takes time. No formal timetable exists for the determination of referrals. If there is a need for urgent action, the CHC should explain this in their letter of referral.

It appears that health authorities are usually supplied with a copy of the CHC's letter of complaint, and asked for their comments. However CHCs have not been provided with the opportunity to comment on the accuracy or otherwise of the submission then made by the authority. This has caused problems, particularly when the Secretary of State has then replied to the CHC's referral with nothing more than a bald statement that he is satisfied with the health authority's approach. A more transparent and open procedure is required if suspicions of collusion are to be avoided.

Protection of the Status Quo during a Referral

No mention is made in the CHC Regulations or in government guidance to the position of a health authority wishing to implement proposals for change while a referral is outstanding. However, the point was raised with Alan Milburn MP and the Minister confirmed that implementation of a disputed

change, which is the subject of a referral, would not be in the spirit of the guidance put out under EL(96)17.[34]

This issue does not appear to have been considered by the courts. However, it is likely that a court would interpret Regulation 18(5) as a safety mechanism and would rule against any health authority which took steps to action their proposals while they were under consideration by the Secretary of State, particularly if the effect would be to limit the available alternative options, or to force the Secretary of State's hand.

If the consulting health authority does attempt to implement its proposals during the referral process, it may be necessary to ask the Secretary of State to instruct the authority to take no further steps until he has reached a decision.

Judicial Review

What is Judicial Review?

Judicial review is a process whereby the courts can consider the lawfulness of decisions or actions of public bodies. Health authorities, NHS Trusts, the Secretary of State for Health and the NHS Executive all fall within this category. (As do Community Health Councils.) Applications can be made to the High Court by individuals or other bodies, which have a sufficient interest in the particular question. CHCs, having a duty to represent the interests of their community in health service matters, as well as having a statutory right to consultation, will have little difficulty in establishing their credentials as interested bodies. The terminology used by the courts is that, the 'applicant' is the person or body asking for the court's intervention and the body which is the subject of the challenge is known as the 'respondent'

It is important to bear in mind that an application for judicial review can be used to challenge the way a decision has been reached, but cannot be embarked upon to challenge the merits of a decision, or to obtain damages/compensation.

All remedies in judicial review proceedings are discretionary, i.e. the judge will only make an order if it believes that the facts of the particular case warrant the remedy requested. The discretionary nature of judicial review is very important. The court will want to be convinced that the applicant, has a need for the remedy and has done all within its power to resolve the matter without recourse to the courts, but without undue delay either. To improve its chances of success the CHCs must be able to show, that they have been

[34] Letter dated 5 June 1997 from Alan Milburn MP to Dominic Ford, Chief Officer of Redbridge CHC.

acting in the best interests of the community and that they have been open in their dealings with the Health Authorities.

If the application is successful, the court will usually quash or overturn the decision complained of, rather than impose its own decision. The public body in question then has to reach a new decision in the light of the court's judgement. There are no guarantees that they will not take the same decision again, avoiding the procedural pitfall they previously fell down. However this is rare.

Bringing an action for judicial review is a way of seeking to ensure that the public body in question reviews its position and if appropriate, changes its stance. Most judicial review cases are settled before the final hearing. For this reason, it is usually worth making an issue out of the fact that the CHC is seeking counsel's opinion. If the opinion is favourable, the CHC may want to supply a copy to the authority, in the hope that it will persuade them to reconsider.

If counsel advises that the application should proceed, then the CHC will need to formally decide whether to issue proceedings and how they intend to meet the costs of doing so.

When is Judicial Review an Appropriate Form of Challenge

There are a number of grounds upon which an application for judicial review can be brought. These include:

1. Illegality

   This arises where the body in question has;

   - exceeded the powers given to it by Parliament in Statutes or Regulations, or
   - attempted to exercise a power they do not actually have, or
   - has failed to meet its statutory obligations, or
   - has acted in a way which is incompatible with European law.

2. Irrationality

   If a decision is so unreasonable as to be irrational, the court may quash it. This ground does actually touch on the merits of a decision, but it is very difficult in practice to persuade a court that a public body has acted irrationally.

3. Procedural Impropriety.

   This arises when the respondent has failed to follow the correct process in reaching a decision, by breaching statutory rules, or showing bias or prejudice, or where it has failed to give a fair hearing to those affected by their decision.

In fact many cases involving complaints about consultation will show many of these grounds and may additionally raise an issue of legitimate expectation that a particular course of action would be followed.

The sorts of circumstances in which legal proceedings may be appropriate against a health authority are when there has been:

- Failure on the part a health authority to consult on a substantial development/variation;
- Consultation only on a general principle and not on detailed plans;
- Changes to the proposals after consultation exercise and refusal by health authority to consult on these - typically with PFI schemes;
- Changes to primary health services and refusal to consult;
- No consultation on funding cuts to voluntary groups and support services providing health services;
- Failure to provide information on request in line with Regulation 19 (although this is not used to its maximum advantage by CHCs);
- Implementation of disputed proposals while a Secretary of State referral is ongoing;
- Consultation is carried out but;
    - inadequate information supplied,
    - too short time to allow for consideration and response,
    - the authority fails to properly take into account the submissions made, or there are indications that decision is a foregone conclusion;
- An attempt by a health authority to implement proposals while a matter is subject to a referral to the Secretary of State.

The sorts of situations where CHC may want to consider judicial review of the Secretary of State for Health are:

- when a referral to Secretary of State is not given consideration by the Secretary of State, or
- where there has been an improper delegation of Secretary of State powers, or
- on the Secretary of State's failure to consult or consult properly on issues of NHS trust establishment, merger, dissolution or extension of trust powers.

Judicial Review Procedure

Unlike some other forms of legal proceedings, the parties are expected to be open with each other from the start. The applicant CHC should give written notification of their grounds of complaint and the result they are seeking, so that the respondent can attempt to put matters right as quickly as possible.

It is important that this letter is sent as soon as the problems have been identified, as the courts require any applicant for judicial review to make their application for leave without delay and in any event within three months of the decision, or action, or omission, complained of.[35] A recent Court of Appeal ruling[36], that an application can be considered when out of time if the issue is one of public importance, is relevant only in exceptional circumstances and when good cause can be made out for the delay in commencing proceedings. Before abandoning hope of a legal challenge because of delay, CHCs should seek legal advice, but clearly the better option is to act quickly from the outset.

The High Court will usually expect an applicant to have exhausted all other possible remedies before making an application for leave for judicial review. It is arguable that CHCs should refer matters to the Secretary of State for Health first, but if time is short, this may not always be practicable.

Judicial review is a two stage process. Before the court will consider a case in full it will first decide whether the application has sufficient merit to warrant a full hearing, A Judge in the High Court will briefly consider whether there is an arguable case, brought by a suitable applicant, without undue delay. By this process 'unwinnable' cases can be weeded out. The application for leave will be considered on an 'ex parte' basis, which means on the basis of the information put forward by the applicant and is often done without a hearing on consideration only of papers submitted in support of the application. Some leave applications are decided after an oral hearing, typically when the applicant is seeking an interim order from the court. Although the Respondent will not normally be represented at this hearing, if the applicant asks for interim relief, the Respondent must be informed and can attend to argue against the granting of an order. If leave is refused, the applicant has the right to make a renewed application, but this time to the Court of Appeal.

There are a number of types of interim orders which the court can make. The applicant must consider whether it needs to make an interlocutory application when applying for leave. This may be appropriate when a health authority refuses to put proposed changes on hold, until the court has fully considered the case.

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[35] Rules of the Supreme Court Order 53 rule 4.
[36] Re S's Application for Judicial Review [1997].

Only if leave is granted, it is possible to proceed to a full hearing of the complaint. This may take place some months after the grant of leave, but either party can ask for an expedited hearing, if the matter concerned needs urgent resolution. In the intervening period, the applicant must serve the order granting leave and all other relevant papers on the Respondent. In turn, the Respondent is required to serve its defence on the applicant. The majority of cases are settled by the parties before the issue goes to a full hearing, once they have fully considered the other side's arguments. In fact, most cases are resolved to the applicant's satisfaction before or shortly after the leave hearing.

Precedents

Decisions in the High Court are not only binding on the parties concerned in the case in question, but effect other public bodies. If the same issue comes before the court, the judge hearing it is unlikely to differ in the decision s/he reaches. Judgements of the Court of Appeal are binding on the lower courts and must be followed in all subsequent cases, as are House of Lords judgements.

Remedies

All remedies in judicial review proceedings are discretionary, i.e. the judge will only make an order if it believes that the facts of the particular case warrant the remedy requested. The court can refuse to make orders asked for and instead impose a remedy that it considers appropriate.

The discretionary nature of judicial review is very important. The court will want to be convinced that the applicant, has a need for the remedy and has done all within its power to resolve the matter without recourse to the courts, but without undue delay either. To improve its chances of success a CHC must be able to show, that it has been acting in the best interests of the community and that it has been open in its dealings with the respondent. While CHCs may not want to reveal their tactics at an early stage, they must advise their opponent of their reasons and grounds for challenge, as soon as is practicable.

Certiorari

The High Court has the power to quash invalid decision(s) of a public body (including those of the Secretary of State). This is known as an order of certiorari. The body in question must then reconsider the question and make a new decision, avoiding the errors in procedure or law that they previously made. It should be noted that occasionally, the respondent will make an identical decision to that which was the subject of the initial complaint, but will do so in such a way that then cannot be challenged.

Prohibition
Where the application is made before the body in question has made a decision, the court can make an order prohibiting it from taking illegal, or improper action.

Mandamus
The court can order the respondent to carry out its statutory obligations, for example to consult with a CHC on proposals which amount to a substantial change in health services.

Declarations
If the matter concerned requires no action by the court, other than a clarification of the law or of the rights or duties of the parties, then the court can do so by declaring the law and/or the obligations placed on the parties.

Appeals

An applicant can seek to appeal the court's decision to refuse leave for judicial review - see above. Either party can appeal to the Court of Appeal if they wish to challenge the High Court's decision on a substantive hearing of the application for judicial review, although it is usually necessary to obtain the High Court's permission to pursue the appeal, which must be lodged within 28 days of the disputed judgement.

Costs

CHCs do face problems if they seek to enforce their rights in the courts, because their budgets are not large enough to meet the costs of bringing proceedings. CHCs are not corporate bodies, or limited by guarantee and thus the individual CHC members are legally liable for costs incurred and indeed any costs order made against the CHC, should they fail in their challenge. The NHS Executive and Treasury indemnity does not appear to provide any cover for legal costs. CHCs can take comfort from the fact that even if they did lose their case, the High Court would be unlikely to order them to pay a health authority's costs, bearing in mind the fact that the CHC would be taking action in the interests of the community.

A CHC can, at any time, decide not to proceed further with an application, but it will be liable for its own costs incurred up to that date. If a CHC decides to drop its case after having obtained leave and issued the full application, but without having gained any concessions, it may be liable for some of the Respondent's costs and should only do so on the advice of their legal representatives.

The costs of obtaining a barrister's opinion on the merits of their case and then bringing an action (CHC own costs) are proving a major stumbling block for CHCs. Although CHCs have the right to ask the Secretary of State for Health to support them with these costs, to date, no such application has

been approved. The current Legal Services service level agreement, provides that any application for support with costs should be supported by a report from the SLA holder. It may be that other bodies, with similar interests to those of the CHC, although without the CHC's statutory rights to be consulted, would agree to either financially support an action brought by a CHC, or take their own action. CHC members are ideally placed to make enquiries of other groups or organisations who may have concerns of their own, with a view to working together. A public appeal for funds to pay the costs, could have the effect of embarrassing a Health Authority into reviewing the position.

If a CHC's application for judicial review is unsuccessful, the court can make an order for costs against the CHC, i.e. that the CHC pay the Health Authority's costs as well as their own. Thus, in the worst case scenario, the CHC could find itself liable for combined costs in the region of £60,000. However, the High Court would be unlikely to make a costs order against a CHC with limited resources which was seeking to defend the interests of its community.

Problems with Judicial Review

- The proceedings are very costly and CHCs do not have the resources to cover these costs.
- Even if the court finds in favour of the applicant CHC there are no guarantees that the decision complained of will be overturned.
- The proceedings must be commenced without delay, but CHCs have cycles of meetings which build delay into making an application for leave.

Summary

CHC officers and members need to be alert to possible grounds for judicial review and to seek legal advice at the earliest date. The CHC cycle of meetings is likely to cause delay in making decisions about whether to proceed with legal proceedings. However in the meantime CHC officers are not prevented from seeking relevant information and advice and should always consider writing at the earliest possible opportunity, to their health authority and to the Regional Office of the NHS Executive, laying out their complaint.

FUTURE DEVELOPMENTS

At the time of writing, the Government's White Paper on the Future of the NHS is expected. However, whatever plans it contains, it is almost certain that consultation with health services users will be prominent. It is not known whether there are any plans to introduce new legislation in the subject, but it is likely that the courts' requirements of a valid consultation exercise, will still apply.

ACHCEW has suggested that there is a need for new Government guidance to all NHS bodies, detailing the legal requirements of and best practice in consultation.

In view of the changes in the NHS over the years, it has become necessary to review which bodies should carry out consultation on proposed changes. The practice of consultation being carried out by one body, but the actual changes by another has, in practice caused considerable problems. It is appropriate to pursue changes in legislation such that NHS Trusts and GPs be placed under the duty to consult CHCs on substantial changes they have under consideration.

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