NEWS BRIEFING · HEALTH N
BRIEFING · HEALTH NEWS B
**HEALTH NEWS BRIEFING** · H
NEWS BRIEFING · HEALTH N
BRIEFING · HEALTH NEWS B

Association of Community Health Councils for England and Wales

30 DRAYTON PARK, LONDON N5 1PB. Tel: 01-609 8405

# C O N S U L T A T I O N

## AND THE RIGHTS OF

## COMMUNITY HEALTH COUNCILS

A paper prepared by West Birmingham Community Health Council

# CONSTITUTION AND THE RIGHTS OF COMMUNITY HEALTH COUNCILS

## Contents

# WEST BIRMINGHAM COMMUNITY HEALTH COUNCIL

## CONSULTATION and THE RIGHTS OF COMMUNITY HEALTH COUNCILS

### 1. SUMMARY

Consultation is joint consideration of a matter. It requires that the consulting body is receptive to the views of those consulted and is willing to change its tentative plans. The consulting body must make a full and frank disclosure of its views and provide such supplementary information as those being consulted might request.

The National Health Service distinguishes between informal consultation (which is envisaged as a continuing exchange of views between CHCs and Health Authorities[1]) and formal consultation (which includes, but is not restricted to, the specific procedure for closures and changes of use of health service premises). Formal consultation requires the circulation of a consultation document by the Health Authority. This should set out the advantages for patients of the action proposed in comparison with other feasible options. When replies have been received, the Health Authority should give further consideration to the issue in the light of the comments received. Such consultation should take place in good time, so that plans can be changed in the light of the comments received.

CHCs have the duty to represent the interests of residents of their Districts and users of services provided by their Health Authorities. They should expect to be consulted on all proposals to change or develop services for these people which are not manifestly trivial. This applies irrespective of whether the proposal emanates from a DHA, and FPC, an RHA or the Department of Health. There is a body of case law on what constitutes a significant variation in service, but the established policy is that, if a CHC considers something "substantial", it should generally be treated as such.

In particular, a temporary closure may be substantial, depending on the other merits of the case.

Consultation is not required where a Health Authority considers that, in the interests of the service, a decision has to be taken without allowing time for consultation. In such cases, the CHC must be informed immediately of what has happened and of the reason for the urgency, and the Health Authority must start consultations on proposals to re-open the service and to provide alternative services in the meantime. It is government policy that urgent closures shall be only temporary, and if there is any likelihood that a temporary closure will be made permanent, formal consultation should start immediately on this issue.

Where a Health Authority is unable to undertake proper consultation, it is expected to do as much as is possible in the time available, but the Secretary of State expects Health Authorities to look ahead and anticipate whenever possible the need for urgent action in sufficient time for consultation to be carried out.

Authority for the above summary is found in the following paragraphs, and in the schedules of publications and relevant judgments.

## 2. INTRODUCTION

This paper is based on a West Birmingham Community Health Council report, "*CONSULTATION - The Rights of Community Health Councils*", (2nd edition, February 1986). It outlines established procedures and, in the light of developments since 1986 and clarification which has been received, attempts to set out the rights which CHCs have to consultation and makes recommendations for further improvements to the procedure.

Over the years, CHCs have suffered from the poorly drafted guidance to Health Authorities in HSC(IS)207[2] and piecemeal interpretation: this has hampered CHCs' attempts to promote their local policies for service provision.

It has normally (and understandably) been the case that procedural debates have occurred in the context of disagreements on substantive service issues. This is not the best time to debate procedures, for the presentation of the service issues has all too often been lost as a result.

Some interpretations are gradually being established as a result of court judgments in particular cases, but the typical response of government has been to disregard procedural problems even when individual cases have forced them into the public domain. Even now, a very low-profile Departmental review of consultation procedures, which was started a full year ago, shows no sign of bringing forward any proposals.

The government attitude is illustrated by a letter to Jeff Rooker, MP, from John Patten, MP, dated 5th February, 1985,[3] where Mr Patten wrote, *"We currently have no plans to introduce new statutory rights or duties into the consultation process. Generally speaking I believe it is in the best interests of good working relationships between CHCs and DHAs for any difficulties to be worked out at local level rather than providing recourse to formal appeals procedures to sort out every failure of communication."*

But procedural rules are most important in those difficult cases where good working relationships have broken down. Therefore they should be drafted to cover precisely those cases. They are rarely important in straightforward cases, and there is no evidence that sensible procedures hamper communication in such cases. This paper, therefore, both sets out existing procedures and seeks to deal with the difficult issues which become significant in a small minority of cases.

In the absence of alternative guidelines, CHCs need to set out their own expectations, and to offer each other mutual support, preferably through ACHCEW, when it is necessary to seek to enforce them. Such a statement is necessary because the government asserts that there is no demand from CHCs for improved procedures. In a letter to Michael Meadowcroft, MP, dated 8th August, 1985,[4] John Patten, MP, argued that the fact that resolutions carried at the 1985 AGM of ACHCEW, and the questions following his speech there, did not cover the material of this paper showed that there was no general concern on the matter. This is not the case.

## 3. AUTHORITY

The ranking of authority for action within the NHS is:

(a) Acts of Parliament, (essentially the National Health Service Act, 1977[5]);

(b) Regulations made under the Acts, (in this context, principally the

Community Health Council Regulations, 1985,[6] (SI 1985 No 304));
(c) Directions issued by the Secretary of State;
(d) Directions issued by a Regional Health Authority;
(e) Circulars and other formal administrative guidance;
(f) Informal indications of policy, (eg press releases).

(A schedule of relevant references is attached at Appendix A.)

Acts of Parliament are liable to interpretation by the courts, as are Regulations, and the courts can also rule that Directions and guidance are unlawful. (A schedule of significant cases it attached at Appendix B.)

Government policy can grant additional rights to the public and CHCs and can provide additional safeguards for services, but cannot reduce those which are based on statute.

It is noteworthy that, pursuant to Section 13 of the National Health Service Act, 1977,[5] the Secretary of State can issue Directions to RHAs, and pursuant to Section 14 RHAs can issue Directions to DHAs, but there is no provision for the Secretary of State to issue Directions to CHCs, (other than with regard to their financial arrangements). (It remains uncertain at the time of writing whether the Health and Medicines Bill[7] will add an authority to give Directions regarding income generation.)

## 4. THE SCOPE OF THE COMMUNITY HEALTH COUNCIL

The duties of CHCs are defined in Schedule 7 of the National Health Service Act, 1977,[5] as follows:

> *"1. It is the duty of a Community Health Council, (in this schedule referred to as a "Council")-*
>
> *(a) to represent the interests in the health service of the public in its district, and*
>
> *(b) to perform such other functions as may be conferred on it by virtue of paragraph 2 below."*

(Paragraph 2 is the authority for the establishing of Regulations, and these have been most recently consolidated in the Community Health Council Regulations, 1985.[6])

At one time it was occasionally argued that the scope of CHCs was seriously limited by the phrase *"in its district"* either in the above extract from the schedule, or in the CHC Regulations. This has now been rebutted. In answer to Parliamentary Questions tabled by Michael Meadowcroft, MP, on 15th March, 1985,[8] John Patten, MP, confirmed that the government had no plans to issue guidance which called into question the right of a CHC to represent its non-resident public, (eg patients in its hospitals from other Districts).

At the same time, Mr Patten confirmed that CHCs are entitled to deal with issues affecting residents of their Districts which are the responsibility of another DHA.

Finally, he confirmed that CHCs are entitled to deal with issues affecting residents of their Districts which extend beyond the geographical boundary of their District.

In essence, therefore, CHCs can use either of two overlapping criteria to define a person as a member of their public; these are the residents of their District and the people receiving services provided by their corresponding

District Health Authority, whether provided inside or outside the boundary of the Health District.

CHCs also claim the right to represent the interests of this public in the health service **at all levels**, because decisions taken at Regional and National level affect services to local people. The government has tended to support this view with respect to Regional Health Authorities, (see section 9), but to resist it with respect to the DHSS, (see section 11). CHCs should act as though they expect that all these bodies will act in accordance with this government's interpretation of the proper wide scope of CHC activities, and that they will provide information and consult widely as implied by this interpretation.

## 5. IN WHAT CIRCUMSTANCES IS CONSULTATION APPROPRIATE?

Paragraph 19 of the Community Health Council Regulations, 1985,[6] provides for consultation by Health Authorities and Family Practitioner Committees of CHCs regarding substantial developments and variations of service. There is an exclusion in cases of urgency where the interests of the NHS would otherwise be prejudiced. There is a right of appeal to the establishing authority, (the RHA in England, and the Welsh Office in Wales), where the CHC considers that the consultation is inadequate or that insufficient time has been allowed.

### 5.1 "Substantial"

The first issue is the definition of "substantial". A strong view was set out in a letter dated 27th July, 1986, to Graham Girvan, Secretary of Bexley CHC, from Mr A P Andrews, the Legal Advisor of South East Thames RHA[9], who wrote that there is a "*duty to consult on any closure that is not **manifestly temporary and trivial***", and in the same letter stated that any permanent closure would be substantial. (This last point may be a retro-argument from the instruction in the 1979 de Peyer letter[10] to consult on all permanent closures, but unless the advice is withdrawn at some future date it is a useful complementary authority to quote.)

At the other end of the scale, suggestions from some DHAs on the basis of tentative legal advice that it is possible to define a numerical threshold for "substantial", (normally 10% of some measure of the service being changed was suggested), is now rejected; (see R v Tunbridge Wells HA ex parte Goodridge and others, 1988[A]). Each case must be taken on its merits, and issues of quality must be given weight as well as issues of quantity, (see Ladbroke (Football) v William Hill (Football), [1964], 1 WLR 273[B]).

Since LB of Lewisham v the Commissioners for Lambeth, Southwark and Lewisham Health Area, 1979[C], it has been confirmed that the court has authority to substitute its own judgment for that of a health authority (or in this case Commissioners) on the question of whether a variation in service is substantial. In a letter to Jeff Rooker, MP, dated 5th February, 1985,[9] John Patten, MP, said that, "*broadly speaking I would expect authorities to go along with the CHC's views in most cases*". Thus it is clear in practical terms that if a CHC says a proposal is for a substantial variation in service, both the law and government policy require the Health Authority to sustain an argument to the contrary, and this argument can expect to come under close scrutiny.

In the same letter to Mr Rooker, Mr Patten declined to provide an explicit statutory right of appeal against a decision not to treat a proposal as

"substantial", arguing that there is already such a right of appeal to the RHA. This clarification is welcome. It had not previously been certain that the right of appeal to the RHA regarding the adequacy of consultation covered the question of whether a proposal was substantial. CHCs now know that appeals on this issue must be considered. In July 1988 West Midlands RHA sustained an appeal by South Birmingham CHC[11] against a decision, (as it happens by *Central* Birmingham HA), that to restrict GP facilities at Birmingham Maternity Hospital to Central Birmingham women was not a substantial variation in service.

However, not all Health Authorities have been prepared to accept this view. Cases have gone to court and case law is beginning to emerge. In the Tunbridge Wells case[9], it was ruled that the closure of a cottage hospital, including the temporary closure for a year, would be "substantial". (That being the issue, there was no need for this court to define a more general, lower threshold.)

## 5.2 Cases of Urgency

Paragraph 19(2) of the Regulations excludes from consultation certain cases of urgency. In response to a question from Clare Short, MP,[12] on 20th November, 1985, Kenneth Clarke, MP, stated that the government did not collect information about the use of these urgency provisions, but that he had advised health authorities (repeating the advice in the De Peyer letter of 1979)[10] that no **permanent** closures should take place without full consultation.

If the urgency procedures are cited, the Health Authority has various obligations. The CHC Regulations, 1985,[6] require that the CHC should be notified immediately both of what action has been taken and of the reasons for which no consultation has taken place. The departmental letter to Regional Administrators of December 1984[13] requires that the Health Authority start consultations on the re-opening of the facilities and the provision of the service in the meantime. If it is envisaged that the unit may be permanently closed for its previous purpose, the De Peyer letter[10] requires that consultation be started on this possible closure.

The De Peyer letter also requires that the reasons for the closure and for the failure to consult be set out in a formal Resolution of the Authority, and although MANN (J) ruled in R v Richmond, Twickenham and Roehampton AHA, ex parte LB of Richmond, (20/2/84, unreported)[9] that this was not a **legal** requirement, it remains good administrative practice. MANN made it clear that the Authority must have in mind the issues which justify closure without consultation if such a closure is to be lawful.

In other replies to Ms Short[12], Mr Clarke did not answer one important question, namely whether on any occasion an urgent situation had arisen as a result of a reckless or negligent failure of a Health Authority to consult a Community Health Council at an earlier time, and whether he intended to take action to prevent any such occurrence. This issue was taken up in correspondence[14] between Michael Meadowcroft, MP, and John Patten, MP, following a debate on the CHC Regulations in a House of Commons Committee on 24th April 1985,[15] and Mr Patten argued that existing guidance should preclude any abuse of the urgent and temporary closure procedures in order to circumvent proper consultation.

This was, in effect, a restatement of a departmental letter to Thames' Regional Administrators in January 1984[16] which said, *"The Secretary of State expects Authorities to look ahead and anticipate whenever possible the need for urgent*

*action in sufficient time for consultation to be carried out*". This opinion was endorsed in legal advice to Lewisham and North Southwark CHC from R Allen in 1986[17], where it was stated that "*... a DHA cannot wilfully create a situation of urgency*", (but did not say explicitly that this was because they would be unlawful). However the Tunbridge Wells case[A], for example, has proved the expectation that Health Authorities will look ahead to be optimistic.

Mr Allen added, "*... Equally a CHC cannot deny the need for urgent action merely because, had their advice been taken earlier, or positive steps taken by a DHA, the situation would have been avoided*".

Mr Patten, in his letter to Mr Meadowcroft of 8th August 1985[4], also argued that a Health Authority would consider how any such problem reflected on a general manager's performance without further guidance from the (then) DHSS.

It remains the case, and is a sensible provision, that a Health Authority or FPC can decide that in the interests of the health service there is not sufficient time for consultation; the question which remains is when it is appropriate to make use of this provision. There is now significant case law on the question of urgency, with the court sustaining the view of the health authorities in R v Richmond, Twickenham and Roehampton AHA, ex parte LB or Richmond, 20/2/84 (unreported)[D] and in R v Hampstead HA, ex parte LB of Camden, QBD 1/10/86[E], but overturning it in the Tunbridge Wells case[A]. Thus it is clear that a court can substitute its judgment on the question of whether a situation is urgent.

In the Lewisham case[C], WOOLF (J) also ruled that it was acceptable for an authority to change its reason for not consulting to that of urgency, even if it had not so decided previously.

In contrast to the ruling that a court can substitute its judgment on the issue of urgency, WOOLF (J), also in the Lewisham case, said that the court could not substitute its judgment as regards the interests of the health service. The distinction is a fine one, but it appears that the judgment of a Health Authority or Family Practitioner Committee cannot be challenged on this question.

CHCs have a piece of useful advice in the legal opinion for Lewisham and North Southwark CHC from R Allen[17], which reads, "*... if the CHC itself anticipates that an urgent need to make financial savings will arise they should quickly make use of their powers under paragraph 20 of the 1985 Regulations to get information about these matters and then to give advice or make recommendations themselves. They need not wait for the DHA to initiate consultation.*

"*If they do that I would advise that the DHA must take into account their advice and/or recommendation before deciding to make an urgent substantial variation, ie one where consultation is avoided. The DHA would otherwise be acting in an unlawful way.*" Presumably, the DHA would also need to explain to the CHC its reasons if it were to reject the advice and/or recommendation. Taking things a stage further, those reasons for rejecting the CHC advice would presumably be susceptible to judicial review.

## 5.3 Temporary Closures

In response to questions from Clare Short, MP, on 20th November, 1984,[12] Kenneth Clarke, MP, reported that the DHSS did not keep information centrally about the incidence of temporary closures which had been outstanding for more

than three months or twelve months, and that the government had no plans to issue instructions defining a maximum period for a temporary closure after which full consultation must be initiated. Shortly afterwards, however, Regional Principals of the DHSS wrote to Regional General Managers[13], re-stating and making firmer advice in the 1979 de Peyer letter[10], as follows;

- that a temporary closure can be a substantial variation in service, especially if, for example, it involves the temporary cessation of the only service of its kind in a District, or relocates it;
- that authorities should carry out full consultation once there is a possibility of their wishing to make a temporary closure permanent;
- that this is particularly likely to be necessary in the case of long-standing temporary closures;
- that when an urgent temporary closure has been made without consultation authorities should consult on arrangements for re-opening and for providing a service in the interim.

The view that a temporary closure can be a substantial variation in service has subsequently been sustained by the courts, for example in R v Hillingdon HA [1984] ICR 800[15] and in the Tunbridge Wells case[8].

CHCs can therefore now expect support in cases where they complain that these guidelines have been breached.

## 6. WHAT IS REQUIRED OF CONSULTATION?

A dictionary definition of "consult" is "consider jointly", with both words necessary; other requirements can be found in the dictum of DONALDSON J in Agricultural, Horticultural and Forestry ITB v Aylesbury Mushrooms [1972] 1 All ER 280 at 284[9], "*The essence of consultation is the communication of a genuine invitation, extended with a receptive mind, to give advice.*"

The key point in this definition is the need for a receptive mind; that the consulter should be genuinely receptive to the view of the person or body being consulted. Without this, only the form and not the substance of consultation exists.

Another essential is that a reasonable period must be allowed for a response. In Lee v Secretary of State for Education and Science (1967) 111 S.J. 756 sub nom. Lee v Dept Education and Science 66 LGR 211 (1968)[14], DONALDSON considered a period of four weeks fair for the (non-NHS) issue being determined, but clearly the appropriate period will vary depending upon various factors, including the complexity of the issue and the urgency of the case. In health service terms, any period which is reduced disproportionately compared with the timetable in HSC(IS)207[12] requires justifying.

For real consultation to take place, the timescale must allow not only for a reply to be received and considered before the tentative plan is implemented, but must allow time for the plan to be changed as a result of the consultation. However, WOOLF (J), in the Lewisham case[16] ruled that it was proper, when an Health Authority was working under the urgency provisions for it to make its decision within hours of receiving the CHC's advice.

The health service consultation procedures are intended to ensure that real consultation takes place.

## 6.1 Levels of Consultation

The NHS recognises two levels of consultation, informal consultation and formal consultation. One kind of formal consultation is that concerning proposed closure or change of use of NHS buildings, set out in HSC(IS)207[22], but contrary to what is sometimes assumed, this is not the only kind of consultation properly called formal.

Informal consultation occurs, for example, when the CHC is notified of very tentative suggestions for changes in service, or of the likely content in plans which will be published in due course. It enables the CHC to give preliminary consideration to likely proposals. Frequently information about the proposals will be incomplete because the Health Authority or FPC has not yet built up the data for its own purposes.

Formal consultation takes place when a document is formally issued to a CHC for that purpose. Certainly, the issuing of a draft Strategic or Operational Plan for consultation falls within this category, even though such a document may not involve the closure or any substantial change of use of a health service building. By the same token, any substantial reduction (or increase) in community health services, even when this does not change the use of any building, **must** be the subject of formal consultation pursuant to paragraph 19 of the CHC Regulations[6].

However, the procedures are prescribed in greatest detail (albeit loosely drafted) in respect of closure or change of use of NHS buildings.

## 6.2 Provision of Information

This section is of wider application than the context of consultation procedures, but is central to good consultation because, in the words of BUCKNELL (LJ) in Rollo v Minister of Town and Country Planning, 1948, 1 All ER 13 at 17[23], "*in my view (consultation) means that on the one side the Minister must supply sufficient information to the (body being consulted) to enable them to render advice*". Similarly, in the Aylesbury Mushroom case[8], DONALDSON (J) made it clear that in order for the conditions to be fulfilled, enough information must be provided to enable a considered view to be given, and that it was not sufficient merely to send a letter inviting comment.

Naturally, a prerequisite to proper consultation is that the consulter makes a full and honest presentation of his case, with no 'hidden agenda' for the proposal. For example, if one reason for the proposal is to save money due to government-imposed restrictions, this should be stated in those terms.

The CHC does not have to rely on information volunteered by the Health Authority. Paragraph 20 of the Community Health Council Regulations, 1985,[6] requires information to be provided to CHCs when requested. This applies irrespective of whether the request arises from a CHC initiative or in response to a Health Authority or FPC initiative, (including a consultation exercise). It provides a right of appeal to the establishing body in the case of refusal. The Health Authority or FPC can decline to provide information of a personal or confidential nature.

The problems which can arise for CHCs are:

- failure to provide information without actually refusing to do so;
- failure to provide information in a form appropriate for the CHC's purposes;
- slow action on a request for information;

- provision of inaccurate information;
- information which becomes superceded.

In a perfect world, the original consultation document would include all the information a CHC considers it needs to agree its response. In practice, this frequently does not apply. Therefore issues regarding the provision of information are particularly important when information is requested to enable the CHC to consider its response to a consultation exercise for which a timetable has been set pursuant to paragraph 19(3) of the CHC Regulations[6]; such circumstances will frequently occur when a Health Authority is proposing a closure or change of use for health service premises using the procedure set out in HSC(IS)207[2].

In response to written questions from Frank Dobson, MP, on 29th October, 1984,[18] Kenneth Clarke, MP, asserted that the existing Regulations and guidance should be sufficient to ensure that Community Health Councils are given reasonable time to comment on proposals. He declined to give the assumptions regarding the speed of response to requests for supplementary information upon which the timetable in HSC(IS)207[2] is based, (it is likely that the Circular was actually drafted without considering the issue). He declined to provide a right of appeal against a **failure** to provide information in cases where there was no **refusal** to provide that information. He declined to instruct RHAs to deal expeditiously with appeals by CHCs against a refusal to provide information, or against a timetable for a consultation exercise. This approach was confirmed in the Patten letter[3] quoted in the Introduction.

To illustrate, a particular problem reported in 1986 was of Bexley HA selling copies of its consultation document to interested parties rather than providing them free. Bexley CHC appealed to South East Thames RHA that this was inappropriate, but the RHA declined to intervene[19], arguing that such selling was not precluded by the Regulations or guidance. There can be no doubt that the action of Bexley HA was contrary to good practice and the spirit of the guidance, but without the support of the RHA, the observations in the previous paragraph apply.

By the same token, there is no specific remedy in the procedures if inaccurate information is provided, or if information provided is then overtaken by events and the changed circumstances are not reported to the CHC. It seems self-evident that this should be required, but while bad practice continues to exist it appears to be necessary to be explicit.

### 6.3 The Mechanics

Informal consultation will normally be a preliminary stage and will frequently do no more than define the issues to which the CHC wishes the formal document to direct its attention. It will frequently comprise merely an exchange of letters or a discussion at an informal meeting.

Formal consultation is not defined in a procedure specification, but it surely requires the publication of a consultation document by the Health Authority or FPC and its delivery to the CHC for comment. Then, when the CHC's response has been received, further consideration by the Health Authority (not merely by officers) of the issue and of all the points made in the response(s).

In all but the simplest cases a simple exchange of letters will not be enough. In many cases, formal consultation will be improved by discussion at meetings. This should ensure that a real exchange of views takes place, that misunderstandings do not arise, and that supplementary issues arising from the

first response of the Health Authority are dealt with. West Birmingham CHC has argued that, in order to show that consultation has taken place, it is appropriate for the Health Authority to publish in its response to the consultation exercise its reasons for rejecting any advice received. If consultation has been properly undertaken, those reasons will have been agreed by the Health Authority in deciding to reject the advice: the additional work involved in transcribing those reasons and forwarding them to the body consulted should be minimal.

An issue which is rarely addressed is what should happen if the plans of the health authority are changed as a result of the consultation exercise. In a typical consultation exercise, clarification of proposals occurs as a result of discussions, and it would be good practice to revise the description of the proposal to take account of this. But there is also the possibility of a material change to the proposal, which might itself be controversial, being adopted by the Health Authority. Anybody being consulted on the original proposal should in such cases be informed of changes to the proposals, and offered the opportunity (and the time) to give further advice. It is not self-evident, however, that these two situations can always be distinguished.

Finally, it is necessary to consider what redress should exist when an agreed package of measures is not, in fact, fully implemented. This can occur, for example, if a move is proposed to a pattern of care in the community for a group of patients, and the old hospital service is closed, but, (perhaps because of a shortage of money), community services are not expanded to the extent originally envisaged. Another example occurred in 1988 in West Birmingham when the closure of St Chad's Hospital was advanced two years from the agreed date, before replacement services were provided at Dudley Road Hospital. The CHC objected to no avail. The procedure as drafted covers only cuts in services which have actually materialised, not cuts in plans for future services, even if implementation has been unjustifiably delayed.

### 6.4 Details of the HSC(IS)207 Procedure for Closure or Change of Use

This procedure was introduced in 1975. It is substantially unchanged, although there have been certain subsequent letters circulated containing Ministerial guidance which are frequently overlooked by Health Authorities, presumably because they have emerged in an ad hoc fashion, and have never been formally consolidated.

The procedure is a two-stage one. In the first stage, a consultation document is circulated to all bodies with an interest, (including all DHAs, FPCs and CHCs whose patients use the services under consideration). This has to justify the closure of change of use for one of the following reasons:

> *"a. the service provided can more efficiently be undertaken elsewhere;*
> *b. the facility is no longer required because of new developments;*
> *c. redeployment of services is essential having regard to the resources of manpower and finance available;*
> *d. it is necessitated by developments outside the NHS, eg road proposals."*[2]

The bodies being consulted are allowed a period, typically three months, to make comments. It is not necessary to register an objection at this stage. Two irritating shortcomings are common during this stage of the proceedings; first, Health Authority officers sometimes inadvertently timetable the three month consultation period to run from the day they start to prepare the consultation packages for circulation, rather than from the day these are likely to be received by the body being consulted; second, health authority

officers frequently seem incapable of replying to requests for information during this consultation period, (see section 6.2 above), but wait until the consolidated responses and comments are published. Thus a CHC with contingent comments to make can expect to have to write a long and complicated letter and to read apparently dismissive replies of the "this does not apply" variety to many of its comments.

At the end of the consultation period, the health authority publishes all the comments received, agrees its response to each, and forwards them to the CHC.

There is no formal provision in the circular for the possibility that the Health Authority might have failed to reply to an issue raised, or might completely have misunderstood one. In practice, it is not uncommon for a Health Authority to respond to a comment without giving any material reply to the point raised.

This is the end of the first stage of the procedure.

When trying to work one's way through the circular, it is necessary to realise that HSC(IS)207 is written on the assumption that the unit under consideration will be managed by the DHA in whose District it is located, and will receive the substantial majority of its patients from that District. In practice, this is frequently not the case. Many of the disputes over the years have concerned which CHC is entitled to be consulted at the second stage. Even the Ministerial guidance resulting from these disputes, (eg a letter from John Patten, MP, to Jeff Rooker, MP, dated 25th June, 1984, about the closure of Blackwell Hospital, Bromsgrove,[20] and a letter from the DHSS to East Hertfordshire CHC, dated 19th August, 1983,[21]), is not couched in terms which are unambiguous on this issue, but the only reasonable interpretation of the guidance is that any CHC representing a public whose service is being substantially varied, (see the discussion of "substantial" in Section 5.1 above), should have the right to press an objection at the second stage. However, some Health Authorities strongly resist this interpretation and it is proving difficult to enforce: a particular illustration is set out in Section 9 below.

After the Health Authority has forwarded its response to the CHC, the CHC - we assume from here on that its standing in the matter is accepted - considers the outcome of the consultation. It has to decide whether to accept the proposal or to object. Again there are two irritating shortcomings in the procedure; first, there is no official way in which the Health Authority can amend its proposal to take account of the consultation, although this often does happen and all parties turn a blind eye. (Presumably there are sometimes fears that a whole new round of consultation would really be required.)

Second, the suggested aim in HSC(IS)207 that events should reach this stage within six months is unrealistic unless the Health Authority reacts to the first round comments almost by return of post; but some Authorities try to suggest that CHCs are being unreasonable if they do not meet the overall time limit suggested in the Circular. A more reasonable assessment is to be found in advice published to South Glamorgan HA[22], which suggests a minimum period of 8½ months is reasonable for the procedure, and even this assumes that the Health Authority responds to the first phase of consultation in only 1½ months.

If the CHC decides to object to the proposal, the circular[2] says that it must then produce a detailed counter-proposal which takes account of the constraints under which the Health Authority is operating. At a meeting between representatives of the Association of CHCs for England and Wales and the DHSS on 11th January, 1979,[23], DHSS representatives suggested the substitution of

"*reasoned*" for "*detailed*", although there was no formal amendment to the circular. Subsequently a letter from the DHSS to Hammersmith and Fulham HA dated 2nd April, 1984,[24] advises that the Minister wishes to consider all proposed closures to which there is an objection in accordance with the terms of the later paragraphs of the procedure, whether or not a counter-proposal is raised, but few health authorities appear to be aware of this guidance.

HSC(IS)207[2] requires the Health Authority to make available to the CHC *"all reasonable information and help they may require in formulating a counter-proposal"*. This can include staff time if the CHC needs this help, but there is no indication whether this should include a formal secondment if the CHC wishes. There is no guidance regarding a reasonable period needed for the production of a counter-proposal, although experience suggests at least two months, and this estimate seems to be endorsed by the timetable proposed in the South Glamorgan paper[22].

If the Health Authority accepts the objection, (with or without the counter-proposal), that ends the matter. If not, the Health Authority forwards the documentation to the RHA.

If the RHA accepts the objection, (with or without the counter-proposal), that ends the matter. If not, the RHA forwards the documentation to the Secretary of State.

The Secretary of State then determines the issue.

### 6.5 Phased Changes

There is no provision in the HSC(IS)207[2] procedure for a phased closure of, for example, a large institution on the change over to community care. Technically, the Health Authority would consult on the strategy as part of the planning system. Once this was approved, there could be a dispute as to whether the closure procedure should be followed just once, or each time a ward or block fell due to close. If the latter procedure were adopted, the administrative burden would be considerable. If the former were adopted, the CHC would have to reach its decision on the basis not of the current situation but of a series of possible future situations, and in the knowledge that there would be no further opportunity within this, the most stringent consultation procedure available to CHCs, for the CHC to object to the timing of a part of the proposal.

CAPRICODE[25] (at paragraph 1.16) notes that, *"In some cases it will be sensible to combine the formal consultation required by HSC(IS)207[2] with the consultation on the package of changes which include the new scheme. Even when formal consultation is reserved for a later stage, it will make sense at this earlier stage to seek the CHC's agreement in principle to any closure ..."*.

To go a stage further, it would be appropriate to agree the closure strategy through the two-phase procedure, but then to have a single phase procedure, still a formal procedure, whereby the CHC would be consulted regarding the timing of each phase and would have the opportunity to object if it considered that the criteria agreed strategically had not been met.

## 7. AT WHAT TIME SHOULD CONSULTATION TAKE PLACE?

Informal consultation should be a continuing activity. As and when ideas crop up, the CHC should be informed and given the opportunity to comment. Where CHCs are represented on client group planning teams or similar groups, this is normally easy - provided the CHC's internal systems are sound. Otherwise some more structured arrangements needs to apply.

Mr R Allen, in his opinion for Lewisham and North Southwark CHC[17] comments, with regard to formal consultation that it is *not* appropriate to wait for the proposal to go to the authority for approval, nor to consult formally when plans are merely being formulated, but that "*... at the latest this obligation arises when proposals are fit to be brought before the Authority and it is contemplated by the Chairman and Senior Officers of the DHA that they will be*". To do otherwise will result in opinions becoming entrenched, and consultation is less likely to be undertaken with the receptive mind which is required.

A similar view that early consultation is sensible is found in a report of the Health Service Commissioner for Wales[26].

In addition, CAPRICODE[25] (paragraph 1.14) requires that consultation be undertaken "*before a formal Approval in Principle submission is made to the RHA or the Department*".

## 8. THE CONFLICT BETWEEN SERVICE NEEDS AND FINANCIAL CONSTRAINTS

Recent advice has, if anything, confused further the conflict between the duty of a Health Authority to provide services and the duty to work within its allocation, especially as regards urgent closures of health service premises.

Section 1 of the National Health Service Act, 1977,[5] places upon the Secretary of State the duty,

> "*... to continue the promotion in England and Wales of a comprehensive health service designed to secure the improvement -*
>
> *(a) in the physical and mental health of the people of those countries, and*
>
> *(b) in the prevention, diagnosis and treatment of illness,*
>
> *and for that purpose to provide or secure the effective provision of services in accordance with this Act.*"

On the other hand, compliance with cash limits has been made a statutory duty.

In 1979, the "de Peyer" letter[10] was issued, which made the assertion that "*the need to make immediate savings so as to avoid over-spending may make closure a matter of urgency.*" This letter was circulated following the Lambeth case and was based on that judgment. This interpretation was endorsed in the Richmond case[D], the Hampstead case[E], and in R v Hillingdon HA, ex parte Goodwin and others (1984) ICR 800[F].

This letter was re-circulated, and therefore implicitly endorsed, with the letter to Regional General Managers[13], but that same letter emphasised the importance of service needs by drawing attention to a case in which Ministers had rejected a closure proposal, "*... in which they felt that the authority had not presented its case sufficiently clearly in the consultation exercise in terms of benefits to patients*", and emphasised that in future Ministers would, "*... be unable to accept proposals unless authorities have clearly paid*

*attention to deciding and setting out convincingly, the advantages their proposal has for patients compared with other feasible options*".

Then, on 31st May, 1985, John Patten, MP, in a letter to Michael Meadowcroft, MP[14], dealing with issues outstanding following the debate on CHC Regulations the previous month[15], said that he did not see any contradiction between an expectation that health authorities should keep within their cash limits, and another expectation that all closure proposals should set out the advantages to patients compared with other feasible options, and that he accepted that on occasions authorities may have to carry out an urgent closure in order to make financial savings.

Perhaps the dilemma is considered resolved by contorted definitions of "advantage" and of "feasible", but this would be an undesirable interpretation for CHCs, and it should be made explicit and be debated if that is the government's intention.

Since it will almost always be the case that patients will benefit from having a service open, and since it is always the case that providing a service costs money, the advices given and the statutory duties seem to be mutually inconsistent and irreconcilable, and this state of affairs will lead to numerous arguments.

## 9. THE APPLICATION TO REGIONAL HEALTH AUTHORITIES

In his parliamentary answer of 15th March, 1985[9], and in the Committee debate on the CHC Regulations[15], Mr Patten recognised the right of a CHC to raise matters with an RHA, and in subsequent correspondence he confirmed that this implied a duty on the part of the RHA to respond. It is necessary to assess how the Regulations and the associated procedures, which were not drafted with RHAs in mind, should be interpreted in that context.

The West Midlands Forum of CHC Chairmen and Secretaries identified five broad areas in which CHCs might wish to be consulted by Regional Health Authorities[27], namely:

- strategic planning;
- the development of 'philosophies of care' likely to be used as guidance to DHAs;
- regional specialty services, and especially their location;
- the pattern of consultant appointments in the region;
- operational services managed directly by the RHA.

There have been several statements made which interpret policy as it applies to RHAs. First, in the debate on the CHC Regulations on 24th April, 1985,[15] John Patten, MP, said that he saw no reason why CHCs should not talk to RHAs, for example about the regional strategic planning process.

West Midlands RHA seemed less enthusiastic about the idea of consulting with CHCs[28]. It accepted the possibility of consulting directly on major restructuring within the West Midlands conurbation, and experience has allowed this practice to evolve. However, the RHA's policy is couched in such broad terms that we can illustrate the theme only by citing examples. In respect of the proposed decentralisation of ENT services in Birmingham, the RHA decided to issue the consultation document: it later insisted that only West Birmingham Community Health Council had a right formally to press an objection[29], and Central Birmingham Community Health Council (which had an objection) was able to press that only through the good offices of West CHC. Thus the aim of

direct consultation was thwarted; indeed, the RHA insisted that formally it was acting only as the agent of West Birmingham HA.

West Midlands RHA has been even less involved in a complicated consultation regarding adjustments to catchment area boundaries for geriatric services in Birmingham. On this occasion, the three DHAs involved issued identical consultation documents in their Districts, and undertook consultation in parallel.

A further example of the less than whole-hearted commitment by West Midlands RHA to the involvement of CHCs in planning occurs with regard to CHC involvement in the Annual Review process. In the notes of a meeting between CHC representatives and Mr V Paige, the then Chairman of the NHS Management Board, on 28th May 1985[30], Mr Paige is recorded as expressing the opinion that the consumer view ought to form part of the review. In practice, this facility has not developed far. West Midlands RHA, however, has resisted CHC attempts to put evidence to review meetings directly, and has said only that it will take account of CHC views, (for example, material in CHC Annual Reports which remain in dispute after District-level discussion), in drawing up its own agenda[31]. In practice such problems are quite likely to be two years under the bridge by the time of a relevant review meeting, and the situation irretrievable. A better arrangement could improve consultation.

We need to establish a common policy across all health regions that CHCs should be consulted by RHAs on substantial developments or variations in service which do not fall within the control of a single District Health Authority, and should be able to ensure that issues which it considers important are discussed between Region and District at Annual Review meetings. The need for a clear policy is underlined by the fact that there is no provision in published procedures for a formal appeal to the Secretary of State against a decision of an RHA, (although CHCs do have a general right of access to the Secretary of State). The government has, in the past, shown itself disinclined to take action when procedures have been breached, or when its policy statements on procedural issues are shown to have been disregarded; its normal response, even when questioned by MPs, has been to forward the protest to the relevant RHA for a response and, of course, if it is against the RHA that the complaint is being raised, that Authority is then able to act as judge and jury in its own cause.

## 10. THE APPLICATION TO FAMILY PRACTITIONER COMMITTEES

It was only in 1985 that Family Practitioner Committees were established as free-standing authorities, and practices of CHC involvement and consultation are still developing. In the debate on 24th April, 1985[16], John Patten, MP, outlined government policy in terms which accorded considerable rights to CHCs in defining the scope of their involvement, for although he indicated examples of areas in which CHCs might be interested, (FPC strategic plans, the opening or closing of a branch surgery, and the dispersal of a vacant medical practice), he affirmed that it was for CHCs to decide what they wished to discuss. This parallels, and perhaps strengthens, the statement with respect to Health Authorities, that the government would expect an Authority to go along with the CHC view of what comprises a substantial variation in service[3].

It is in this context that the statement in paragraph 10 of HC(85)11[32], (which also advises on the provisions of the Community Health Council Regulations, 1985), must be interpreted. This paragraph falsely implies that the regulations provide that *"FPCs may however refuse to disclose information*

*which they regard as confidential as confidential ...' relating to individual practitioners in contract with the FPC."* The Community Health Council Regulations 1985[6] actually provide explicitly that *"Confidential information about ... personnel matters relating to individual officers* ***employed by*** *a ... Committee"* shall be withheld, but makes no explicit reference to practitioners **in contract with** a Committee, and in that contractors make such play with this distinction, it cannot seriously be argued that the distinction was not intentional.

An FPC would therefore have to rely on other justifications for withholding information about individual practitioners, related to the nature of the information requested. The interpretation of confidentiality must not be such as to infringe the right to be consulted on the examples given by Mr Patten, which means, for example, that list sizes cannot be withheld.

## 11. THE APPLICATION TO DHSS POLICIES AND RELATIONSHIPS WITH NON-NHS BODIES

It has not been common for CHCs to be directly consulted by the DHSS about national policies; the government has said that its view is that CHCs are essentially local bodies[13]. It was, however, acknowledged that the Association of CHCs for England and Wales was entitled to be consulted about the Community Health Council Regulations, 1985, before these were published[14], and that the action taken had been insufficient. CHCs have been included in several major DHSS consultation exercises recently, for example that leading to the publication of the Primary Care White Paper. Moreover, the Mental Health Act Commission has routinely consulted CHCs on its proposals. In other cases, any unsolicited comments submitted by CHCs have been accepted.

An area which needs more consideration is the rights which CHCs have, or should have, in respect of non-NHS bodies where their policies or activities affect health. It would be helpful for example, for CHCs to be offered the right to attend meetings of the Health Committees which some local authorities have established, (although to suggest that they have some sort of *duty* to attend would be unhelpful).

West Birmingham CHC has little experience in these fields, and would need to draw on the experience of other CHCs to develop a canon of precedents from which to define a general policy.

## 12. ENFORCING PROPER PROCEDURES

In England, the Regional Health Authorities have a key role under the CHC Regulations[6] to deal with appeals from CHCs against Health Authorities which refuse to provide information or which fail properly to undertake consultation. The Secretary of State has a similar role with regard to FPCs, and the Secretary of State for Wales fulfils both roles.

It is now government policy that this role includes a duty to deal with an appeal against a determination that a variation in service is not substantial[9].

In response to a question from Frank Dobson, MP, on 29th October, 1984,[16] Kenneth Clarke, MP, stated that information about the frequency with which such appeals are sustained is not collected centrally, and it appears that the DHSS does not monitor the way in which RHAs fulfil this role.

In the same series of questions, Mr Clarke declined to instruct RHAs to deal expeditiously with such appeals.

This matter was pursued further in the correspondence between John Patten, MP, and Michael Meadowcroft, MP, following the debate on the CHC Regulations. Mr Patten wrote[14] that he was concerned at any suggestion that RHAs were unable to take a detached view of an appeal because of an involvement with the policy issue in question. In response to a suggestion from Mr Meadowcroft that he should collect information about appeals for a period, he employed the argument given in the Introduction, that there was no visible demand for such a review, for the matter was not raised at the ACHCEW AGM.

In the same Patten letter, he declined to provide further safeguards to ensure the expeditious provision of information. Thus where good working relationships between a CHC and a DHA have broken down, the Council's adminstrative recourse is limited to the RHA properly and sympathetically fulfilling its adjudicating role, which is very loosely defined in Regulations.

Similarly, the parliamentary answers from Kenneth Clarke, MP, to Clare Short, MP,[12] and the correspondence from John Patten, MP, to Michael Meadowcroft, MP,[14] show that as regards the use of the urgency procedures the government intends to work on the assumption that Health Authorities will always act in accordance with the spirit of CHC involvement. If a Health Authority puts off consultation until a crisis has arisen, there is no administrative procedure of appeal. Where a Health Authority asserts that a proposal is in the interests of the service, a CHC seems to have no protection.

West Birmingham CHC remains unconvinced that the appeal mechanism is effective. If it is not, the CHC can take no further action itself, but third parties can do so on its behalf.

An aggrieved individual can, for example, pursue a case of maladministration to the Health Service Commissioner, arguing that by failing to consult the CHC properly, the Health Authority has caused the complainant an injury. Such an individual could, in practice, be closely related to the CHC. However, Health Service Commissioner investigations are generally slow, and such an individual would have to give the Health Authority an opportunity to deal with the complaint first, thereby lengthening the process even further.

Alternatively, a third party could take legal action against a Health Authority. CHCs cannot take legal action on their own behalf, but a third party, (for example, a local authority), can take action and assert that a decision was taken improperly for lack of consultation. Several of the cases cited in this paper have been of that nature.

The situation regarding legal advice is rather different. In response to a Resolution of the 1984 AGM of ACHCEW, (moved by West Birmingham CHC), the DHSS acknowledged[24] that there might be instances when it would be reasonable for a Council to receive independent legal advice, (for which it would be the duty of the RHA to meet the cost).

West Birmingham CHC had argued that such a case might occur if the RHA's own legal advisor had already advised the other party to a dispute, for it would not then be ethical for him to advise the CHC. It may still be too early to draw general conclusions from experience; different CHCs have reported widely different experiences in this regard; but West Birmingham CHC has itself suffered a rebuff. In a case where the CHC argued that the legal advice offered to a meeting of West Midlands RHA was incorrect, and appeared to be a material factor in determining the RHA's decision, the CHC was refused access

to independent advice. The RHA officers asserted that the members' decision would not have been affected by the advice.

This is a somewhat different circumstance than applies in the field of consultation, for the issue there would not be the legal basis of the Authority's decision, but a question of whether the Authority was acting in accordance with proper procedures. The assumption has to be made that an Authority which received advice obtained by a CHC that it was acting improperly would either seek its own opinion, or concede the CHC's claim and act acordingly.

In practice, however, all present appeal and enforcement procedures are weak and slow.

## 13. CONCLUSIONS

There is a need to consolidate previous formal and informal advice into a revised procedure which takes account of relevant court rulings. It should emphasise the need for early consultation and the necessity of the consulter having a mind receptive to the views of the people and bodies being consulted.

Such a procedure should concern itself with complex situations as well as straightforward ones. It should recognise that several CHCs will have a proper interest in some proposals, and ensure that each such CHC can separatelypromote that interest effectively to the responsible managers.

It should set out the requirements when significant changes are made to a proposal during the course of consultation, the modifications to the procedure necessary when a phased implementation is proposed, and the remedies available to CHCs and other interested parties if a proposal is agreed but then not implemented or not fully implemented

It should set out reasonable criteria for the consultation timetable, having regard to the need for supplementary information in many cases, and should ensure the speedy resolution of disputes.

Finally, it should recognise that it is a feature only of totalitarian systems that a course of action is either compulsory or forbidden, and should emphasise to health authorities that the rights of CHCs set out in the procedure are a minimum, and that it will frequently be helpful to provide greater facilities than are explicitly provided by the procedure.

## 14. ACKNOWLEDGMENTS

I would like to thank all CHCs and other individuals and bodies who have provided the source documents for this paper. I would like to thank the various Members of Parliament identified who have tabled parliamentary questions and initiated debates to clarify government opinion on important issues. I would particularly like to thank Peter Moodie, one-time Chairman of West Birmingham CHC for reading the developing drafts of this paper and making many helpful suggestions for improving the text. Naturally, outstanding errors are my own responsibility.

APPENDIX A - Reference Documents

(1) In general, any reference to Health Authorities should be taken as referring equally to Family Practitioner Committees. The context will show when this is not the case.

(2) HSC(IS)207, "Closure or Change of Use of Health Buildings", October 1975.

(3) Letter, John Patten, MP, Parliamentary Under Secretary of State for Health, to Jeff Rooker, MP, 5th February 1985.

(4) Letter, John Patten, MP, Parliamentary Under Secretary of State for Health, to Michael Meadowcroft, MP, 8th August 1985.

(5) National Health Service Act, 1977, section 20 and Schedule 7.

(6) Community Health Council Regulations, 1985, SI 1985 No 304, especially Part IV.

(7) Health and Medicines Bill, under consideration in 1985, section 7.

(8) Parliamentary Questions 3197-3200/1984/85, by Michael Meadowcroft, MP, answered by John Patten, MP, Parliamentary Under Secretary of State for Health, tabled on 15th March 1985.

(9) Letter, A P Andrews, Head of Legal Services, South East Thames RHA, to G Girvan, Secretary to Bexley Community Health Council, 28th July 1986.

(10) Letter, D de Peyer, DHSS, to Regional Administrators, 7th December 1979.

(11) Letter, K F Bales, Regional General Manager, West Midlands RHA, to F Willock, Chairman, South Birmingham Community Health Council, 13th July 1988.

(12) Parliamentary Questions 229-232/1984/85, by Clare Short, MP, answered by Kenneth Clarke, MP, Minister for Health, on 20th November 1984.

(13) Letter from P A Hill, Regional Principal, to K F Bales, Regional General Manager, West Midlands RHA, 6th December 1984.

(14) Letter, John Patten, MP, Parliamentary Under Secretary of State for Health, to Michael Meadowcroft, MP, 31st May 1985.

(15) Official Report of the Sixth Standing Committee on Statutory Instruments etc, (Community Health Council Regulations), 24th April 1985.

(16) Letter, S F Thorpe-Tracey, Assistant Secretary, Regional Liaison Division, to D Kenny, Regional Administrator, North West Thames RHA, 27th January 1984.

(17) Opinion, R Allen for Lewisham and North Southwark CHC, 2nd June 1986.

(18) Parliamentary Questions 7787-90/1983/84, by Frank Dobson, MP, answered by Kenneth Clarke, MP, Minister for Health, tabled on 29th October 1984.

(19) Letter, Dr J M Forsythe, Director of Planning, South East Thames RHA to G Girvan, Secretary to Bexley CHC, 24th July 1986.

(20) Letter, John Patten, MP, Parliamentary Under Secretary of State for Health, to Jeff Rooker, MP, 25th June 1984.

(21) Letter, R C Livermore, Regional Liaison Division, DHSS, to P Phillips, Secretary to East Hertfordshire CHC, 19th August 1983.

(22) Report to South Glamorgan HA, "Public Consultation on Closures and Changes of Use", B Dimond, 1988.

(23) Note of meeting between DHSS and Association of CHCs for England and Wales, 11th January 1979.

(24) Letter, S D Catling, Regional Principal, DHSS, to A D M Lidsell, District Administrator, Hammersmith and Fulham HA, 2nd April 1984.

(25) CAPRICODE, DHSS, 1987, (especially paragraphs 1.14 to 1.16).

(26) Health Service Commissioner for Wales, Case W255 78-79, Selected Investigations August 1979-March 1980, page 82

(27) Report, D Hopkins, I McArdle and M Smith to West Midlands Forum of CHC Chairmen and Secretaries, "Regional Planning, including Strategic Planning and Regional Specialties", 26 October 1984.

(28) Letter, J Ackers to Chairmen of West Midlands CHCs, 19th April 1985, and letter, A Coulson, Regional Planning Administrator, West Midlands RHA, to M Smith, Secretary to West Birmingham CHC, 30th December 1985.

(29) Letters, Dr A McGregor, Regional Medical Officer/Director of Planning, West Midlands RHA, to M Smith, Secretary to West Birmingham CHC, 24th August 1987 and 15th September 1987.

(30) Note of meeting between V Paige, Chairman of the NHS Management Board, and the Association of CHCs for England and Wales, 28th May 1985.

(31) Letter. A Coulson, Regional Planning Administrator, West Midlands RHA, to M Smith, Secretary to West Birmingham CHC, 29th August 1985.

(32) HC(85)11, Community Health Councils, March 1985.

(33) Letter, Dr G Vaughan, MP, Minister for Health, to Dr R Griffiths, Chairman of the Association of CHCs for England and Wales, 23rd June 1981.

(34) Letter, Mrs M Fry, DHSS, to T Smythe, Secretary to the Associciation of CHCs for England and Wales, 19th December 1984.

**APPENDIX B - Relevant Judgments**

(A) R v Tunbridge Wells HA ex parte Goodridge and others, (27/4/88), (Guardian LR 4/5/88, also The Independent 28/4/88).

(B) Ladbroke (Football) v William Hill (Football) [1964] 1 WLR 273.

(C) LB of Lewisham v Commissioners for Lambeth, Southwark and Lewisham Health Area, (12/10/79 before Griffiths J, and 15/11/79 before Woolf J).

(D) R v Richmond, Twickenham and Roehampton AHA ex parte LB of Richmond, (20/2/84), (unreported).

(E) R v Hamstead HA ex parte LB of Camden, QBD, 1/10/86, (Kennedy J).

(F) R v Hillingdon HA ex parte Goodwin and others, [1984] ICR 800. Times LR 13/12/83.

(G) Agricultural, Horticultural and Forestry ITB v Aylesbury Mushrooms Ltd (1972) a All ER 280 at page 284.

(H) Lee v DES (1968) 66 LGR 211.

(J) Rollo v Ministry of Town Planning [1947] 1 All ER 13.