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Wednesday 5 November

# NHS Law Conference 2025

LAG

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# Welcome from Chair

David Lock KC

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# Keynote address

Prof. Emily Jackson CBE

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# Integrated care: interaction of NHS services with social care and education

Galina Ward KC

Claudia Hyde

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# Integrated working in education, health and social care: an overview

Claudia Hyde

# Health and social care interactions: Who's who?

**National**

- NHS England

**Regional**

- Integrated Care Systems
- Provider collaboratives

**Local**

- Local authorities
- Health and Wellbeing Boards

# Health and social care interactions: The key duties (1)

| Local authorities | NHS bodies |
| --- | --- |
| Duty to take such steps as appropriate to improve the health of the people in its area: NHS Act 2006, s. 2B<br>Duty to establish Health and Wellbeing Boards: Health and Social Care Act 2012, s. 194<br>Duty to exercise care functions "with a view to ensuring the integration of care and support provision with health": Care Act 2014, s. 3 | Duty to exercise functions with a view to securing that health services are provided in an integrated way with social care: NHS Act 2006, s. 13N<br>Duty to notify relevant local authorities of patients likely to need community care services on discharge: Delayed Discharges (Mental Health Care) (England) Order 2003 |
| *Duty to prepare joint strategic needs assessment (HSCA 2012, s. 192) and a joint health and wellbeing strategy to meet those needs (HSCA 2012, s. 193)*<br>*Duty to have regard to needs assessment, integrated care strategy and joint local health and wellbeing strategy (Local Government and Public Involvement in Health Act 2007, s. 116B)*<br>*Duty to provide aftercare to those detained under section (Mental Health Act 1983, s. 117)* | |

# Health and social care interactions: The key duties (2)

BUT: Care Act 2014 s. 22 also provides:

"(1) A local authority **may not** meet needs under sections 18 to 20 by providing or arranging for the provision of a service or facility that is required to be provided under the National Health Service Act 2006 unless—

(a) doing so would be merely incidental or ancillary to doing something else to meet needs under those sections, and

(b) the service or facility in question would be of a nature that the local authority could be expected to provide."

# Health and social care interactions: Delivery mechanisms

## Section 75 NHS Act 2006:

"(1) The Secretary of State may by regulations make provision for or in connection with enabling prescribed NHS bodies (on the one hand) and prescribed local authorities (on the other) to enter into prescribed arrangements in relation to the exercise of–

(a) prescribed functions of the NHS bodies, and

(b) prescribed health-related functions of the local authorities,

if the arrangements are likely to lead to an improvement in the way in which those functions are exercised."

## Provision given effect through NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000

# Won’t somebody think of the children?

SEND Regs reg 12(1) and the Code require an EHC plan to include the child or young person’s health care needs which relate to their SEN (section C) and the child or young person’s social care needs which relate to their SEN or to a disability (section D).

EHCP must include (per Children and Families Act 2014 s. 37(2)):

- Any healthcare provision reasonably required by the learning difficulties and disabilities which result in the child or young person having special educational needs (section G); and
- Any social care provision which must be provided (or which is reasonably required by the learning difficulties and disabilities which result in the child or young person having SEN) (sections H1 and H2)

# Education vs health and social care: the faultlines (1)

S.21(5) Children and Families Act 2014:

- "Health care provision or social care provision which educates or trains a child or young person is to be treated as special educational provision (instead of health care provision or social care provision)."

If the provision educates or trains, it can be deemed special educational provision and must be recorded as such in an Education Health and Care Plan: s.37 CFA 2014

However, dividing line (and jurisdiction of FTT on appeal) often not clear as they are not wholly distinct categories: *London Borough of Bromley v SENT* [1999] ELR 260 at [295] per Sedley LJ

Provision necessary for education ≠ educational provision

# Education vs health and social care: the faultlines (2)

*Why does this distinction matter?*

LA has duty to secure and fund special educational provision, but no duty to fund healthcare provision, which is the responsibility of the relevant NHS body: Children and Families Act 2014, s. 42.

Cannot be left to relevant social services or NHS body to secure / fund SEP although they can be used to secure / fund provision if they agree: *N v North Tyneside BC* [2010] EWCA Civ 135; s.26 CFA 2014.

Affects the jurisdiction of the FTT on appeal: no power to add, amend or remove provision from the EHCP, save for the power to make recommendations in 'National Trial' cases. See *East Sussex CC v TW* [2016] UKUT 528 (AAC)

# Education, health and social care interactions: Key challenges

Enforcement of healthcare provision

- While clear accountability and enforcement mechanisms exist in relation to LA duties, same cannot be said of healthcare provision
- Further difficulty from boundary differences

Falling between the faultlines: who pays?

- No clear mechanism for deciding where disputed

Looking ahead to the SEND White Paper: is change on the horizon?

# Integrated working in practice

Galina Ward KC

# Children's services

"It is no doubt in an attempt to mitigate the effects of the differing systems that provisions such as section 25 and 28(3) of the 2014 Act …and statutory guidance in the social services field have been put in place."

*VS v Hampshire CC* [2021] UKUT 187 (AAC) at [53]

# What does the guidance say?

16. Unless there is a good reason for this not to happen, continuing care should be part of a wider package of care, agreed and delivered by collaboration between health, education and social care.


National Framework for Children and Young People's Continuing Care

2016

January 2016

# What does the guidance say? (2)

2.21 Local authorities should adopt a key working approach, which provides children, young people and parents with a single point of contact to help ensure the holistic provision and co-ordination of services and support...Approaches will vary locally, but the main functions of key working support should include some or all of the following:

...

- facilitating the seamless integration of clinical and social care services with specialist and universal services

Department for Education

Department of Health

**Special educational needs and disability code of practice: 0 to 25 years**

**Statutory guidance for organisations which work with and support children and young people who have special educational needs or disabilities**

**January 2015**

# What does the guidance say? (3)

234. ICBs are one of the three statutory safeguarding partners as set out in chapter 2. NHS organisations and agencies are subject to the section 11 duties set out in this chapter. Health practitioners are in a strong position to identify welfare needs or safeguarding concerns regarding individual children and, where appropriate, provide support. This includes understanding risk factors, communicating and sharing information effectively with children and families, liaising with other organisations and agencies, assessing needs and capacity, responding to those needs, and contributing to multiagency assessments and reviews.

HM Government

**Working Together to Safeguard Children 2023**

**A guide to multi-agency working to help, protect and promote the welfare of children**

**December 2023**

# Transition to adult services

- SEND Code para 3.2: The Care Act 2014 requires local authorities to ensure co-operation between children's and adults' services to promote the integration of care and support with health services, so that young adults are not left without care and support as they make the transition from children's to adult social care.
- National Framework for Children and Young People's Continuing Care para 113: Every child or young person with a package of continuing care who is approaching adulthood should have a multi-agency plan for an active transition process to adult or universal health services or to a more appropriate specialised or NHS Continuing Healthcare pathway.

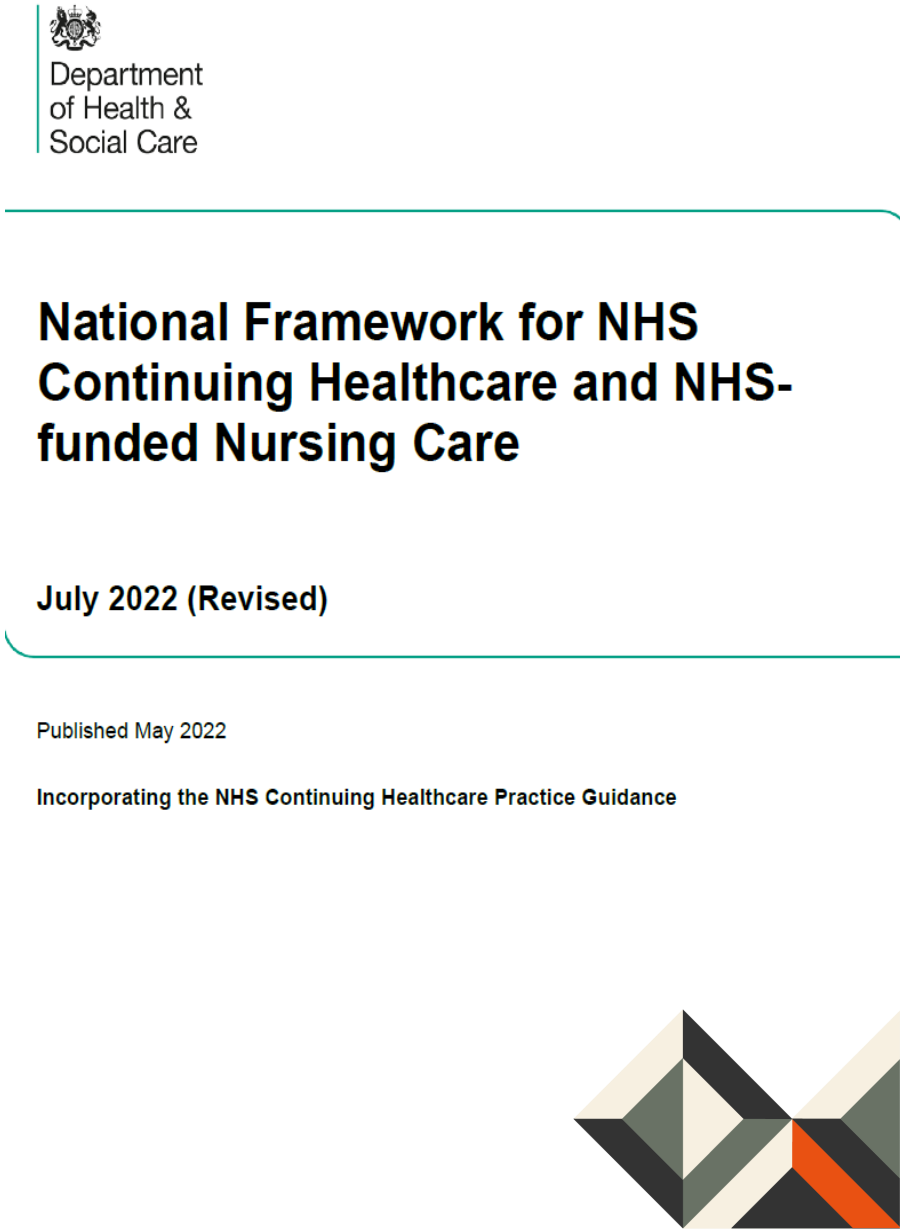
# Home care and care homes

Chapter 15: Integration and partnership working

- Vision for integrated care and support that is person-centred, tailored to the needs and preferences of those needing care and support, carers and families
- Working practices could include recruiting and training individual care coordinators or working to provide a seamless service to people being discharged from hospital
- Considering sharing information between assessments or working together to develop a single, compatible assessment.

# Care planning

193. Care planning for needs to be met under NHS Continuing Healthcare should not be carried out in isolation from care planning to meet other needs, and, wherever possible, a single, integrated and personalised care plan should be developed.


Department of Health & Social Care

National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care

July 2022 (Revised)

Published May 2022

Incorporating the NHS Continuing Healthcare Practice Guidance

# Mental health

33.7 Mental health after-care services must be jointly provided or commissioned by local authorities and CCGs. They should maintain a record of people for whom they provide or commission after-care and what after-care services are provided. Services provided under section 117 can include services provided directly by local authorities or which local authorities commission from other providers. CCGs will commission (rather than provide) these services.

Department of Health

Mental Health Act 1983: Code of Practice

# Housing

- Under s117?
- NHS or local authority?
- *R (Mwanza) v LB Greenwich & LB Bromley* [2010] EWHC 1462 (Admin)
- National Framework for NHS CHC PG56 encourages housing authorities, ICBs and social services to work together with home improvement agencies and RSLs on integrated adaptions services: "Whether or not such integrated services are in place, ICBs should have clear arrangements with partners setting out how the adaptation needs of those eligible for NHS CHC should be met, including referral processes and funding responsibilities."

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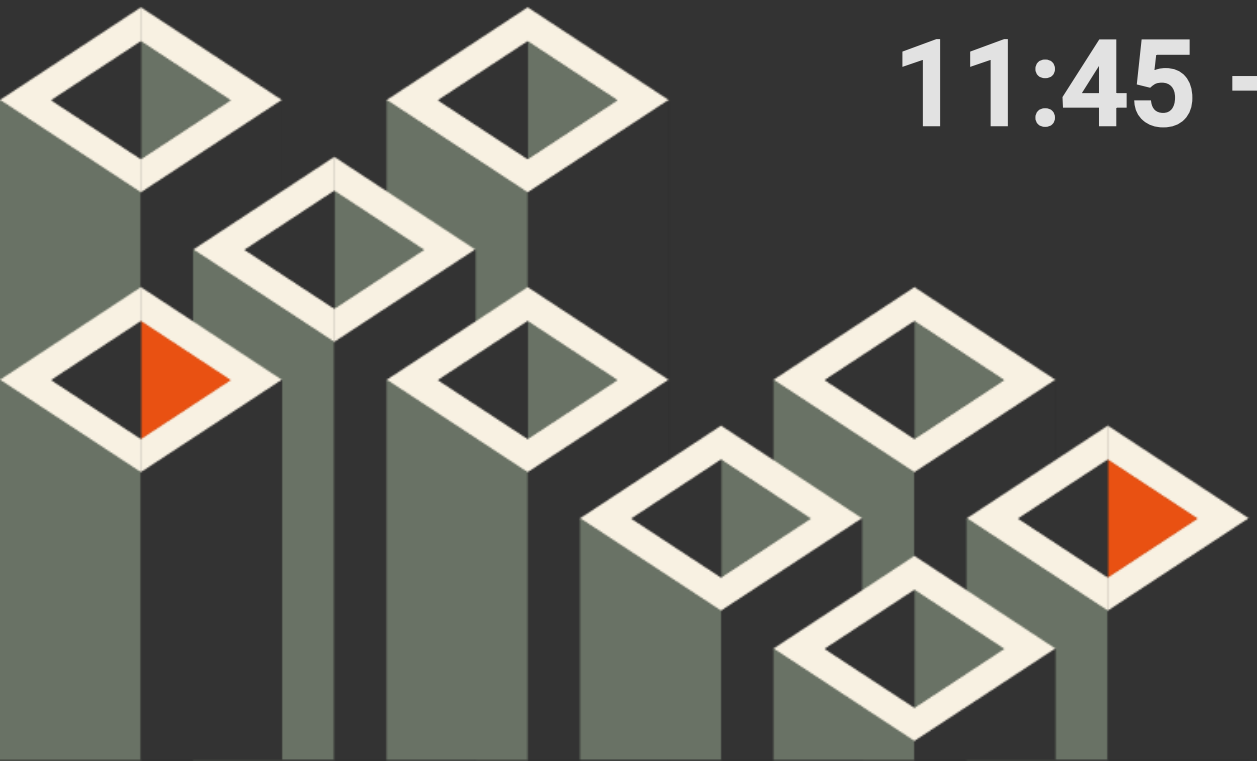
# Q&A

**We will now answer as many questions as possible.**

# Refreshment break

## 11:45 – 12:10



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# NHS procurement and the NHS Provider Selection Regime: an update

James Neill

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# NHS Procurement and the Provider Selection Regime

- NHS procurement: overview of the current regulatory regime
- Current challenges faced by NHS bodies procuring services: some recent examples
- Key features of the Procurement Act 2023
- The Provider Selection Regime 2 years in: lessons learnt

# (1) NHS Procurement:  now a tale of 3 regimes

- The **Public Contract Regulations 2015** still apply to procurement competitions commenced before  24 February 2025 (the "Go Live" date for the Procurement Act 2023) for non-health related services.
- The **Procurement Act 2023** applies to procurement of non health services / goods/works contracts (from 24 February 2025)
- **NHS Provider Selection Regime** applies to procurement competitions commenced on or after 1 January 2024 for "relevant" health care services (see Reg 2 PSR Regs and Schedule 1)

# (2) Major  challenges faced by NHS bodies under historic PCR procurements

- Major issues faced by Trusts in particular those trying to modernize IT services.  Several awards of high value/major NHS IT contracts regularly being litigated in the Technology and Construction Court under the PCRs, eg:
  - Mersey and West Lancashire Teaching Hospitals NHS Trust withdrew  electronic patient record contract award and abandoned process once proceedings brought (Nov 2024)
  - Award by Liverpool Hospital NHS Trust of EPR Contract currently subject to automatic suspension (*Altera v LUHFT*)
  - Challenge to modernization of Welsh Blood Service Electronic Computer System currently subject to automatic suspensions (*Mak-Systems Ltd v Velindre University NHS Trust)*
- Although applications to lift generally are being granted (mainly on issue of adequacy of damages), several instances of consequent abandonment (due to damages risk)

# (3) The Procurement Act 2023 is unlikely to significantly reduce the risk of litigation in the case of complex/high value procurements

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- Damages still available, and the measure of loss still likely to be the value of the loss of opportunity.
- Automatic suspension still available
- More simplified processes. But the new principle of “having regard to the importance of acting with integrity” likely to engage similar issues of equal treatment etc under the PCRs

# (4) The new(ish)  PSR Regime at a glance

2023 No. 1348

HEALTH SERVICES, ENGLAND

PUBLIC PROCUREMENT, ENGLAND

## The Health Care Services (Provider Selection Regime) Regulations 2023



| | |
|---|---|
| *Made* | *6th December 2023* |
| *Coming into force* | *1st January 2024* |

The Secretary of State makes the following Regulations in exercise of the powers conferred by sections 12ZB(1), (2) and (3) and 272(7) and (8) of the National Health Service Act 2006[1] and section 182 of the Health and Care Act 2022.

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# The NHS Provider Selection Regime: an overview

- Applies to procurement of primary care services, of whatever value
- 5 Award Process – 3 Direct Award Process, Competitive Process and Most Suitable Provider Process.
- Duty to act transparently, fairly and proportionately
- More flexibility re conflicts of interest
- Supported by statutory guidance under s.12ZB(5) NHSA 2006
- 8 day standstill period to make written reps
- Remedies regime: the Independent Patient Choice and Procurement Panel (and judicial review)

# Scope

- Applies to “relevant health care services for the purposes of health services in England”.
- Applies to combined authority, ICB, NHS England, or NHS Foundation Trust or NHS Trust
- Health services are specified in Schedule 1: includes  general-practitioner services.  So primary care included.
- No thresholds BUT: new replacement contract for existing provider can be provided if less than £500K or less than 25% in lifetime value of the initial contract

# The Five Award Processes

- **3 Direct Award Processes:** no requirement to advertise and run a competition.
- Much greater flexibility to re-appoint existing provider. Direct award possible:
  - "*where the services are capable of being provided only by the existing provider due to the nature of the relevant health care services*"
  - Replacement contract which is below the "*considerable change threshold*" and existing provider is satisfying the existing contract "*to a sufficient standard*"
  - The "considerable change threshold": lifetime value is £500,000 higher and 25% higher than previous contract
- **Suitable provider process:** authority identifies for itself potential providers and assesses in accordance with key criteria and basic selection criteria.
- **Competitive process:** bids submitted and assessed in accordance with bespoke contract award criteria

# Duty to act fairly, transparently and proportionately

- Similar concepts to PCRs
- Key issues likely to recur:
  - Misinterpretation of the ITT criteria
  - application of undisclosed criteria
  - not treating bidders the same
  - misunderstanding bids
  - Manifest errors

# Greater flexibility regarding conflicts of interest

- Historically, systemic issues with involvement of GPs in CCGs leading to allegations of conflicts of interests
- Regulation 21(3): where ICB is the commissioner, an individual who is employee/director/partner with a provider and also a member of ICB does not "*in itself create a conflict of interest or potential conflict of interest*"
- Duty to recuse only arises in the Competitive Process
- Issues still being encountered: see eg Lewisham and Greenwich NHS Trust's £14m procurement of GP services at the Lewisham Urgent Treatment Centre and conflict of interest allegation (still on-going)

# Remedies (1): the standstill period

- Only applies to Direct Award Process C, Most Suitable Provider Process and Competitive Process (although notices of award have to be published for any process)
- Notice of award published on UK e-notification service
- Written reps have to be submitted before midnight on end of 8th working day
- Standstill ends 5 working days after outcome of review by the authority

# Remedies (2): the Independent Patient Choice and Procurement Panel

- Non-statutory: processes are set out in the NHS Guidance although Reg 23 refers to ability for authorities to “receive independent expert advice”.
- Representations have to be made within 5 working days of outcome of local authority review
- Only issues advice. Guidance (not PSR Regs) says standstill should continue “other than in exceptional circumstances”
- Unlikely to constitute an adequate alternative remedy for the purposes of judicial review?

# The IPCP Panel: what are the trends in recent decisions?

- 17 decisions in 2025 so far
- Post award decision disclosure obligations under Reg 24 frequently breached
- Rare to find recommendations to re-run process altogether (only 2 so far in 2025)
- First criticism of Use of Direct Award Process C and MSP Process (see Decision 16-25)
- Delay is becoming an issue: no imposition of deadlines for authorities to disclose documents or reconsider decisions under Reg 12 and 24 PSRs
- Panel now experiencing capacity constraints – only capacity for 4 cases concurrently ( see Decision 17 – 2025), and cases now being declined due to capacity.

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# Q&A

**We will now answer as many questions as possible.**

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# The Assisted Dying Bill

Alex Goodman KC

Siân McGibbon

# Terminally Ill Adults (End of Life) Bill 2024

Alex Goodman KC

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# Current Position

- Private Members Bill, First Reading 16 October 2024
- Has now passed Committee, Report Stage and Third Reading in Commons, Second Reading in HoL, now at House of Lords Committee Stage with sittings on 14, 21 November and 5, 12 December scheduled.
- Government has published:
- ECHR memorandum" confirms that "the government is of the view that the bill is compatible with the ECHR".
- Equality Impact Assessment
- Memorandum on Delegated Powers
- Financial Impact Assessment4 .

# Main Sources

Terminally Ill Adults (End of Life) Bill - Parliamentary Bills - UK Parliament

Terminally-Ill-Adults-End-of-Life-Bill-briefing-May-2025.pdf

Terminally-Ill-Adults-End-of-Life-Bill-2024_Legal-briefing-18-November-2024.pdf

R (Pretty) v DPP (2002) 63 BMLR 1

Pretty v UK [2002] 35 EHRR 1

R (Purdy) v DPP [2010] 1 A.C. 345

R (Nicklinson) v Minister of Justice [2015] 1 AC 657

Nicklinson and Lamb v United Kingdom [2015] 61 EHRR SE7

Conway v Secretary of State for Justice [2018] EWCA Civ 16.

# Suicide Act 1961

Section 1 of the Suicide Act 1961 abrogated the crime of suicide in England and Wales

Rt Hon Sir Stephen Sedley: “one corollary of the now accepted decriminalisation of suicide is that life is a right which it is open to the individual to surrender” .

Section 2 of the Suicide Act 1961 provides that it is a criminal offence to assist the suicide of another person, regardless of their circumstances. A person convicted of assisting another to end their life faces up to fourteen years imprisonment.

# Amendment to Section 2 of 1961 Act

The Bill proposes amendment to section 2 of the Suicide Act 1961 so that the offence does not include providing assistance in accordance with the Act (clause 29).

Consequently:

(a) a terminally ill person in the last six months of life who is contemplating ending their own life will be able to discuss that decision and make it in an informed and supervised way; and

(b) if they do decide to end their life, they may do so by self-administering an approved substance, rather than by travelling abroad or engaging in a dangerous method.

# The Process Under the Bill

Over the space of at least a month:

- Two doctors and a multidisciplinary panel must be satisfied that the person who wishes to seek assistance to end their life is terminally ill, in the last six months of their life, has capacity to make the decision, has a clear, settled and informed wish to die, has made the decision voluntarily, and has not been coerced or pressured.

- In practice, the terminally ill person will need to formally consider their decision at least seven times including on at least four or five occasions to a professional person and will have to self-administer a lethal substance.

# The Voluntary Assisted Dying Commissioner and the Assisted Dying Review Panel (Amended Clauses 14-16 and Sch. 2)

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- Amendments from HoC Committee Stage.
- Multi-disciplinary Assisted Dying Review Panel comprising a psychiatrist member, a registered social worker and a current or former judge or Deputy Judge of the High Court, or King's Counsel (instead of a judge of the High Court sitting alone) (sch.2, para 2(2)).
- Commissioner will make arrangements for appointing the panel (clause 4(1)) and must ensure a panel has had training in respect of domestic abuse, coercive control and financial abuse (clause 4(3)).

# Disability Advisory Board

- To advise on the operation and implementation of the Act in its operation on disabled people (Clause 44).
- The board must include people who have a disability as well as representatives from disabled people's organisations.

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# Some of the Issues

- Protection of the Vulnerable.
- Safeguards against Abuse.
- Human Dignity/ the Primacy of Human Life.
- Courts or Legislature subsequently broadening the law?
- Is the Bill too restrictive- doesn't engage with intolerable suffering.
- Over-engineered? Too much complex interaction with officialdom?

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# Terminally Ill Adults (End of Life) Bill 2024: Procedures, Safeguards, and Protections

Siân McGibbon

# Preliminary Discussion and First Declaration

- Where a person has indicated a wish to seek assisted dying a medical practitioner may (but is not required to) conduct a '**preliminary discussion**'

- **Must include discussion of treatment options**
- **Must include discussion of palliative, hospice, and other care**
- **Must be recorded in the person's medical records**

- Following the preliminary discussion a person wishing to proceed should make a '**first declaration**'

- **Two forms of ID are required**
- **The declaration is in a form to be prescribed**
- **Must be witnessed by the 'coordinating doctor' and one other person**

# Doctors' Assessments

- A '**First Assessment**' is carried out by the coordinating doctor as soon as possible after the 'first declaration' is made
- A seven day '**period of reflection**' following the first assessment
- A '**Second Assessment**' is carried out by an independent doctor
- If the independent doctor is not satisfied the requirements are met the person / coordinating doctor may request a second opinion
- Requirements for the coordinating / independent doctor:
- **Must not be a relative**
- **Must not be a beneficiary under the will or stand to benefit financially / materially from the death**
- **Must have received training to be detailed in regulations (to include assessing capacity, identifying coercion, and – for coordinating doctor – adjustments for autism / learning disability).**

# Review Panels

- Following first declaration, first assessment, and second assessment, the Commissioner must refer to an Assisted Dying Review Panel
- Independent multidisciplinary panels:
- **A 'legal member' (current or former deputy High Court Judge or above / Silk) who will act as chair.**
- **A 'psychiatrist member' (a practicing psychiatrist)**
- **A 'social worker member' (a registered social worker)**
- Panel members appointed by the Voluntary Assisted Dying Commissioner
- Panel members must receive training on domestic abuse (including coercive control and financial abuse).

# Responsibilities of the Review Panel

- The Panel must hear from the person (save in exceptional circumstances), the coordinating doctor, and the independent doctor.
- The Panel may hear from any other person.
- The Panel will sit in public by default (a person may request to sit in private).
- The central role of the Panel is to determine whether all eligibility requirements are met including:
- **The person is terminally ill;**
- **The person has mental capacity;**
- **The person has a clear, settled, and informed wish to end their life;**
- **The decision has been made voluntarily and without coercion.**
- Written reasons for the decision should be provided to the person, coordinating doctor and Commissioner.

# Review Panel Decisions

- If the Panel is satisfied the eligibility criteria are met it must grant a ‘certificate of eligibility’ which allow the process to proceed
- If the Panel is not so satisfied it must refuse to grant a certificate. If any member votes against or abstains the certificate is refused.
- If the certificate is refused the person may apply to the Commissioner for reconsideration on grounds of:
- **Error of law**
- **Irrationality**
- **Procedural unfairness**
- If the Commissioner is satisfied that the grounds apply the case should be referred to a different panel for a fresh determination.

# Second Declaration

- Where a certificate of eligibility is granted there Is a second ‘period of reflection’ (14 days or, if the death is likely to occur within one month, 48 hours).
- The coordinating doctor must make a further statement that the criteria are met immediately before the second declaration.
- Following this the person may make a ‘second declaration’ witnessed by the coordinating doctor and one other person.
- A first or second declaration can be cancelled orally or in writing at any time.
- Only once the process has been completed can assistance be provided under section 27.

# Thank you

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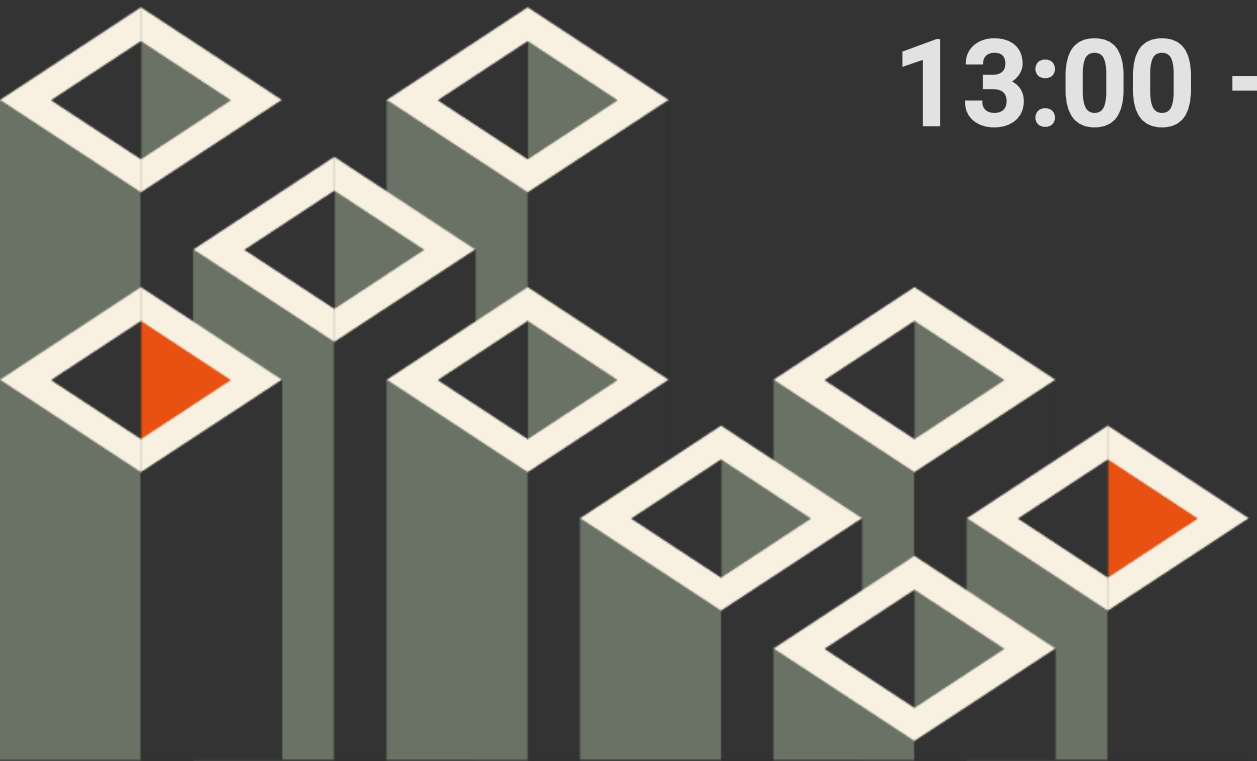
# Lunch

## 13:00 – 14:00



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# The powers and duties involved in NHS service reconfiguration

Leon Glenister

Charles Bishop

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# Charles Bishop

# Overview – sources of duties

Distinction in duties between commissioners and providers.

Commissioners:

- NHS England commissioned health services: s. 13Q NHSA 2006.
- ICB commissioned health services: s. 14Z45 NHSA 2006.

Providers:

- NHS trusts and NHS foundation trusts: section 242 NHSA 2006.

Can mean two sets of consultation process, or a joint process.

Don't forget common law fairness, PSED, *Tameside* duties, as well as procurement duties and principles of contract law.

# Overview – sources of duties

NHS England guidance (updated 2018) “Planning, assuring and delivering service change for patients” and addendum dated May 2022: https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/

Considered as formal guidance under s. 14Z51(2) NHSA 2006 in *R (Nettleship) v NHS South Tyneside CCG* [2020] EWCA Civ 46 para 5 and *R (Glatter) v NHS Herts Valleys Clinical Commissioning Group* [2021] EWHC 12 (Admin) paras 71-72.

# Scope of the public involvement duties: what kinds of changes are captured?

NHS England: “health services” provided (or are to be provided) pursuant to arrangements made by NHSE. “Health services” means services provided or to be provided as part of the health service: s. 13Z4.

ICBs: “health services” provided (or are to be provided) pursuant to arrangements made by an ICB. This means services “provided” (but not “to be provided”?) as part of the “health service”, meaning the “health service in England” (s. 14Z64)

NHS trusts and foundation trusts: “health services for which it is responsible” – not defined.

# What is a service provided as part of the health service?

- No consistent definition across the NHSA 2006. Not a specifically defined term at ss. 275-276.
- Other similar terms: “health-related services (s. 13N(4) and s. 14Z42(3)) and “health care service” (s. 12ZB(7) and s. 150 of the Health and Social Care Act 2012).

# The five tests

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- Clear, clinical evidence base.
- Support for proposals from clinical commissioners.
- Conditions met where proposals include plans to significantly reduce hospital bed numbers

The first four derive from a letter to NHS bodies on 20 May 2010 following the election of the Coalition Government. The fifth was introduced in 2017.

Interpretation is a question of law: *R (Lewisham LBC) v SSH* [2013] EWHC 2381 (Admin) para 118.

# When should involvement/consultation take place?

- The statutory public involvement duties require arrangements giving the public the right to be involved in the "*development*" of proposals.
- Consultation must take place at a "formative" stage if it is to be lawful, and so cannot take place after in substance a decision has taken (see also legal requirements in respect of pre-determination).
- But strong desire to develop contentious proposals away from public scrutiny before they can be presented to public in a fully-articulated form.
- Is this lawful? Consider the relationship between "public engagement" and "consultation": *R (National Council for Civil Liberties) v Secretary of State for the Home Department* [2025] EWCA Civ 571 - remains uncertainty as to when an engagement exercise triggers common law requirements of consultation.
- Consider also the interaction with freedom of information requests, which may require disclosure of internal documents at a later point.

# Timing of consultations

Risk and timing of JR challenges: avoiding the premature and the out-of-time. *"[i]nherent in the consultation process that it is capable of being self-correcting … courts should therefore avoid the danger of stepping in too quickly … should, in general, do so only if there is some irretrievable flaw in the consultation process": R (Royal Brompton and Harefield Hospital NHS Foundation Trust v Joint Committee of Primary Care Trusts* [2012] EWCA Civ 472 (para 91).

But see also *R (CU) v Secretary of State for Education* [2024] EWHC 638 (Admin) paras 64 – 86, esp para 83 (exploring situations when a JR can be brought on inadequacy of information, but unclear how this would interact with failure to consult at all).

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# Leon Glenister

# Public involvement: initial stages

- ICB's duty to make arrangements to secure involvement "in the planning of the commissioning arrangements": section 14Z45(2) NHSA 2006
- It is "good practice for commissioners to involve stakeholders in the early stages of building a case for change": *'Planning, assuring and delivering service change for patients'* (NHS England) ("Service Change Guidance") para 7.2
- BUT: "No service change option should be exposed for public engagement/consultation unless prior to launch there is a high degree of confidence that it would be capable of being delivered as proposed: Service Change Guidance para 7.3

# Public involvement: does it mean consultation?

- ICB's duty to make arrangements for 'involvement' in the "development and consideration of proposals in commissioning arrangements" where they would have an impact on manner of service delivery or range of services: section 14A45(2) NHSA 2006
- "Involvement" does not mean "consultation" and could be, e.g. communication, user groups, committees: *Khurana v North Central London ICB* [2022] EWHC 384 (Admin) para 117.
- There is "continuum" of what is required, and Court is not limited to Wednesbury review: *R (Dawson) v United Lincolnshire* [2021] EWHC 928 (Admin) para 119 (see further *R (Buckingham) v NHS Corby CCG* [2018] EWHC 2080 (Admin)).

# Public involvement: does it mean consultation?

- Possible exception where there is a “substantial variation or development of a service”.
- See Service Change Guidance: “In general, where there is commissioner led consultation with the local authority on a substantial service change, full public consultation will also be required”.
- See further *R (Glatter) v NHS Herts Valleys CCG* [2021] EWHC 12 (Admin) paras 71-72

# Public involvement: a lawful consultation

- For general principles: *R (Moseley) v Haringey LBC* [2014] UKSC 56
- No requirement to consult on everything that is not impossible: *R (Nettleship) v NHS South Tyneside CCG* [2020] EWCA Civ 4

# Secretary of State call in

- Duty on ICBs to “notify” SoS where it “proposes” there is a substantial variation in provision of services: NHSA Sch 10A(2)
- SoS has power to call in
- SoS maintains the Independent Review Panel to assist decision making

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# Q&A

**We will now answer as many questions as possible.**

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# Resolving disputes on responsibility

Tim Buley KC

Joe Thomas

# Resolving Disputes on Responsibility

Outline of Today's Session

In short, who pays?

- Legal Framework
- Key Questions
- Primary Care & Public Health
- Secondary Care – NHS England v ICB
- Secondary Care – ICB v ICB
- Resolving Disputes

Key Questions
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# Legal Framework

The key legislative provisions relating to the determination of commissioning responsibility are contained in the NHS Act 2006 and:

- NHS (ICB: Responsibilities) Regulations 2022
- NHS (ICB: Exceptions to Core Responsibility) Regulations 2022
- NHS (ICB: Description of NHS Primary Medical Servcies) Regulations 2022
- NHS Comm Board and Clinical Comm Groups (Responsibilites and Standing Rules) Regs 2012

Supplemented and explained by the NHS "Who Pays" Guidance: NHS England » Who Pays? (https://www.england.nhs.uk/long-read/who-pays/)

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# Key Questions

It will first be necessary to consider whether (a) the patient entitled to NHS-funded health services, and (b) if so, what health services they may require.

Most people are entitled to NHS services (other than certain foreign nationals) and what health services they need is largely a question of clinical judgment rather than law. Once those questions are answered, the following two questions arise as to “who pays”?

(1) For each service required by the patient, is NHS England responsible or an ICB?

(2) If it is an ICB, which ICB?

# (1) Responsible commissioner: NHS England or ICB?

The responsible commissioner (the RC) cannot (i.e. it is ultra vires) for them to commission (which is not the same thing as discretionarily fund) treatment unless they are responsible for the patient and the service.

Primary Care

GP practices, NHS community pharmacies and NHS dentists are commissioned by NHS England.

Paragraph 24.2 of the Who Pays guidance, says ICBs are responsible for:

a) Out of hours where GP practices have opted out under the GP contract

b) Community-based services that go beyond the scope of the GP contract (AKA local enhanced services)

c) Secondary ophthalmic services

Public Health

Anyone who is physically present in the LA's area.

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# NHS England v ICB

Part 3 National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (the 'RSR Regs') sets out services that are the responsibility of NHS England and not the ICB.

a) Oral surgery and other NHS England commissioned dental services

b) Services for Armed Forces [worth checking the table 22.7 of Who Pays – particularly for fertility services]

c) Services for prisoners and other detained persons (e.g. Immigration detention centres and children's homes).

d) Specialised services. Schedule 4 of the RSR Regs contains a list of c.144 services ranging from ataxia telangiectasia services to xerodema pigmentosum service. Critically this list includes the very expensive Adult secure mental health services.

What about patients with multiple conditions including specialised services that combine to make the patient eligible for CHC?

There is an arguable case that where a patient is outside hospital, diagnosed with a specialised service then NHS England could be responsible for some of that cost of CHC. HOWEVER, in practice NHS England does not appear to fund CHC directly.

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# (2) ICB v ICB (Part One)

Depends on whether it is a “core responsibility” or an additional service

Section 14Z(31)(1) provides that the NHS must publish rules for determining the group of people for whom an NH?S body has core responsibility. Para 10.2 of the Who Pays Guidance says:

> ***The general rules for determining core responsibility between ICBs.***
>
> *Where an individual is registered on the list of NHS patients of a GP practice, the ICB with core responsibility for the individual will be the ICB with which that GP practice is associated.*
>
> *Where an individual is not registered with a GP practice, the ICB with core responsibility for the individual will be the ICB in whose geographic area the individual is ‘usually resident’. (See Appendix 2 for more details on determining usual residence.*

“Usual residence” is presumably closely akin to, if not identical to, “ordinary residence” (see in particular *R v Barnet CC, ex p Shah* [1983] 2 AC 309)

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# (2) ICB v ICB (Part 2)

## In practice, therefore:

| Situation | ICB A | ICB B | Responsible Commissioner |
|---|---|---|---|
| Patient not yet moved | Registered and resident | – | ICB A |
| Patient not moved but registers as an out of area patient in area of ICB B | Resident | Registered | ICB B |
| Patient moved to area of ICB B | Registered | Resident | ICB A |
| Patient moved | De-registered | Resident but not yet registered | ICB B |
| Patient moved | Was never registered | Registered and / or resident | ICB B |
| Patient moved | De-registered | Registered | ICB B |

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# ICB v ICB (Part 3)

What if they are not registered and their residence appears transient (appendix 2 of the Who Pays guidance):

a) If they give an address, usually trust them.

b) If you can work out they are in the ICB without an exact address, that is sufficient.

c) Hostels should be accepted.

d) If no clue, where they are physically present.

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# ICB v ICB (Part 4)

Additional services that do not rely on ordinary residence test: Paragraph 2 of Schedule of The National Health Service (Integrated Care Boards: Responsibilities) Regulations 2022

a) Emergency treatment including ambulance (Category 1)

b) Placed adults (Categories 2 and 5)

c) Placed children (Categories 3 to 7 (except 5))

d) Patients from resident outside England (Category 8 and 11)

e) Mental health patients (Categories 9, 10 and 12)

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# ICB v ICB (Part 5)

Emergency Treatment:

a) Emergency Ambulance Travel – ICB where the journey starts pays in all circumstances

b) A&E Treatment – para 17.3, under s.14Z50 of the 2006 Act, the ICB that commissions the A&E treatment does not pay, that rests with the ICB according to the normal rule (so if I end up in A&E in Cornwall, my ICB is London can expect to be invoiced).

c) Further scenarios at para 17.4 of the Who Pays? Guidance.

n.b. For the time being Community Diagnostic Centres are being funded without re-allocation but that is due to change (para 17.7).

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# ICB v ICB (Part 6) – Section 14 of Who Pays

Placed Adults– Patient X is resident in ICB A, but placed by ICB A in accommodation in ICB B by ICB A– ICB A will retain responsibility for commission if the conditions in para 3 to the Schedule to the NHS (ICB: Responsibilities) Regs 2022. In practice that means they must:

a) Condition One: Ceased to be registered in GP in ICB A.

b) Condition Two: Provided with accommodation in a care home or independent Hospital.

c) Condition Three: Must be for continuing care needs (not necessarily continuing healthcare, but also including rehabilitation)

d) Condition Four: Must include commissioning at least one additional service

e) Condition Five: the Patient must be resident in the care home

f) Condition Six: The patient requires the additional services.

The placing ICB (ICB A) only retains responsibility for commissioning (and funding) for the accommodation and services in the care home. Other services, the usual rule applies and therefore ICB B will be paying for an unexpected cataract operation.

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# ICB v ICB (Part 6) – Section 15 of Who Pays

Placed Children– Child X is placed by ICB A into a care home in ICB B.

Three conditions:

a) Must be a qualifying child– i.e. looked after the local authority (the rules are quite technical) or requires accommodation in a care home to meet their needs.

b) Must be accommodated by the ICB (potentially in partnership with the LA). For the first group of children, the residence does not have to be a care home.

c) Placing ICB no longer has core responsibility (i.e. deregistered from GP)

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# ICB v ICB (Part 6) – Section 15 of Who Pays

Placed Children– Child X is placed by ICB A into a care home in ICB B.

Three conditions:

a) Must be a qualifying child– i.e. looked after the local authority (the rules are quite technical) or requires accommodation in a care home to meet their needs.

b) Must be accommodated by the ICB (potentially in partnership with the LA). For the first group of children, the residence does not have to be a care home.

c) Placing ICB no longer has core responsibility (i.e. deregistered from GP)

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# Resolving disputes

Who Pays Guidance:

> *"We strongly recommend that commissioners do not spend public money on taking external legal advice on Who Pays? Guidance"*

b) Instead you are meant to submit to the 'mandatory' dispute resolution service run by NHS England

Step 1: Directors are expected to talk to one another

Step 2: Arbitration through NHS England national team (8 weeks at no cost!)

Except that where NHS England feels the case is complex, they may commission legal advice.

In the meantime, a) one commissioner must commission b) costs shared equally on a without prejudice basis.

Alternatively, you could agree to take advantage of Landmark's fixed price Who Pays resolution service: https://www.landmarkchambers.co.uk/resources/guides/who-pays

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# Test

a) Tim is a 23-year-old in a local prison. He sustains a serious head injury resulting in an acquired brain injury requiring intensive support, speech and language therapy and physiotherapy.

b) Joe is registered with a GP practice associated with ICB I. ICB I assesses Joe as eligible for NHS CHC and arranges a home care NHS CHC package. Joe then moves house to the area of ICB J and registers with a GP practice associated with ICB J. He remains eligible for NHS CHC. Who pays?

c) Fiona is registered with a GP practice associated with ICB F. Following lengthy hospital treatment, she requires rehabilitation and is placed in a specialist nursing home based in ICB G. She then re-registers with a GP practice associated with ICB G.

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# Test

(d) Following completion of the programme of rehabilitation, Fiona is assessed as requiring an NHS CHC placement in a care home. She is discharged from the rehabilitation provider to a care home in the area of ICB H and registers with a GP practice associated with ICB H. Fiona has an expensive operation to remove a hernia.

**Who pays for the hernia operation? Who pays for the CHC? Is it different?**

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# Thank you

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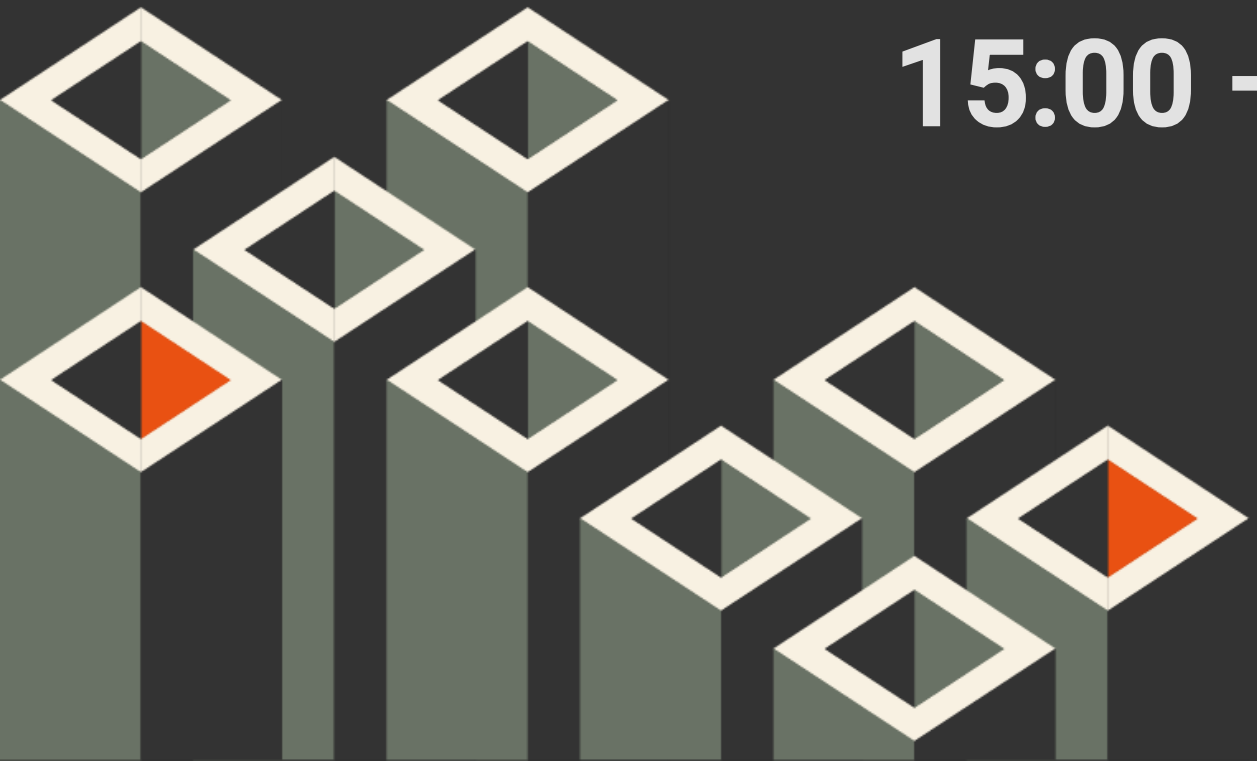
# Refreshment break

## 15:00 – 15:15



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# Panel discussion: Looking forward as NHS lawyers – what legal obstacles lie ahead

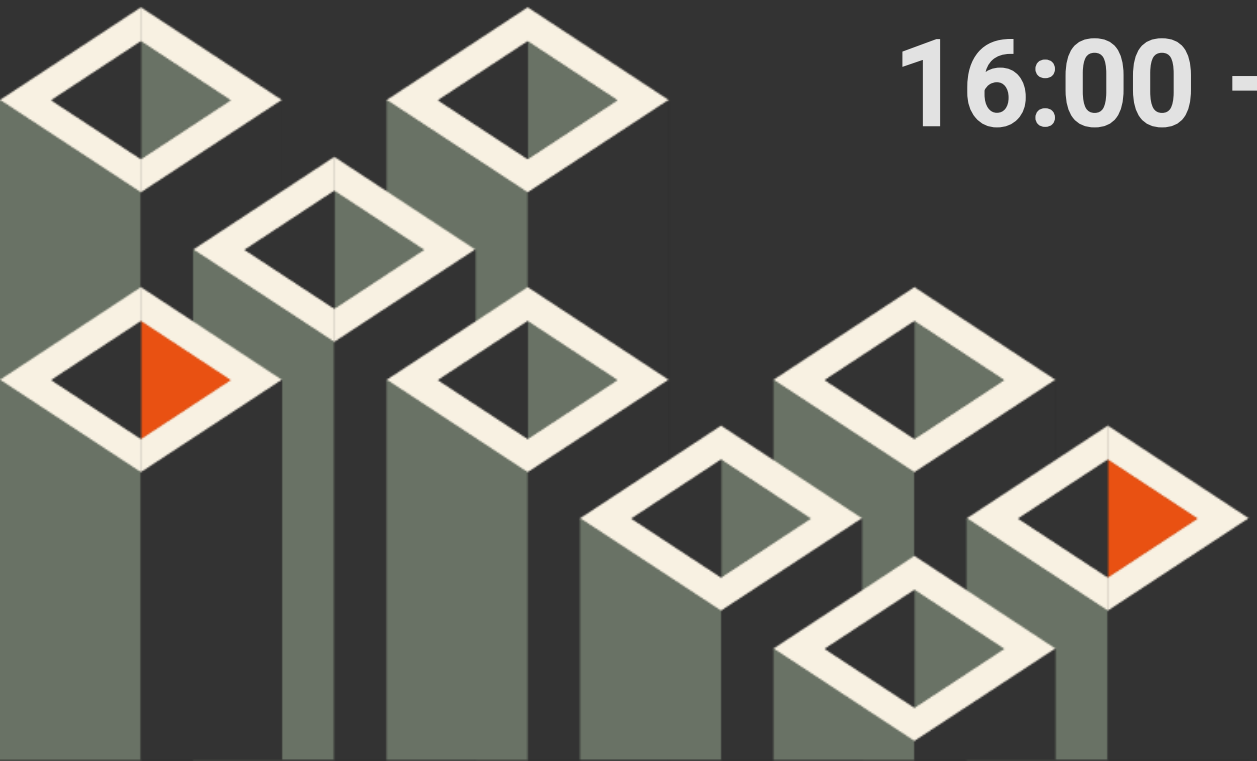
David Lock KC

Fiona Scolding KC

Samantha Broadfoot KC

# Networking

## 16:00 – 18:00



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