City and Hackney
Clinical Commissioning Group

Paper Title	Supporting background information - New Shared Commissioning Arrangements for North East London
Paper Author	Various
Lead Presenter	Not applicable
Paper Summary (*3 bullet points of relevant background to the paper*)	Please see attached documents for background information: 1. Letter to Clare Highton, CCG Chair from Councillor Ann Munn, Chair of Health in Hackney Scrutiny Commission; 2. Questions submitted to the Inner North East London Joint Health Overview Scrutiny Committee; 3. Response to Councillor Clare Harrisson, Chair of Inner North East London Joint Health Overview and Scrutiny Committee from ELHCP CCG Chairs; 4. Public questions to the Friday 29 September 2017 CCG Governing Body.
Purpose (*delete unnecessary*)	For Information
Recommendation (*state what you are asking for (eg support a proposal, debate and decide options, provide feedback etc. List all that's applicable*)	Not applicable
Where else has this paper been discussed?	Not applicable
What was the outcome of previous discussions?	Not applicable

Overview & Scrutiny

Health in Hackney Scrutiny Commission

Hackney Council
Room 118
Town Hall
Mare St, E8 1EA

Reply to: jarlath.oconnell@hackney.gov.uk

19 June 2017

Dr Clare Highton
Chair
City and Hackney Clinical Commissioning Group Governing Body

By email

Dear Clare

Creation of single Accountable Officer for East London Health and Care Partnership

We are writing in relation to the decision which we understand has been made to create a single Accountable Officer for the 7 CCGs in the NEL STP area and to express our concern about the wider reorganisation of the NHS in East London which is taking place at pace without any significant formal public consultation.

We understand the City and Hackney CCG has not yet agreed to create a single Accountable Officer and the matter is due to go to its June Board meeting.

As the local Health Scrutiny Committee we have serious concerns that this reorganisation represents a weakening of local accountability structures. In London 32 CCGs with accountability links to local councils will be replaced with just 4 CCG clusters.

We commend the successes that you have made of local NHS services and your commitment to work with the Council on establishing integrated commissioning. We acknowledge that City and Hackney CCG is one of the highest performing in the country. We believe that local control of decision making has greatly contributed to this success and we also believe that effective health services are only possible with effective scrutiny.

The Department of Health's own key messages on health scrutiny include[1]:

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf

(i) *The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs are considered as an integral part of the commissioning and delivery of health services and that those are effective and safe.*

(ii) *Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working.*

Your Chief Officer attends all our meetings to answer questions in public on behalf of the NHS. One of our concerns is that a single Accountable Officer covering 8 local authorities will not be able to replicate this level of local engagement. Some scrutiny can and does happen at a wider level than the local authority, however this scrutiny struggles to be truly effective given differing local knowledge and needs, and crucially it cannot take account of the whole local health economy; public health and social care being provided at local authority level.

We are concerned that this change reflects a wider drive to take major decisions affecting local health services at such a high level that any meaningful holding to account will become impossible.

We are very concerned that money allocated to City and Hackney CCG will continue to go out of the City and Hackney CCG area, whether presented as efficiency savings or otherwise. The CCG has a statutory duty to deliver health services for the residents of City and Hackney and it will be impeded in doing so if significant amounts of its funding continue to be diverted from it to provide fiscal balance across the NEL patch.

We are also of the view that the proposed ELHCP Community Group which will encompass a wide range of stakeholders across 8 local authorities will be so large as to be totally unwieldy and is no replacement for the existing holding to account by Elected Members which takes place in each borough.

The existing structures were created by primary legislation. There has been no democratic mandate for this transformation of the local NHS and it appears as if it is being done without the necessary changes to primary legislation that you would expect. Such primary legislation would of course mean that the proposals would have to stand up to intense public scrutiny.

STPs have no status in law. We requested and have been provided with a summary of the legal advice the CCG has received which makes clear that decisions made by way of ‘collaboration’ cannot be binding on the partners nor can decisions be made by majority vote. This is a voluntary ‘agreement’ and is no basis for providing important NHS services.

The purpose of this letter is to ask:

1. To provide us with details on what the proposal to create a single Accountable Officer will mean in practice, specifically -

    i. What powers would they have?

    ii. What impact will this proposal have on how City & Hackney's budget allocation is spent?

    iii. What impact will this proposal have on the commissioning of services for the residents of City and Hackney, both now and in the future?

    iv. If the CCG is to remain sovereign (as per your legal advice) what is the point of one Accountable Officer? Does a sovereign body not need to retain leadership and an Accountable Officer?

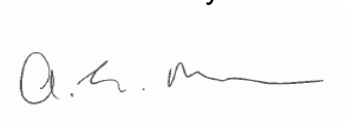
    v. How does the one Accountable Officer intend to work with the respective 'sovereign' CCGs and how will decisions be made?

2. In the absence of primary legislation, we ask that the CCG Governing Body does not agree to the proposal to create a single Accountable Officer across the NEL patch and that the existing structures be retained.

3. In light of the significant cumulative impact of the gradual, 'step by step' changes being brought about by the ELHCP which undermine structures put in place by Primary Legislation, why you and/or the ELHCP have not undertaken a formal public consultation as per the *The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013* and whether you or the ELHCP have formal legal advice that you do not need to consult? If so, please can we be provided with the same?

We look forward to hearing from you.

Yours sincerely



Councillor Ann Munn
Chair of Health in Hackney Scrutiny Commission

cc Jane Milligan, ELHCP Executive Lead
Diane Abbott MP
Meg Hillier MP
Paul Haigh, Chief Officer, City and Hackney CCG
Cllr Jonathan McShane, Cabinet Member for Health, Social Care and Devolution
Tim Shields, Chief Executive, Hackney Council
Cllr Clare Harrisson, Chair of INEL JHOSC
Jon Williams, Director, Healthwatch Hackney
Members of Health in Hackney Scrutiny Commission

Questions.

1. Has a decision about the establishment of a single accountable officer for INEL been made in advance of this meeting or is it to be decided following discussion and consultation. If a decision has already been made, may we know by whom

2. What public consultation was undertaken? What evidence base was presented to explain the creation of this post?

3. What consultation was undertaken with the LAs across the STP area to determine whether LAs support a single accountable officer? What evidence was presented to the LAs to justify this move? How will the LA scrutiny functions continue alongside their local CCGs with a single accountable officer?

4. The greatest driver of ill health is poverty. In May 2017, A report from the Royal College of Paediatrics and ChildHealth (RCPCH) and Child Poverty Action Group (CPAG) estimate that 4 million children in the UK are living in poverty.
   Local authorities, with detailed knowledge of their local populations, play a vital role in preventing and addressing child and adult poverty through housing, education, social services, public health and early years services. The devolution pilot in Hackney, which has been in development since 2013, strengthens joint working between the LA and the CCG to address poverty and poor health in Hackney. What evidence is there that a single accountable officer for the whole STP area will not disrupt this integrated joint working?

5. The clinical indicators in the STP dashboard published in July 2017 do not contain anything new. The C&H CCG has shown improved performance against these indicators over several years, working alongside the Homerton Hospital, the local authority, the Clinical Effectiveness Group based at Queen Mary University and local GPs. What analysis has been undertaken of the risk that performance might fall back if Hackney's Accountable Officer is replaced by a Single accountable Officer?

6. East London has shown the greatest improvement in diabetes and cardiovascular care of any area in England. This is a combination of local joint working and academic research. What mechanisms will the STP put in place to ensure indicators are the most appropriate for each area?

7. What impact will this proposal have on how City & Hackney's budget allocation is spent? The final indicator on the STP dashboard asks for 'CCG/Trust combined surplus or deficit vs. total resource available (control total)'
   How will specific needs of a particular CCG population be taken into account within an overarching total? Of great significance is that Barts Health is in financial special measures. Under a single accountable officer, will money be diverted from Hackney people to pay for the PFI debt of the RLH?

NHS
Tower Hamlets
Clinical Commissioning Group

NHS
City and Hackney
Clinical Commissioning Group

NHS
Newham
Clinical Commissioning Group

Councillor Clare Harrisson
Chair of Inner North East London Joint Health
Overview and Scrutiny Committee
c/o London Borough of Tower Hamlets
6th Floor, Mulberry Place
5 Clove Crescent
London
E14 2BG

Sent via e-mail

Tuesday 13 September 2017

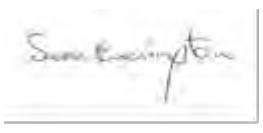
Dear Clare,

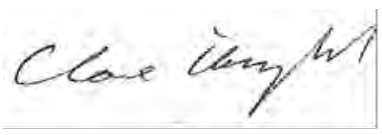
Many thanks for your letter and the opportunity we had to discuss potential plans going to our respective CCG Board this month, with your INEL Joint Health and Overview Scrutiny Committee.

We will ensure all our board members receive a copy of your letter along with other information provided by all the stakeholders we have engaged with.

Best wishes

Yours sincerely





Dr Sam Everington
Chair
NHS Tower Hamlets CCG

Dr Clare Highton
Chair
NHS City & Hackney CCG

Dr Prakash Chandra
Chair
NHS Newham CCG

cc. Daniel Kerr

Inner North East London Joint Health Overview & Scrutiny Committee

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Reply to: daniel.kerr@towerhamlets.gov.uk

September 2017

Dear Dr Prakash Chandra

Creation of single Accountable Officer for East London Health and Care Partnership (ELHCP)

Following the consultation undertaken at the Inner North East London Joint Health Scrutiny Committee (INEL JHOSC) meeting on 6th September 2017, the Committee would like to formally notify you that they decline to endorse the proposals for the creation of a single Accountable Officer (SAO) for the East London Health and Care Partnership.

Dr Sam Everington (Chair of NHS Tower Hamlets Clinical Commissioning Group), Dr Clare Highton (Chair of NHS City & Hackney Clinical Commissioning Group) and Dr Prakash Chandra (Chair of NHS Newham Clinical Commissioning Group) presented a report to INEL JHOSC. The report recommended a new shared commissioning arrangement for the 7 CCGs in North East London in the form of a single Accountable Officer and supporting governance arrangements. The report set out the significant context, talked about the direction for local accountable care systems, before setting out the proposals for a single Accountable Officer and supporting governance arrangements. Following scrutiny of their proposals members of the INEL JHOSC voted against endorsing the creation of an SAO.

The Committee has serious concerns that this reorganisation represents a weakening of local accountability structures. The Committee believes that local control of decision making ensures the best performance and that effective health services are only possible with effective scrutiny. The appointment of an SAO relinquishes the ability and means for local committees to perform effective scrutiny via their elected representatives. We are concerned that centralising authority in an SAO will lead to major decisions affecting local health services being made at such a high level that any meaningful accountability will become impossible.

As the system is currently constituted, the appropriate Chief Officer reports to their local Health Scrutiny Committee to answer questions in public on behalf of the NHS. We are concerned that a SAO covering 8 local authorities will not be able to replicate this level of local engagement. We understand that more decisions will be taken at an ELHCP footprint level and to date scrutiny at this

level has taken place through INEL JHOSC. However the JHOSC does not cover the whole footprint and is inadequate to go into the same level of detail that local health committees can. The scrutiny processes for the new ELHCP are yet to be decided and without knowing what this will look like it is impossible to guarantee that decisions taken at a footprint level will have the appropriate level of scrutiny.

Additionally, the timeframe in which decisions are being made and presented to the Committee makes little sense. We remain unclear as to why separate Accountable Care Systems cannot be established first and then the leadership structures designed to fit the needs of the new system. This would ensure that the governance systems were appropriate for the needs of each local area. It appears as if power is being taken away from the local areas before any decision has been made about how the Accountable Care Systems will be structured and what environment the SAO will be operating in.

Whilst we recognise the opportunities Accountable Care Systems present, we are deeply concerned by the governance and accountability they will have if the SAO position is created. We would like to make clear our position and state that without knowing what the Accountable Care Systems will look like the Committee is not in a position to endorse the proposals.

Recommendation

INEL JHOSC recommends that the CCG governing bodies delay their decision to appoint the SAO until such a time where it has been made clear to the Committee what the new ELHCP system will look like and we receive guarantees that local health scrutiny committees will continue to strengthen the voice of local people. We consider this absolutely essential to ensuring that our residents' needs are considered as an integral part in the commissioning and delivery of safe and effective health services.

Could you please reply to inform the Committee if you will take our comments and recommendations into account, and if you are not could you please provide your reasons why.

Yours sincerely,

Councillor Clare Harrisson
Chair of Inner North East London Joint Health Overview and Scrutiny Committee

Questions from the public

1. In regard to the letter from the Inner North East London Joint Health Overview and Scrutiny Commission following the discussion of this matter at its meeting on 6 September. Can the Board confirm that the reasons it gave for not endorsing these proposals do not give rise to any issues which the Board feels need further consideration?

2. Is the Board happy that the concerns raised in the two submissions (see following documents) to the Overview and Scrutiny Commission, on the legality of these proposals are not well founded so as to give rise any concern by the Board on the legality of the proposals?

SUBMISSION

To	Inner North East London Joint Health Overview and Scrutiny Commission
From	Michael Vidal – Member of the Public in receipt of services from NHS City and Hackney CCG
Subject	Proposal to have a Single Accountable Officer for all North East London CCGs 'The Proposal'

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1. INTRODUCTION

1.1 While I graduated with a second class honours Degree in Law from the University of Teesside in 1996 I have never gone on to take my professional exams. Accordingly, any views I express on the law in this submission are my personal views and not meant as legal advice. The Commission should take such advice on what I say as they feel appropriate.

1.2 These submissions are provided to give the Commission a view from the perspective of the patient. I am a former member of the Board of Healthwatch Hackney. I am also a member of the Patient Participation Group at Brooke Road Surgery.

1.3 Of necessity these submissions have been written without having had sight of the proposal. My knowledge of the proposal has been based on what it has been able to be gleaned from discussions where the proposal has been discussed but not in any detail.

2. FUNCTION OF A CCG

2.1 To put the proposal in context I would argue that we need to understand what the function of a CCG is. Clinical Commissioning Groups were created by S.1I of the National Health Service Act 2006 'The 2006 Act.' (As inserted by S.10 of the Health and Social Care Act 2012 'The 2012 Act'). This provides as follows

> '1IClinical commissioning groups and their general functions
>
> (1) There are to be bodies corporate known as clinical commissioning groups established in accordance with Chapter A2 of Part 2.
>
> (2) Each clinical commissioning group has the function of arranging for the provision of services for the purposes of the health service in England in accordance with this Act."

2.2 A clinical commissioning group's function is that given by the Act. It follows that the only statutory function it has is that defined in the Act. This becomes important when it comes to deciding what responsibility, if any; a CCG has beyond its own area.

2.3 The duties of a CCG are found in S.3 of the 2006 Act as amended by S.13 of the 2012 Act. This as far as it is relevant says

’13 Duties of clinical commissioning groups as to commissioning certain health services

(1)Section 3 of the National Health Service Act 2006 is amended as follows.

(2)In subsection (1)—

(a)for the words from the beginning to “reasonable requirements” substitute “A clinical commissioning group must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility”, and

(b)in each of paragraphs (d) and (e) for the words “as he considers” substitute “as the group considers”.

(3) After that subsection insert—

“(1A) For the purposes of this section, a clinical commissioning group has responsibility for—

(a) persons who are provided with primary medical services by a member of the group, and

(b) persons who usually reside in the group's area and are not provided with primary medical services by a member of any clinical commissioning group.

(1B)Regulations may provide that for the purposes of this section a clinical commissioning group also has responsibility (whether generally or in relation to a prescribed service or facility) for persons who—

(a) were provided with primary medical services by a person who is or was a member of the group, or

(b) have a prescribed connection with the group's area.

(1C)The power conferred by subsection (1B)(b) must be exercised so as to provide that, in relation to the provision of services or facilities for emergency care, a clinical commissioning group has responsibility for every person present in its area.

(1D)Regulations may provide that subsection (1A) does not apply—

(a) in relation to persons of a prescribed description (which may include a description framed by reference to the primary medical services with which the persons are provided);

(b) in prescribed circumstances.

(1E)The duty in subsection (1) does not apply in relation to a service or facility if the Board has a duty to arrange for its provision.”

(4)After subsection (1E) insert—

"(1F) In exercising its functions under this section and section 3A, a clinical commissioning group must act consistently with—

(a) the discharge by the Secretary of State and the Board of their duty under section 1(1) (duty to promote a comprehensive health service), and

(b) the objectives and requirements for the time being specified in the mandate published under section 13A."

2.4 As will be seen the area of responsibility of a CCG is prescribed by S.3(1A) –(1C). There is nothing in this wording I would submit that gives rise to a statutory responsibility for a wider group of people.

3 NEED FOR THE PROPOSAL

3.1 The question arises is there a need for the proposal. S.3(1F)(b) of the 2006 Act (as inserted by S.13(4) of the 2012 Act) does require the CCG to discharge its functions consistently with the requirements and objectives of the Mandate to NHS England. Paragraph 1.11 of the 2017 -2018 Mandate states

> 'We expect the NHS to deliver the Five Year Forward View and close the gaps in the quality of health, care and NHS finances through Sustainability and Transformation Plans (STPs). For the first time local service leaders in every part of England, both on the commissioner and provider side, have come together to develop these plans, with the aim of transforming health and care in the communities they serve. A number of metrics will be used to measure progress across STP footprints in delivering the Five Year Forward View, linking performance of the NHS at a local level more explicitly to national accountability. '

The objectives in the Mandate are at paragraph 2 of the Mandate. The Mandate is attached to these submissions.

3.2 It is my argument that there is no need consistent with the wording of paragraph 1.11 of the Mandate or any of the objectives in paragraph 2 of the Mandate for there to be a single accountable officer for the seven CCGs in North East London. This is especially true when you recall that the North East London Sustainability and Transformation Plan contains three sub plans. Each of the sub plans can be delivered as efficiently with a separate Accountable Officer for each CCG as one for all seven CCGs. In fact the argument can be made that as the current accountable officers have already started on delivering the sub plans you may cause disruption to the plans by making significant management changes.

3.3 A further argument against the proposal goes back to the point about the function of a CCG that I alluded to before. Under S.3(1A) of the 2006 Act as amended the statutory responsibility of a CCG is only to the people in its area. A CCG has no statutory responsibility for any wider area. Therefore in discharging its statutory duty under S.3(1F)(b) of the 2006 Act it does not have, in my submission, any wider responsibility as neither the

Mandate or Sustainability and Transformation Plans can amend in any way a statutory duty. Accordingly, a CCG's duty remains as in the Act to the people in its area.

3.4 It follows from what I said in paragraph 3.3 above that if a CCG has any wider responsibility to people in the STP area that responsibility is subject to the statutory duty to the residents in its area. A non statutory responsibility cannot fetter the exercise of a statutory responsibility. Accordingly in as far as the proposal is needed to further the aims of the STP it can only be done in as far as it does not interfere in the exercise by a CCG of its statutory responsibility.

4 IS THE PROPOSAL LEGAL

4.1 It is accepted that under paragraph 12(3) of Schedule 1A to the 2006 Act as inserted by Schedule 2 to the 2012 Act that 'The Board may appoint a person to be the accountable officer for more than one clinical commissioning group.' Accordingly the Accountable Officer is an NHS England appointee. However, paragraph 12 contains no provision for the removal by NHS England of the Accountable Officer. The only provision for terminating the appointment of the Accountable Officer that I am aware of is in S.14Z21(4) of the 2006 Act (as inserted by s.26 of the 2012 Act.) This provision comes in the intervention powers of NHS England. However, these powers can only be used where a CCG fails or is failing to perform a function. It follows that absent a merger of CCGs there is no power to remove an Accountable Officer so as to replace him with a joint appointment. I would accept that if the Accountable Officer was to resign or retire then he could be replaced by a joint appointment. However, I doubt that it would be permissible to bring in a new management structure across CCGs on the basis that a number of Accountable Officers will retire at the same time.

4.2 In as far as it is sought to argue that the proposal is in the interest of the health service it is noted that while the definition of failing to perform a function in relation to a CCG includes 'a failure to discharge it consistently with what the Board considers to be the interests of the health service.'[1] This only relates to the performance of a function of a CCG and commissioning services on a regional basis is not a function of a CCG. As under s.3 of the 2006 Act (as amended) a CCG's responsibility is only for people in its area and nothing more.

4.3 It has been stated publicly that the STP is not a new body it is a forum for discussing how to do things that need to be done once across a wider area. However, there have been other comments which cast doubt on this public statement.[2] It would seem from the way that the STP has developed and the responsibilities given to it[3] that it is a de facto regional health authority.

4.4 In as far as the STP is a regional body this would be contrary to the intent of Parliament in passing the 2012 Act. Therefore, in as far as the proposal is designed to further

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[1] See s.14Z21(14)(b) of the 2006 Act as inserted by s.26 of the 2012 Act

[2] For example in a letter to NHS City and Hackney CCG dated 18 June 2017 it states 'In such circumstances we would wish to review the governance and financial arrangements in advance of any future change so that we are assured that such arrangements are consistent with the strategic commissioning plans of the STP and that all relevant parties have been consulted.' The existence of a strategic commissioning plan of the STP is inconsistent with it being merely a forum

[3] By way of example the STP has to assure all applications for transformation funds. It decided which applications for funding from the ETTF were submitted.

this it is tainted by illegality. In that NHS England is acting ultra vires in setting up a body contrary to the intent of Parliament.

5 CONCLUSION

5.1 In conclusion it is my submission that the proposal is unnecessary and has the potential of hindering transformation work already underway in Inner North East London. This transformation work is in accordance with the statutory duties and responsibilities of the CCGs in Inner North East London. I would respectfully ask that the Inner North East London Joint Health and Overview Scrutiny Commission declines to endorse the proposal.

Michael Vidal
August 2017

SUBMISSION

To	Inner North East London Joint Health Overview and Scrutiny Commission
From	Michael Vidal – Member of the Public in receipt of services from NHS City and Hackney CCG
Subject	Proposal to have a Single Accountable Officer for all North East London CCGs 'The Proposal'

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1. INTRODUCTION

1.1 These submissions are supplementary to the submissions dated August 2017 and deals with issues arising from the details of the Proposal which were disclosed on 1 September 2017. Due to the brevity of the details of the Proposal that have been given there is a risk that what follows might be based on a misconception of what is proposed.

1.2 Statutory references in this submission have the same meaning as in the submission dated August 2017.

2. CONFLICTING DUTIES AND POWERS

2.1As I understand the Proposal certain functions are to be delegated to a Joint Committee of CCGs (the Committee). This is to be done under the power in S.14Z3 of the 2006 Act (as amended by S.26 of the 2012 Act.) when read with the Legislative Reform Order made in 2014. Accordingly, subject to what is said below there is statutory power to create the Committee.

2.2 However, while there is a statutory power to create the Committee it is a permissive power which may be used to further the functions of the Clinical Commissioning Group. This discretionary power is to be contrasted with the mandatory duty under S.14Z1 to promote integration. It is my argument that if there is a conflict between the two then the duty under S.14Z1 takes precedence.

2.3 I would submit that there is a potential conflict between the two duties. This arises because if you delegate powers to the Committee then you cannot then delegate those powers in order to integrate health and social care. It would therefore seem that the Proposal has the potential to fetter the way that the Clinical Commissioning Groups discharge a mandatory statutory duty.

3 LEGALITY OF THE PROPOSAL

3.1 I would repeat what I said in paragraph 4.1 of the submission of August 2017. Moreover, it is submitted that there is no power to create the single management team across the seven Clinical Commissioning Groups in North East London. As I said in paragraph 2.1 there is power to establish the Committee, however, it is my argument that in this case the use of the power would be an abuse of power as its use would go against the intent of Parliament as I stated in paragraph 4.4 of the submission of August 2017.

3.2 Section 33 of the 2012 Act states ’33 Abolition of Strategic Health Authorities

(1) The Strategic Health Authorities continued in existence or established under section 13 of the National Health Service Act 2006 are abolished.

(2) Chapter 1 of Part 2 of that Act (Strategic Health Authorities) is repealed.’

Unlike with PCTs no replacement body was created this indicates that it was the intent of Parliament that there should not be any strategic health commissioning bodies. Accordingly, it is my submission that the power under S.14Z3 cannot be used to do what Parliament did not legislate for.

3.3 Further while S.14Z3(1) states ‘(1) Any two or more clinical commissioning groups may make arrangements under this section.’ It is my submission that arrangements under the section do not include the power to create a single management structure. This argument is reinforced by the fact that the section as originally enacted did not include a power to create Joint Committees and a Legislative Reform Order was needed to give this power. Accordingly, absent a specific provision in S.14Z3 there is no power under that section to create a single management structure. I am not aware of any provision in the 2012 Act that allows such a structure to be created.

3.4 As both NHS England and Clinical Commissioning Groups are creatures of statute they only have the powers given to them under the statute that created them. It follows that unless there is specific statutory authority, and I have not been able to find any, there is no power to create the single management structure that is proposed.

4 CONCLUSION

4.1 For the reasons given above and in my submission of August 2017 I would invite the Joint Health Overview and Scrutiny Commission to make a referral to the Secretary of State of the Proposal.

Michael Vidal
September 2017