Neutral Citation Number: [2019] EWCA Civ 646

Case No: C1/2018/0152

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE ADMINISTRATIVE COURT
Mr Justice Mostyn
CO/1587/2017

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 11/04/2019

Before:

SIR TERENCE ETHERTON, MASTER OF THE ROLLS
LORD JUSTICE McCOMBE
and
LORD JUSTICE LINDBLOM

- -

Between:

KEEP THE HORTON GENERAL (acting by KEITH STRANGWOOD)	**Appellant**
- and -	
OXFORDSHIRE CLINICAL COMMISSIONING GROUP	**Respondent**
-and-	
CHERWELL DISTRICT COUNCIL & OTHERS	**Interested Parties**

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Samantha Broadfoot QC and Leon Glenister (instructed by Leigh Day) for the Appellant
Fenella Morris QC (instructed by Capsticks LLP) for the Respondent
The Interested Parties did not appear and were not represented

Hearing date: 14 March 2019

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Approved Judgment

Lord Justice McCombe:

(A) Introduction

1. The appellant, "Keep the Horton General" (a campaign group which acts by one of its members, Mr Keith Strangwood) appeals, with permission granted by Newey LJ by his order of 28 October 2018, from the order of Mostyn J of 21 December 2017 dismissing the judicial review claim of the Interested Parties brought against the respondent Oxfordshire Clinical Commissioning Group ("the CCG"). The claim was brought by four local government authorities as claimants, challenging the lawfulness of a public consultation launched by the CCG in January 2017 about proposals for changes in the provision of hospital and other health care services in the Oxfordshire area. The appellant group was joined as an interested party to the claim. The claim form was issued on behalf of the four claimant authorities on 30 March 2017.

(B) The Consultation: overview

2. The main public consultation document, issued on 16 January 2017, was entitled "The Big Consultation: Best Care, Best Outcomes and Best Value for Everyone in Oxfordshire". It was planned by the CCG as the first part of a two-phase consultation exercise and was conducted pursuant to the CCG's statutory duty set out in section 14Z2 of the National Health Act 2006. In its material parts, that section provides as follows:

> **"14Z2 Public involvement and consultation by clinical commissioning groups**
>
> (1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").
>
> (2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)—
>
> (a) in the planning of the commissioning arrangements by the group,
>
> (b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
>
> (c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

> These proposals set out in phase 1 would involve investment in some areas and would not be at the cost of other proposals we will be discussing in the consultation for phase 2."

It was not said when the second phase would be undertaken, although I understand that, by the time of the hearing before Mostyn J in December 2017, it was envisaged that Phase 2 would take place during 2018.

5. The consultation document stated expressly that the aim was to keep the HGH open and to "develop [it] to become a hospital fit for the 21st century". It was said there were plans "to invest significantly in the hospital so that it can continue to develop and change as healthcare evolves and meet the needs of local people". In contrast, in the appellant's skeleton argument for this appeal it was said that:

> "The Appellant was (and remains) concerned that the service changes, incrementally proposed, will in due course spell the end of the HGH as a general hospital because the elimination of some services will in due course make other services unviable."

6. As part of the processes of decision making and implementation of changes to healthcare provision CCGs are required to follow guidance issued by NHS England in implementing the government's "mandate" to that body: see section 14Z2(4) and (5) above. The relevant guidance informs CCGs (among with other matters) that they must provide to NHS England assurance that certain tests of "service reconfiguration" are satisfied before they proceed to the statutory public consultation. As the guidance provided, in the form it was in prior to this consultation, the four tests were: 1. "Strong public and patient engagement"; 2. "Appropriate availability of choice"; 3. "Clear clinical evidence base"; and 4. "Clinical support". Initial approval of the proposals upon which consultation was to take place was given by NHS England on 5 December 2016 in approving the CCG's "pre-consultation business case" ("PCBC").

7. The consultation document informed readers that the CCG had to satisfy the four tests identified by NHS England and that it had stated in the PCBC how the tests had been met. There was a cross-reference to the web link for the PCBC where these matters were addressed. In the course of the consultation, however, on 3 March 2017, NHS England announced a further assurance test in addition to the original four, which would have to be satisfied in a case of a proposal to close hospital beds. This additional test was to apply from 1 April 2017 and provided for three new conditions as follows:

> - "Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or
>
> - Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
>
> - Where a hospital has been using beds less efficiently than the national average, that it has a credible plan

understand the pressures we are facing. We had many examples of people's own experiences and many ideas and suggestions for improving care. Thank you to everyone who took the time to share their views, attend events and respond to the survey.

We have now reached a point where we want to ask the public and our partners questions and seek feedback on some more specific proposals for change. In this document you will find proposals for changes to the following services.

- Changing the way we use our hospital beds and increasing care closer to home
- Planned care services at the Horton General Hospital
- Acute stroke services
- Critical care
- Maternity

These changes are being considered now because the quality of care for patients will be affected if we delay making decisions. Furthermore, some of these services do not meet national clinical best practice recommendations.

A further set of proposed changes will be presented in a ***Phase 2*** consultation but more work is needed to develop these options before a second consultation can be launched."

In the body of the document, there appeared the following about the phasing of the consultation:

"During the second phase we will also be looking in more detail at plans to develop primary care, which will underpin all our other changes (primary care services include GPs, nurses, healthcare assistants, community nurses and other clinicians).

This document focuses on *Phase 1* only. It includes proposals for formal public consultation on:

- changes to acute hospital bed numbers in Oxfordshire as part of a plan to provide more care out of hospital
- more planned care at the Horton General Hospital in Banbury (planned care is a term for Healthcare which has been planned in advance and which is not urgent or an emergency, such as diagnostic tests, outpatient appointments and surgery)
- stroke services in Oxfordshire

> These changes mean that patients can be cared for in a range of places which are better for them than being in a busy acute hospital ward."

16. The document went on to explain further proposals to reduce the need for in-patient hospital care and stated that the need for hospital beds had been reduced. It said this:

> "As a result, the number of hospital beds we need reduced and we closed 146 acute hospital beds on a temporary basis. Initially 76 beds were temporarily closed in the winter of 2015/16, then in September 2016 a further 70 beds were temporarily closed. These beds were in Oxford (101 beds) and Banbury (45 beds) from areas including post-acute and surgical emergency units, general medicine, elective surgery, orthopaedics, and other wards at the John Radcliffe Hospital."

Ms Broadfoot took issue with the Banbury figure which she said involved 23 closures during the winter of 2015/6 and a further 28 on 1 October 2016 at the HGH, the latter being only just before the consultation began in January. In my view, however, this small discrepancy in numbers does not affect any of the issues on the appeal.

17. The document went on to give some details about an evaluation of 483 patients discharged from hospital into nursing home care between December 2015 and August 2016. A survey of such patients was described which had yielded a high level of satisfaction with the process. It was said that changes to the acute beds provision was expected to result in savings of £4.9 million the bulk of which would be invested in the new services described. Again, cross-reference was made to the web link to the PCBC.

(D) The Law

18. The law was not in dispute between counsel and no reported cases upon the main principles relating to the law's requirements for a public consultation had to be cited to us, either in written or in oral argument. It appeared to be common ground that "fairness" underpins all; to be lawful a consultation must be fair, but fairness does not require perfection. A challenge will not necessarily succeed simply by pointing out a way in which the consultation could have been better, unless the failure to proceed in that way has led to real unfairness.

19. It is sufficient for our present purposes to recall certain passages from the judgments of the Supreme Court in *R (Moseley) v Haringey LBC* [2014] 1 WLR 3947. The well-known principles underlying the common law on the subject of lawful consultation appear in the judgment of Lord Wilson of Culworth (with whom Lord Kerr of Tonaghmore agreed) at paragraph 25 as follows:

> "25. In *R v Brent London Borough Council, Ex p Gunning* (1985) 84 LGR 168 Hodgson J quashed Brent's decision to close two schools on the ground that the manner of its prior consultation, particularly with the parents, had been unlawful. He said, at p 189:

> ensure public participation in the local authority's decision-making process.
>
> 39. In order for the consultation to achieve that objective, it must fulfil certain minimum requirements. Meaningful public participation in this particular decision-making process, in a context with which the general public cannot be expected to be familiar, requires that the consultees should be provided not only with information about the draft scheme, but also with an outline of the realistic alternatives, and an indication of the main reasons for the authority's adoption of the draft scheme. That follows, in this context, from the general obligation to let consultees know "what the proposal is and exactly why it is under positive consideration, telling them enough (which may be a good deal) to enable them to make an intelligent response": *R v North and East Devon Health Authority, Ex p Coughlan* [2001] QB 213, para 112, per Lord Woolf MR."

21. In the light of this nuance in approach between Lord Wilson and Lord Reed, Baroness Hale of Richmond and Lord Clarke of Stone-cum-Ebony added this at paragraph 44:

> "44. We agree that the appeal should be disposed of as indicated by Lord Wilson and Lord Reed JJSC. There appears to us to be very little between them as to the correct approach. We agree with Lord Reed JSC that the court must have regard to the statutory context and that, as he puts it, in the particular statutory context, the duty of the local authority was to ensure public participation in the decision-making process. It seems to us that in order to do so it must act fairly by taking the specific steps set out by Lord Reed JSC, in para 39. In these circumstances we can we think safely agree with both judgments."

22. In the present case, it was not suggested that any such nuance of approach was required. Both Ms Broadfoot and Ms Morris adopted the yardstick of "fairness" in their submissions and I am content to adopt their common approach, while noting the slight differences appearing in the judgments of Lords Wilson and Reed in the *Moseley* case, in a rather different statutory context from the present.

(E) <u>The Grounds of Appeal and my Conclusions</u>

23. The ground of appeal upon which Ms Broadfoot concentrated was ground 1 (inter-dependency of the two phases of consultation) although, to my mind, all four grounds were to a degree linked. I will take grounds 1 and 3 together.

Grounds 1 and 3

24. Ground 1 contends that the judge was wrong in failing to find the consultation unfair in failing to bring into the "bed closure" issue the question of alternative services in the community which was intended to be part of phase 2. It was submitted that consultees could not sensibly consider how to respond to the bed closure points without knowing what was to be proposed about future community care overall. Linked into that issue is

> "The local campaign group 'keep the Horton General' participated in the consultation in a number of ways. Members of the group attended every public consultation meeting and distributed material about the consultation and their campaign to those attending and to households across the area. They provided information via their website and Facebook page. They expressed their concern about the consultation survey and encouraged people to seek advice from them before completing it. They also provided a template letter that people concerned about the proposals could use to respond to the consultation."

28. A later passage in the paper referred to answers from respondents to the specific question whether they agreed with the bed closure proposal. It was reported that 50% did not agree with it. The reasons for disagreement were summarised as follows:

> "Reasons for disagreeing with the proposal focused on a belief that the hospital was already stretched, with more beds needed not less. These was also a concern about the knock on effect of closing beds; which other services would it have an impact on? Some felt closing the beds simply wouldn't solve 'the problem' and that the 'alternative' model of care needs to be in place and fine-tuned before any beds are closed. Others commented that it was too difficult or took too long to get to Oxford."

Similar comments were reported from public consultation events. The complaint as to the splitting of the consultation into two phases was also reported.

29. Ms Morris submitted that this material shows that the public, including the appellant, were well aware of the arguments against the bed closures and stated them; there was, she argued, no more that could reasonably have been said to the public to enable them to have a better ability to respond to the phase 1 consultation.

30. Ms Morris went on to take us to passages in the "Decision Making Business Case" ("DMBC") which was placed before the CCG when it took its decision on the proposals on 10 August 2017, in the light of all the materials including the responses to the consultation. She argued that these extracts showed that the public had responded fully to the consultation and had not been hampered in doing so by a lack of information.

31. The DMBC made a modified recommendation for bed closures, proposing a "staggered" implementation: 110 beds were to remain closed; the remaining 36 would only be permanently closed "...when the system has made significant progress in reducing the numbers of delayed transfers care". Permanent closure of these further beds would be "subject to further Thames Valley Clinical Senate review and NHS England assurance".

32. The DMBC outlined the alternative provision already being made to meet the bed closures proposed (quite apart from anything to be proposed in Phase 2) and said, with reference to a diagram, that:

> "Overall, the number of beds in the system has not reduced markedly, but these beds are used in different ways to ensure that

37. In my judgment, looking at ground 3 first, and assessing whether the information provided enabled the public to respond effectively to the bed closure issue, I believe that the material provided in the consultation (which I have outlined above) was adequate. It is clear that there was significant response to the bed closure proposal and it largely questioned the ability of alternative care proposals outlined in the consultation to meet the need. I believe that Ms Morris was correct in her argument that the potential disadvantages of the proposal (the "cons") were obvious and that is what the respondents pointed out. The response clearly influenced the decision made.

38. Turning to ground 1, Mostyn J questioned the desirability of splitting of the consultation but found that the data provided in the late evidence showed that the decisions in Phase 1 would have no material effect on Phase 2. He said this at paragraphs 25 and 26 of his judgment:

> "25. The conclusions I have reached thus far should not be taken to signify that I personally approve of the decision to split this consultation. It was said that the reason it was done in this way was because of the urgency of the matters covered by phase 1. But they were not urgent. The obstetric unit had already been closed, albeit temporarily. The number of Level 3 critical care and stroke victims was tiny compared to overall activity. And in any event, it proposed that phase 2 should follow very shortly after phase 1 – the papers mention the consultation for phase 2 beginning in April 2017. Miss Morris QC argued that to leave the obstetric unit temporarily closed without a definitive decision was bad for morale, but that was mere assertion and did not, in my opinion, justify taking the risks in splitting which I have mentioned above.
>
> 26. I can well see why in the absence of hard data the claimants and the interested party would assert that as a matter of principle decisions made following phase 1 would queer the pitch when the phase 2 consultation came around. However, as I have demonstrated, the hard data shows quite clearly that the decisions on the very small number of cases involved will have no material effect on the scope of the phase 2 consultation. It is a mystery to me why that data was not supplied sooner."

39. Before the judge, however, the concern as to the splitting of the consultation arose principally in relation to issues other than bed closure, i.e. obstetrics and gynaecology, anaesthetics and accident and emergency. The preceding passage of the judge's judgment (paragraphs 17-24) shows this and indicates that in the judge's mind the new evidence related largely (if not exclusively) to these other issues. It dispelled his initial anxieties as to the split in the consultation phases.

40. Ground 1 attacks the splitting of the consultation on the basis that the judge failed to consider it at all in relation to the specific issue of bed closures. It might have been better if the judge had specifically addressed that question in his judgment. However, as I see it, he saw other issues as far more material to the wider challenge that was before him on this point. Looking at the issue in the light of all the material to which our attention was drawn, I think he was right to do so.

46. As already mentioned, Mostyn J admitted into evidence, at a very late stage in his hearing, the additional witness statement of Mr David Smith of the CCG, supplying the more detailed data which opponents to its proposals had been seeking for a considerable time. As the judge noted, it was a mystery to him why it had not been supplied earlier.

47. We were told that the statement (dated 6 December 2017) was submitted, without prior warning to other parties, at about 3 p.m. on the second day of the hearing, Thursday, 7 December 2017. In the face of objection from the claimants and the present appellant, the judge made his decision to admit the statement, but he allowed those parties to file evidence and argument in response (which they did on Monday 11 December). There was no application for an adjournment.

48. Ms Broadfoot informed us, however, that the judge told the parties, perhaps unwisely, that he planned to begin writing his judgment on the Friday (8 December) and, we were told, a draft of the judgment was supplied to the parties on Tuesday, 12 December. The perception of hasty acceptance of the new material created in this way was perhaps unfortunate.

49. The manner in which this late material was produced was clearly highly unsatisfactory and, if it was to be admitted, the other parties had to be given the opportunity to make an adequate response. If an adjournment for that purpose had been sought, it seems to me that it would have been irresistible. However, no such application was made.

50. Ms Broadfoot submitted that the new evidence was an important feature in the judge reaching the decision that he did, as was shown by his statement in paragraph 25 of the judgment that he was not to be taken as personally approving the decision to split the consultation. She argued that it was what judge saw to be the "hard data" in the new statement that prevented the opponents of the proposals succeeding in their challenge based upon the phasing arrangement.

51. It seems to me, however, that the failure to seek an adjournment when this new material was presented is fatal to this ground of appeal. A focussed request for more time to respond and, perhaps, for a re-convening of the hearing when the response had been prepared would have carried weight. As it is, the judge gave time for a response and there is no indication in the responses that more might have been forthcoming if more time had been allowed. Further, the material advanced on each side was not bulky and the judge would have had time to digest what had been submitted, at a time when he was immersed in the detail of the case and before circulating his draft judgment on Tuesday, 12 December.

52. Moreover, as already mentioned, the new evidence did not address further the bed closure proposals to any great extent: for example, there was one paragraph in Dr Fisher's response statement, on behalf of the appellant, touching directly on the question to which Ms Morris drew our attention.

53. As I have said, I would reject ground 4.

54. I would add that on the morning of the hearing of the appeal, the CCG again presented last minute evidence, in a witness statement and exhibit dated 13 March 2019, which was said to be directed to "bringing matters up to date" and might be relevant to any relief to be granted if the appeal were successful. This new statement too seems to have

of appropriate community facilities and care would be dealt with in Phase 2, identifying in that context community hospitals, including MLUs, and the development of primary care, including GPs, nurses, healthcare assistants, community nurses and other clinicians.

65. The DMBC stated that: "The decision to split the Oxfordshire Transformation Programme into ... two phases was taken based on advice from the Joint Health Overview and Scrutiny Committee ("JHOSC")". Nevertheless, in view of the interdependency between the merit or otherwise of bed closures and the provision of community facilities, it was entirely logical for Ms Samantha Broadfoot QC, for the appellant, to submit that either the consultation should have dealt with everything at one and the same time or, alternatively, the decision as to what to do about the closure of hospital beds should await the outcome of the consultation on Phase 2. She was also correct to highlight that the Judge did not expressly address in his judgment the issue of the absence of that interdependency in the consultation.

66. As Lord Justice McCombe has emphasised, however, and indeed was common ground before us, the consultation will only have been unlawful if, in the actual circumstances of the case, including the statutory context, it was unfair: *R (Moseley) v Haringey LBC* [2014] UKSC 56, [2014] 1 WLR 3947. The mere fact that it was not perfect or could have been improved is not enough to make the consultation unlawful if, in all the circumstances, it provided a fair opportunity for those to whom the consultation was directed adequately to address the issue in question.

67. In the circumstances of the present case, there are several reasons why the consultation was sufficiently fair to have been lawful.

68. Firstly, it was obvious and inevitable that the issue of whether there was appropriate and sufficient community care to counter the consequences of the bed closures was bound to be a concern of consultees and would be addressed by them. That was reflected in Q4 of the consultation survey, mentioned below.

69. Secondly, the consultation document said that consultees could read more about the vision for healthcare services in Oxfordshire in the Transformation Programme Pre-Consultation Business case on the website, the address of which was given.

70. Thirdly, Q4 of the consultation survey asked the specific question (at (e)) whether: "Too many people are admitted to hospital in the first place when they could have been assessed, treated and supported at home or in community settings such as a community hospital, care home or at home".

71. Fourthly, it is clear that consultees did in fact express their concerns about the adequacy of community services. There were various different ways in which members of the public, including patients, were engaged in the consultation, including events and meetings of various kinds, Qa Research Consultancy ("Qa Research") prepared a report analysing for the CCG the responses that were made, totalling some 9248 letters and emails from individual members of the public. The Qa Research report said that: "Uncertainty and a lack of confidence was expressed as to whether the new model of provision of out-of-hospital support would actually work and some people suggested it was high-risk to close hospital beds until it has been further proven" and "There was significant interest in ensuring the adequate provision of intermediate care beds. People

77. It is to be noted that, when the JHOSC wrote to the Secretary of State on 30 August 2017 seeking a review, it limited its request to a review of the decision of the CCG permanently to close consultant-led maternity services at HGH. It made no complaint about the failure to consult on satisfaction of NHS England's new bed test.

Appeal ground 4

78. I have nothing to add to what Lord Justice McCombe has said on this ground of appeal.