Neutral Citation Number: [2020] EWCA Civ 46

Case No: C1/2019/1974

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM QUEEN'S BENCH DIVISION, ADMINISTRATIVE COURT
His Honour Judge Mark Raeside QC
CO/1968/2018

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 28/01/2020

Before:

PRESIDENT OF THE FAMILY DIVISION
LORD JUSTICE PETER JACKSON
and
LADY JUSTICE NICOLA DAVIES DBE

- -

Between:

THE QUEEN on the application of RACHEL NETTLESHIP	**Appellant**
- and -	
(1) NHS SOUTH TYNESIDE CLINICAL COMMISSIONING GROUP **(2) NHS SUNDERLAND CLINICAL COMMISSIONING GROUP**	**Respondents**

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Vikram Sachdeva QC and Annabel Lee (instructed by **Irwin Mitchell LLP**) for the **Appellant**
Eleanor Grey QC and Adam Fullwood (instructed by **Capsticks LLP**) for the **Respondent**

Hearing date: 19 November 2019

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Approved Judgment

Lady Justice Nicola Davies:

1. In proceedings for judicial review the appellant seeks a declaration that the decision of 21 February 2018 ("the Decision") taken by NHS South Tyneside Clinical Commissioning Group and NHS Sunderland Clinical Commissioning Group ("the CCGs") to reconfigure certain hospital services (stroke, obstetrics and gynaecology and paediatric services) such that they would continue only at the Sunderland Royal Hospital ("SRH") and not at the South Tyneside District Hospital ("STDH") was unlawful and should be quashed. On 23 July 2019 HHJ Mark Raeside QC dismissed the appellant's claim on the seven grounds before the court. Four grounds of appeal are raised by the appellant, permission to appeal was granted by Lindblom LJ on 10 September 2019.

2. The appellant is a resident of South Tyneside and daughter of the unofficial chair of the Save South Tyneside Hospital campaign group, Roger Nettleship. The appellant, her father, together with other members of the local community, have provided witness statements setting out the opposition to the reconfiguration. The population encompassed within South Tyneside Clinical Commissioning Group is 152,000. Life expectancy in the South Tyneside area is considerably beneath the national average, with levels of health and underlining risk factors being some of the worst in the country. Levels of smoking, consumption of alcohol and obesity leading to cancer and heart disease are among the highest causes of death. The appellant contends that local hospital services are particularly important to such a population. The campaign group's petition to retain consultant-led services at STDH received between 30,000 and 40,000 signatures.

3. The respondents are CCGs who are the relevant commissioners of a range of acute and community NHS healthcare services. Their core statutory duties are set out in section 3(1) of the National Health Service Act 2006 ("the 2006 Act"). Pursuant to those provisions the legal duty of the CCGs is to arrange for the provision of such services "to the extent it considers necessary to meet the reasonable requirements of the persons for whom they have responsibility".

4. Pursuant to section 14Z2(2) of the 2006 Act the respondents are obliged to involve persons who are or might be provided with the services, it states:

> "(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."

5. Pursuant to section 14Z2(5) of the 2006 Act, all CCGs must have regard to the guidance published by NHS England in respect of the process of reconfiguration of health services. This is set out in "Planning, assuring and delivering a service change for patients: A good practice guide for commissioners on the NHS England assurance process for major service changes and reconfigurations" ("the Service Change Guidance"). Further, relevant guidance is available from NHS England in "Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups in NHS England (2017)" ("the Participation Guidance").

6. The Service Change Guidance prescribes a six-stage process commencing with the identification of the need for service reconfiguration through to implementation. The stages are:

   i) discussion;

   ii) proposal;

   iii) assurance;

   iv) consultation, public consultation may not be required in every case;

   v) decision;

   vi) implementation.

Background

7. In 2016 the respondents established the Path to Excellence Programme in order to review and plan the future of hospital services at STDH and SRH. It aimed to address three care gaps outlined in the NHS Five-Year Forward View: health and wellbeing; care and quality; finance and efficiency. The aim of the programme was to undertake a full review of hospital services at both hospitals. However, due to the substantial pressures facing stroke, obstetrics and gynaecology and paediatric emergency services it was decided that phase one of the programme would deal with those areas as a priority. It is the respondents' case that the programme had been clear from the outset: services could not be retained in their current form. This was consistent with national strategies for change taking place across the NHS and was in response to particular issues faced by the two hospitals.

The Issues Paper – November 2016

8. The first step in the process leading towards the consultation was a pre-engagement listening phase. The respondents published an Issues Paper which identified the challenge facing local health services and the proposals for change. It provided information as to the steps being taken at that stage. The document was published on

websites and was available to the public. A series of engagement events were held relating to the content of the paper.

9. The identified purpose of the programme was to secure safe and sustainable NHS services in the future. Identified problems included the recruitment of staff in key clinical specialities, the impact of a failure to recruit on patient clinical care, recognition of the financial challenges which the NHS faced and the fact that the best use of staff expertise and other resources was not being made. In the first section of the Paper entitled "Why things cannot stay as they are" it was stated that the quality of care received by people in the area could vary. It identified growing demands upon the NHS which resulted in financial pressure on local organisations at a level never before seen. It acknowledged that the needs and expectations of the public were changing, that different and more complex care was required and that local health services needed to change in order to produce a more effective and efficient local health service. Duplication of services and system pressures were identified as particular problems. The gaps in the provision of care as highlighted in the National Five-Year Forward View Plans which include ensuring quality of care, seven day working, access targets, local sustainability, artificial mass concerns, workforce issues and the "financial picture" were identified.

10. The pressures facing each of the identified three services were set out in the Issues Paper as follows:

> "A Stroke services: there had been a serious inability to recruit sufficient consultant numbers. In October 2016 this led to the temporary relocation of patient stroke services from STDH to SRH. The specific reason being the inability to recruit sufficient consultant numbers and the ability to recruit a full-time stroke consultant for more than two years, leaving a single part-time consultant covering the service and little prospect of recruitment.
>
> B Obstetrics and gynaecology: staffing issues led to the closure of the special baby care unit at STDH and maternity services in December 2017 and January 2018.
>
> C Emergency paediatric care: difficulties in recruiting and maintaining a sufficiency of senior doctors to provide the emergency care services at South Tyneside 24/7."

The Pre-Consultation Business Case ("PCBC") – 28 June 2017

11. This was published by the respondents and was available online. This represented phase 1(a) of the Path to Excellence Programme. It describes the potential options for future services reconfiguration. The aims sought were to improve stroke clinical outcomes, to strengthen the safety and quality of maternity care, to ensure the right balance of locally accessible and specialist paediatric care and to produce more sustainable workforce models to retain the services as locally as possible for the longer term.

12. The document stated that clinically-led design teams had developed potential options for change as part of the service review programme overseen by both CCGs and hospital clinical and non-clinical leaders. A minimum of two potential options for each of the three services had been developed and agreed to be subject to a formal consultation. Each set included one option to develop single-site services at SRH and each included one option to retain appropriate safe service delivery at STDH in order to maximise patient choices.

13. The options contained within the PCBC were taken from a longer list of options which had been reviewed by design groups in the clinical service reviews. The clinical design process was described at Appendix 5.1 of the document, hurdle criteria were used in order to reduce the list of options. The hurdle criteria were set out as:

    i) support sustainability/service resilience;

    ii) will it deliver high quality care;

    iii) will it be affordable;

    iv) will it be deliverable within the next one/two years?

14. As a result of the application of the hurdle criteria the options were reduced and the retention of the option of consultant-led services at STDH was discarded. Not included within the PCBC was the table setting out the original list of options, the CCGs' evaluation of how each option was to be evaluated against the hurdle criteria and the evidence relied upon in concluding which of the options was to go forward. Prior to these proceedings neither the appellant nor members of the campaign group requested the further information as to the evaluation process which was not included in the PCBC.

NHS England Assurance – 20 April 2017

15. The Service Change Guidance mandates that the consultation process could not proceed until the CCGs receive an Assurance from the NHS that the process thus far was in accordance with the Service Change Guidance. NHS England seek compliance with the tests for service change (set out in the guidance), which are:

    i) strong public and patient engagement;

    ii) consistency with current and prospective need for patient choice;

    iii) a clear, clinical evidence base;

    iv) support for proposals from clinical commissioners.

16. NHS England declared itself satisfied that the process thus far had complied with the Service Change Guidance and could proceed to the next stage. Criticism was made of the process, directed at the linguistic incomprehensiveness of the PCBC and the failure of the respondents to make public the list of options prior to the establishment of the shortlist. However, NHS England were assured that the process had complied with the guidance and the four identified tests and could proceed to the consultation.

Formal Public Consultation – 5 July to 15 October 2017

17. A Public Consultation document was published by the CCGs, distributed to the public and was available online. Within the document links were provided to the Issues Paper and the PCBC together with supporting documents. The document stated that it would provide details of current services, the challenges faced and potential ways that services could be rearranged in the future. The specific challenges identified included the shortage of consultants to provide out of hours cover, the need to improve quality and performance nationally, modernising and reforming services in line with local and national strategies, the needs of individuals and the communities. The particular challenges relating to stroke, obstetrics and gynaecology, and urgent and emergency paediatric hospital services were identified as including recruitment challenges due to current service arrangements, often unattractive to potential new staff, an inability to improve long-term clinical quality and hit key clinical standards due to smaller patient numbers, insufficient medical staff at the correct level resulting in reliance on expensive locum doctors, difficulties in implementing improvements set out in the relevant national strategies.

18. Identified was the need to adapt and change the way things were done in order to create a better future for the NHS. The aim was to work together to develop plans for better quality care and meet key quality standards while at the same time recognising the need to be as efficient as possible. In a user-friendly document statistics were set out in an accessible manner, accompanied by diagrams, drawings and photographs.

19. One section was headed "Why doing nothing is not an option". It stated:

> "The 'do nothing' option was discounted as this would not lead to improvements in the service, particularly in relation to staffing shortages and the limited number of specialist medical trainees as this problem exists on a national level. Nor did we consider discontinuing these valuable services as the team are focused on finding a local sustainable solution that would best serve the population of South Tyneside and Sunderland."

20. The proposed options were set out, as were the impacts of the same:

    i) Stroke services: three options were identified which involved the combining of all hyper acute and acute stroke care at SRH and therefore the closure of stroke services as STDH.

    ii) Obstetrics and gynaecology: two options were presented, both involved the closure of the consultant-led maternity unit at STDH. The choice offered was as to the development of a free-standing midwifery-led unit at STDH.

    iii) Paediatrics: two options were presented, both involving the downgrading of STDH's 24/7 paediatric emergency department. The choice presented was whether there should be a 12-hour paediatric emergency department at STDH, with a 24-hour paediatric emergency department at SRH to be implemented in the short term as a transitional step to the other option, which was a 12-hour nurse-led paediatric minor injury or illness service at STDH with a 24-hour emergency paediatric service at SRH.

Consultation Feedback Analysis Report – 5 December 2017

21. Not strictly required by the Service Change Guidance, the respondents took the further step of commissioning and publishing a Feedback Analysis Report which was conducted by an independent review body. The report expressed concerns that all the shortlisted options resulted in a downgrading of services and facilities at STDH, serious concerns as to the issues of travel time between South Tyneside and Sunderland for both those with cars and using public transport, equality concerns as to people living in deprived circumstances being disadvantaged in terms of access, and the ability of ambulance services to provide a safe and timely transfer of South Tyneside residents to Sunderland.

The Decision-Making Document – 21 February 2018

22. This document reported on the public consultation process. Feedback had been received from many sources including clinical service review groups and the public. Insofar as the public were consulted there had been 805 interviews on a street survey, 409 responses online, 324 responses by direct email and 19 public meetings which had received 443 participants when taken together with telephone submissions.

23. The feedback received was considered and the conclusion reached was that the evidence indicated that the need for change of the current services was unavoidable and compelling.

24. The Decision proposed the following reconfiguration of local health services:

> "A Stroke services: relocate all acute stroke services from STDH to SRH and to deliver all inpatient stroke care at the latter hospital. Discharge to local community stroke teams who would provide any further rehabilitation and support locally.
>
> B Obstetrics and gynaecology: to close the medically led obstetric unit at STDH and to develop a midwifery-led unit; SRH would be the location for the medically-led obstetric unit.
>
> C Emergency paediatric services: option 1 (a 12-hour daytime paediatric emergency department at STDH with a 24-hour paediatric emergency department at SRH) to be implemented in the short-term as a transitional step to option 2. Option 2 was a nurse-led paediatric minor injury and illness facility open from 8am to 10pm at STDH and a 24/7 emergency paediatric service at SRH. The implementation of option 2 was to include an independent external review group to review the transition and to proceed at an appropriate pace over the medium-term with likely completion by 2021."

25. The CCGs have commenced the proposed reconfiguration.

The common law

26. There is no authority on the duty identified in section 14Z2(2) of the 2006 Act. It is accepted by the appellant and respondents that the common law applies and requires

application of the principles set out in *R v Brent London Borough Council, Ex parte Gunning* (1985) 84 LGR 168 which are that:

i) consultation must be at a time when proposals are still at a formative stage;

ii) the proposer must give sufficient reasons for any proposal to permit of intelligent consideration and response;

iii) adequate time must be given for consideration and response; and

iv) the product of consultation must be conscientiously taken into account in finalising any statutory proposals.

27. In *R (Moseley) v Haringey London Borough Council* [2014] 1 WLR 3947 Lord Wilson expressly endorsed the four principles set out in the authority of *Gunning*. At [24] he advanced two purposes of the duty to consult, taken from the judgment of Lord Reed in *R (Osborn) v Parole Board* [2014] AC 1115 namely:

i) the requirement "is liable to result in better decisions, by ensuring that the decision-maker receives all relevant information and that it is properly tested";

ii) it avoids "the sense of injustice which the person who is the subject of the decision will otherwise feel".

Lord Wilson added a third, namely that the duty is to be "reflective of the democratic principle at the heart of our society".

28. At [25] the judgment of Lord Woolf MR in *R v North and East Devon Health Authority, ex parte Coughlan* [2001] QB 213 at [112] was cited which states:

> "It has to be remembered that consultation is not litigation: the consulting authority is not required to publicise every submission it receives or (absent some statutory obligation) to disclose all its advice. Its obligation is to let those who have a potential interest in the subject matter know in clear terms 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. The obligation, although it may be quite onerous, goes no further than this."

At [26] two further general points were identified from the authorities, namely the degree of specificity with which, in fairness, the public authority should conduct its consultation exercise may be influenced by the identity of those whom it is consulting and secondly that:

> "…the demands of fairness are likely to be somewhat higher when an authority contemplates depriving someone of an existing benefit or advantage than when the claimant is a bare applicant for a future benefit."

At [27] Lord Wilson stated:

> "Sometimes, particularly when statute does not limit the subject of the requisite consultation to the preferred option, fairness will require that interested persons be consulted not only upon the preferred option but also upon arguable yet discarded alternative options. …"

At [28] Lord Wilson stated that:

> "…even when the subject of the requisite consultation is limited to the preferred option, fairness may nevertheless require passing reference to be made to arguable yet discarded alternative options. …"

In referencing earlier authorities, Lord Wilson identified the proposition that "a decision-maker may properly decide to present his preferred options in the consultation document, provided it is clear what the other options are".

The judgment of the Administrative Court

29. In dismissing the appellant's challenge the judge considered the various steps in the consultation. He begins with the Issues Paper:

> "The NHS Sunderland and South Tyneside Clinical Commissioning Groups undertook a listening process. This was entirely transparent and any objective reader of the Issues Paper which at the relevant time included members of the public and patients could not have thought other than this was a genuine wish to hear what they had to say but on the understanding that doing nothing was not an option. Precisely what was to be done was entirely open and without any premeditated decision or limitation on the options available."

30. The judge "could see no case whatsoever of a lack of involvement provided to the public at a formative stage or any insufficiency of information to the public": [101]. He found that the Issues Paper was deemed to provide sufficient information to enable members of the public generally to give intelligent consideration and response: [101].

31. The judge was satisfied that the PCBC fully appreciated the need for public involvement and sufficiently provided the public with what was of necessity an overview of the clinical design process which had been adopted. As to the use of the hurdle criteria the judge was satisfied that the public was still fully involved, no final view had been formed, but options were starting to crystallise. The judge accepted at [103] that "it may have been better to include that table (citing the long list of options) or similar evidence of the time so the public could appreciate that the do nothing option has in fact been considered and rejected for perfectly cogent reasons from the perspective of the clinical teams". However, he was not satisfied that there was any lack of transparency nor that it would have made any difference at all: [103].

32. As to the final Decision the judge was satisfied that it properly, fully and fairly set out the entire background of the public consultation process which he found both transparent and carried out with integrity: [107]. He found that throughout the

process there had been constant interaction with the public to deal with concerns, he identified the real complaint made on behalf of the appellant's group was that they fundamentally opposed any reorganisation which would result in the downgrading of STDH: [107]. He concluded that it was an understandable complaint but did not provide the basis for judicial review.

Grounds of appeal

Ground 1

33. The Decision breached section 14Z2(2) of the 2006 Act and/or followed an unlawful consultation process contrary to the first *Gunning* principle and/or breached the principle of procedural fairness and/or were tainted by predetermination. Since the key decisions concerning the future of STDH had been taken in committee, and the options chosen for consultation merely differed in matters of detail, on the unusual facts of this case, compliance with the duty of public involvement and consultation under section 14Z2(2) of the 2006 Act meant that, as a matter of law, the respondents were required to consult on the "retain services" option.

34. It is the appellant's contention that in order for the duty to consult at a formative stage criterion to be met, the consultation needed to have taken place before the "retain services" option had been discarded. If it was permissible for the most controversial aspect of a reorganisation of NHS service, which the appellant submits to be the decision to remove key services from STDH, to be decided in committee and for the consultation to be restricted to the less controversial consequential questions, that renders the statutory right meaningless.

35. The judge's conclusion that an objective reader would conclude that the CCGs retained an open mind about the options was wrong, it conflicts with his conclusion that the CCGs were entitled not to consult or provide information about options which they considered were not viable or feasible.

36. The judge failed to grapple with the fundamental legal issue of this case, namely whether this was an example, as identified in *Moseley*, of requiring consultation upon an initially arguable but discarded option. The judge admitted that it would have been better had the respondents included the information attached to the letter before claim in the consultation.

Ground 2

37. The Decision breached section 14Z2(2) of the 2006 Act and/or followed an unlawful consultation process contrary to the second *Gunning* principle. Given the central importance of the decisions taken behind closed doors in committee, even if the respondents were not obliged to consult on the "retain services" option, they were obliged as a matter of law to explain why they had rejected the "retain services" option, giving sufficient information to enable an intelligent member of the public to comment on the decision that the "retain services" option was not viable.

38. The appellant submits that the only relevant information at the formal consultation stage provided by the respondents as to their decision to jettison the option to "retain services" was that provided in Appendix 5.1 of the PCBC. This gave only a general

description of the process of achieving the shortlist rather than information which would allow intelligent comment on the decision not to proceed with the "retain services" option. The options which were said to pass the hurdle criteria did not pass all of them.

39. Insufficient information was provided to allow for intelligent comment and response and thus amounted to a breach of the second *Gunning* principle. What is required will vary greatly on the context of the consultation, this is particularly relevant to the population of South Tyneside given that the proposals resulted in the absence of a consultant-led service at their local hospital.

Ground 3

40. The Decision was *Wednesbury* irrational. The decision to consult on the three options put forward was irrational, for none of them met the "financial sustainability" driver for change, and if none of the options was financially sustainable, it was arbitrary and irrational to exclude the "retain services" option on financial sustainability grounds.

41. It is contended that the two main drivers for service change were a failure to recruit medical and nursing staff and financial difficulties. The reconfiguration Decision is said to be irrational for "plainly failing to meet both objectives". The respondents accepted that the changes were cost neutral to the commissioners, further, no attempt was made to explore the possibility of increased recruitment efforts which a rational public authority would have done before imposing cuts on services.

Ground 4

42. The respondents unlawfully failed to reconsider the Decision in the light of two significant and material changes in circumstances announced by the Government:

    i) On 15 June 2018 the Government announced the removal of doctors and nurses from the immigration cap for skilled worker visas, in order to respond to "the particular shortages and pressures facing the NHS at the current time". This means there will no longer be a cap on the number of doctors and nurses who can be employed through the Tier 2 visa route;

    ii) On 17 June 2018, the Government announced £20 billion in additional funding for the NHS. This has been estimated to mean an average of 3.4 per cent real increase in funding for the NHS over the next five years.

43. The appellant contends that the announcements served to materially alter the two main drivers for service configuration, thus rendering a failure to reconsider the original Decision irrational. The appellant accepts that there is no duty to re-consult unless there is a "fundamental difference" that has arisen owing to the change in circumstances.

The respondents' submissions

Ground 1

44. The respondents rely upon the witness statements of Dr David Hambleton, the Chief Executive of NHS South Tyneside Clinical Commissioning Group. Dr Hambleton

had responsibility for the process which led to the Decision. In his witness statements he sets out the background, the thinking behind and the detail of the process.

45. The essence of the respondents' case is they undertook a lengthy and full engagement exercise which culminated in the formal consultation process during which the preferred options for change were put forward. There was no breach of section 14Z2(2) of the 2006 Act. The legal obligation was to involve, including by way of consultation if appropriate, the public in the "development and considerations of proposals by the group for changes" (section 14Z2(2)(b)), this is what the respondents did. There was no obligation to put forward the "retain services" option given that such an option was not one of the respondents' proposals for change.

46. The engagement process followed the applicable statutory guidance from the NHS. The appellant's suggested approach would have contravened the approach set out in the Service Change Guidance by including unviable and unrealistic options among the proposals. There was no legal obligation to include in the PCBC or otherwise put forward unfeasible proposals as part of the consultation exercise.

47. The common law has affirmed that where shortlisted options are based upon careful analysis by specialists working in the relevant areas, which are properly considered by the decision-maker, it is open to them to decide if they were the appropriate options: *R (WX) v Northamptonshire County Council* [2018] EWHC 2178 (Admin) at [67]. In *R (Kidderminster and District Community Health Council) v Worcester Health Authority* [1999] EWCA Civ 152 Simon Brown LJ, in expressly rejecting a submission that a decision by a health commissioner to proceed to consultation with its preferred and only option was unlawful, stated:

> "If, as is clearly established (and is, in any event, only plain common sense) an authority can go out to consultation upon its preferred option, per O'Connor LJ, or with regard to 'a course it would seek to adopt if after consultation it had decided that that is the proper course to adopt' per Woolf J, then it seems to me plain that it can chose not to consult upon the less preferred options. It does not, in other words, have to consult on all possible options merely because at some point they were developed, crystallised, canvassed and considered."

Ground 2

48. Proper and sufficient information was provided to the public throughout the engagement process, including at the formal consultation stage, about the need for change and why the retention of services option was not a sustainable option. As to the provision of information relating to the discarding of the "retain services" option and the creation of the shortlist of options, the PCBC provides a full explanation as to why retaining the existing services at STDH were not feasible. It explained how clinically-led teams comprising clinicians in each relevant service area from both hospital sites developed the proposals which included, at Appendix 5.1 that "[e]ach group developed a long list of potential scenarios, including the 'do nothing' configuration, which were then assessed against a set of hurdle criteria." It explained the process that was followed and that the "do nothing" options had been appraised and rejected;

49. Throughout the pre-consultation process, and during the consultation process, those affected by the proposals could have sought further information about the "retain services" option. They did not.

Ground 3

50. The respondents rely upon the fact that the proposals were supported by NHS England through its assurance process and by the expert clinical groups consulted. Following the respondents' Decision, the proposals were supported by the Secretary of State for Health and the Independent Reconfiguration Panel, following referral to the Secretary of State.

51. The respondents weighed the limited financial benefits to be secured by change against the improvements to patients' safety, quality and sustainability. Their primary concern was to secure improved services. It was in that context that, as the NHS England assurance letter put it, the changes would be cost-neutral to the commissioners. The service providers would reduce their costs. There was no requirement for external capital funding. The judgement upon risks as against anticipated benefits was one for the respondents to make, it was not *Wednesbury* irrational.

Ground 4

52. There was no fundamental change of circumstances as a result of the announcements identified in [42] above. Efforts had been made to recruit and retain staff but these had not been successful "due largely to the fact that these roles are not an attractive option for prospective candidates". As was noted in the PCBC, recruitment to small teams such as that at STDH can be a problem as, for example, consultants often wish to work in large teams which offer them a number of opportunities to participate in wide-ranging aspects of their chosen discipline. Small teams can lead to onerous and unstable on-call rotas, the relatively small number of patients treated at STDH can result in clinicians being unable to maintain and develop their clinical skills. It was such considerations which led Dr Hambleton to conclude that "unfortunately, STDH remains an unattractive option for doctors, and there is no evidence that the visa cap has been a significant cause of recruitment problems or that the hospital is anticipating any significant changes as a result of the lifting of the Tier 2 cap".

53. As to the increased funding announcement, Dr Hambleton's statements provide the following response:

> "Whilst the CCGs welcome this announcement, it has not as yet resulted in any additional money becoming available to support services in Sunderland and South Tyneside. The announcement made clear that the details of how additional funding would be made available would need to be determined by the Treasury, and that some of the extra funding will come from the money the government will no longer spend on the annual membership subscription to the European Union after Britain has left the EU which is not due to take place until March 2019. Given the urgency of the need to stabilise the fragile services that were the subject of the phase 1 proposals,

> any additional funding will unfortunately not provide an immediate solution."

Discussion and conclusion

54. It is clear from the documentation that the process upon which the respondents embarked, which led to the Decision of 21 February 2018, was driven by a need to change the provision of clinical services, not only to benefit the local population but to deliver a programme which would be consistent with national strategies. From the outset the programme was clear: services could not be retained in their current form. Such an aim was consistent with national strategies for change taking place across the NHS and was in response to particular issues at SRH and STDH. It is also clear that the respondents were mindful of their statutory duty and the relevant guidance which brought with it a duty to involve the public at each stage of the relevant consultation.

55. The details of identified problems were set out in the Issues Paper ([8]-[10] above). Of note is the first section of the Issues Paper entitled "Why things cannot stay as they are". No one accessing this user-friendly document could have been in doubt as to the nature and scale of the problems and the need for change.

56. As to the need for change, the words of section 14Z2(2)(b) of the 2006 Act are significant in that they tie the statutory duty to "involve" to the development and consideration "of proposals by the group for changes". Upon a straightforward reading of this section it is clear that it does not impose a duty to consult on options which the CCGs deem to be unviable, unrealistic or unsustainable as they do not represent proposals for change. Further, such an interpretation of section 14Z2(2)(b) is consistent with the guidance contained in the Service Change Guidance which, pursuant to section 14Z2(5) of the 2006 Act, the CCGs *must* have regard to. Page 25 of the guidance states:

> "[T]here is no requirement, and it would be misleading, to consult on adopting options which are not genuinely under consideration, or are unrealistic or unviable – but it may be necessary to provide some information about arguable alternatives."

57. The same principle is reflected in the Participation Guidance at page 25:

> "Meaningful consultation cannot take place on a decision that has already been made. Decision makers can consult on a single option or a 'preferred option' … so long as they are genuinely open to influence. There is no requirement, and it would be positively misleading, to consult on adopting options which are not genuinely under consideration or are unrealistic or unviable – but it may be necessary to provide some information about arguable alternatives."

58. This guidance is also consistent with the common law authority of *R (Kidderminster and District Community Health Council) v Worcester Health Authority* [1999] EWCA Civ 152.

59. In my judgment the words of section 14Z2(2)(b), coupled with the statutory guidance, result in a duty upon CCGs to consult only on options which represent genuine proposals for change. I do not accept the submission made by counsel on behalf of the appellant that the natural language of section 14Z2(2)(b) "involved the duty to consult on everything that is not literally impossible". He submitted that, in the absence of literal impossibility subsection (2)(b) mandates that the status quo (retention of services options) be part of the consultation. I find that this does not accord with the wording of 14Z2(2)(b) and it conflicts with the statutory guidance.

60. I do not accept the appellant's contention that the facts of this case come within the ambit of [27] of the judgment of Lord Wilson in *R v Moseley* ([28] above). In this case the statute **did** limit the subject of the required consultation to realistic and viable options. That being so, [28] of Lord Wilson's judgment is relevant, namely that fairness requires passing references be made to arguable yet discarded options.

61. The Issues Paper and the PCBC refer to the "retain services" option. In the PCBC, Appendix 5.1 described the clinical design process and the hurdle criteria which were used in order to reduce the list of options. I agree with the judge that it would have been preferable for the longer list of options to have been included in the PCBC but I am satisfied that sufficient reference was made to the "retain services" option to meet a standard of fairness which required no more than passing reference to arguable yet discarded alternative options.

62. The Issues Paper and the PCBC could also be accessed by means of an electronic link in the later Public Consultation Document. Within the Public Consultation Document is the section identified at [19] above, namely "Why doing nothing is not an option", which is the clearest of references to the "retain services" option.

63. I am satisfied that there was sufficient reference to the "retain services" option within the public documents produced at different stages of this process. The local public were well aware of this option as it represented the status quo. If it was felt that insufficient information relating to this option had been made publicly available then more could have been requested. This was not done.

Grounds 1 and 2

64. For the reasons given, I find that pursuant to the provisions of section 14Z2(2) of the 2006 Act the respondents were not under a statutory duty to consult upon the "retain services" option.

65. As to the options which the CCGs considered viable, the consultation process followed that required of them by the statutory framework and in the statutory guidance, in fact the respondents did more than was formally required. At each stage there was genuine engagement with the public and reasons were given as to why the retention of services option was not viable. The CCGs provided sufficient information in the published documents produced during the consultation process, together with the opportunities which the appellant and the broader public had to engage with the process, to allow for intelligent comment and response.

Ground 3

66. In conducting the consultation process and considering service change the respondents' primary concern was not to reduce costs but to secure improved services. It was in that context that the changes were described as being cost-neutral, there was no requirement for external capital funding. The respondents' decisions represented judgments arrived at in carrying out a balancing exercise as between identified risks as against anticipated benefits. There are no grounds upon which to find that the decisions made were *Wednesbury* irrational.

Ground 4

67. The two changes announced by the Government do not amount to a fundamental difference in the context of this case. The visa regime was not the root cause of STDH's failure to adequately recruit, the problem was more deeply rooted in difficulties in attracting qualified individuals at the requisite level to a hospital which could not offer a sufficient breadth of experience or sufficiently large teams. Further, the funding difficulties of STDH would not immediately be rectified by the Government's nationwide announcement to provide additional funding to the NHS. Neither of the changes serve to fundamentally alter the assumptions upon which the Decision was made and provide no basis upon which to mandate a remaking of the Decision.

68. Accordingly, and for the reasons given, I would dismiss the four grounds of appeal.

Lord Justice Peter Jackson:

69. I agree with both judgments.

Sir Andrew McFarlane P:

70. I am in full agreement with the judgment of Lady Justice Nicola Davies and only wish to add the following observations concerning the process adopted by the judge in giving judgment so that the unfortunate procedural consequences that flowed from that process may be avoided in future cases.

71. The oral hearing of the application concluded on 20 December 2018 and on 21 December the judge gave a full extempore judgment. The judgment concluded that the judicial review application was dismissed, however no final order was made at that time. The final order was not issued until 23 July 2019 and it was only after that date that the judge was prepared to consider the appellant's application for permission to appeal. Once the order had been made the appellant was only then able to approach this court for permission to appeal. The respondent CCGs had, however, taken the decision announced by the judge in December 2018 at the conclusion of the judicial review process and, thereafter, it proceeded to implement the disputed changes by closing down provision of services at STDH.

72. This unsatisfactory situation apparently arose from the position taken by the judge which was to hold that, although he had given a full oral judgment in December 2018 and announced his final decision at that time, the case was not concluded until a written version of his judgment had been handed down in the form of an approved

and corrected transcript of the December oral judgment. For reasons of which we are unaware, there was plainly a delay in the process of approving the transcribed judgment so that it was not 'handed down' until 23 July 2019, some seven months after the full oral judgment. We anticipate that the judge may well have had significant difficulties in obtaining a workable transcript or even, as is sometimes the case, having to reconstruct his oral judgment from notes. We are therefore sympathetic to the likelihood that the judge may have had difficulties of this nature, which were outside his control. Whatever the reason may have been, we were told by counsel that the consequence was that, because the judge considered that judgment had not been given until the handing down of the transcribed judgment in July, the court did not issue a final order until July and the court declined to consider the issue of permission to appeal until that date.

73. On 7 February 2019, the appellant wrote to the respondents requesting details of its plans for implementing the service changes. The respondents replied on 14 February 2019 stating that changes would take place in or around June 2019. On 11 April and then again on 23 April, the appellant wrote to the respondents requesting their agreement to postpone implementation pending receipt of the final written judgment and order, and the appellant's application for permission to appeal; on both occasions the respondents refused to postpone implementation.

74. On 30 May 2019 a partial draft judgment was circulated to the parties. On 5 July 2019 the appellant made an application for an interim injunction, seeking to prohibit the respondents and the Sunderland and South Tyneside NHS Foundation Trust from implementing the service changes, pending receipt of the final written judgment and Order.

75. The full draft judgment was circulated to the parties on 11 July 2019, at which time the appellant withdrew her application for interim relief. On 23 July 2019, the final approved judgment was handed down and the Order made. At the start of the written judgment, HHJ Raeside QC apologised for the delay in handing down. He stated that he had belatedly received a transcript, which was of poor quality, and that he therefore had to make several corrections. We are sure that, had he known that providing a written version of his oral judgment would take seven months, the judge would have taken a different course.

76. Whatever the reason for the delay may have been, the situation created by this process was plainly most unsatisfactory with the result that the respondents were able to continue to implement the service changes which were the subject of the appellant's claim, however the appellant was not able to appeal the judge's decision, as she was not in receipt of the final approved judgment and no court order had been issued.

77. The process adopted by the judge, and not effectively challenged by the appellant at the time, did not comply with the Civil Procedure Rules ("CPR"). By CPR, r 40.7(1), "a judgment or order takes effect from the day when it is given or made, or such later date as the court may specify".

78. In *Civil Procedure: Principles of Practice 3rd Edition* (2013) Zuckerman sets out that "while a judgment is valid from the time that it is pronounced by the judge, it still needs to be entered and perfected into a formal document. This is done by drawing

up and sealing the judgment or order (CPR 40.2, CPR 40.3)" [23.20]. Zuckerman then goes on to state, at [23.23]:

> "The principle that a judgment takes effect immediately sits awkwardly with the rule that a court is functus officio only when its judgment has been formally entered and perfected. Until a judgment has been perfected, the court's jurisdiction is not exhausted and the court may recall the judgment or vary it, as described below. It would therefore appear that a judgment takes effect before the matter has been conclusively determined in the sense that the judgment can no longer be recalled."

79. Thus, in *Robinson v Fernsby* [2003] EWCA Civ 1820, Lord Justice May said:

> "[91] If a judgment has not been handed down or delivered, it has not been given. Until it is given, it is of no effect. Granted that there are obvious reasons why it would be unfortunate … for a judge to alter a draft judgment which has been handed to the parties, it remains a draft judgment which, in my view, the judge is at liberty to alter. The jurisdiction to do so is not in doubt."

80. In *MRH Solicitors Ltd v The County Court Sitting at Manchester & Ors* [2015] EWHC 1795 (Admin), Mr Justice Nicol, sitting with Lord Justice Burnett, found that the Recorder in the case under appeal was wrong to think that he had no power to alter a transcript which recorded what he had said in his ex tempore judgment:

> "[26] … it is common practice for a Judge who gives an oral ex tempore judgment to refine it when asked to approve a transcript. Ordinarily, this is limited to tidying up the language, but in principle we see no reason why it may not include more significant changes. In *Day v Harris* [2014] Ch 211 CA, for instance a judge added a passage to the transcript which had not been included in his oral judgment. The Court of Appeal described this as 'unfortunate' because the addition was made long after the trial and it added a finding of fact on a controversial issue. The Court did not suggest that the Judge was disempowered from changing his oral judgment and there would have been no comparable objection to an alteration in the present case. If, as in this case, the order of the Court consequent on the judgment has been sealed, the changes cannot usually alter that order. Otherwise, though, it is a matter for the Judge's discretion as to what changes are appropriate."

81. In *Bath v Escott* [2017] EWHC 1101 (Ch), the applicant claimed that the transcript of the judgment did not accurately set out the oral judgment which the judge had delivered in court. HHJ Matthews found:

> "[6] … the mere fact that the transcript of the judgment, as approved by the judge, and sent to the parties, is in any way different from the reasons actually pronounced by the judge at

> the time of giving judgment, is not wrong in law. Nor does it in itself even give rise to concern. It is an entirely lawful and proper practice for a judge, on receiving a transcript of what was said at the time in giving judgment, to alter that transcript, not only to correct garbled or incorrect transcriptions, spelling and grammatical mistakes, and even matters of style, but also so that the reasons recorded accurately reflect why the judge made the decision that he or she made, even if they were not then properly or fully articulated …
>
> [8] It is clear that a judge who gives reasons for a decision may alter those reasons, indeed sometimes even the decision itself, after having made them known to the parties. So, it has long been the practice for judges to revise transcripts taken of their judgments given in court for the purpose of publication …
>
> [13] What all this means is that, if a judge on later reading the transcript of an oral judgment already delivered considers that what is written there does not accurately represent his or her reasons for the decision, the judge may and indeed should alter it so that it does accurately record the reasons that the judge had for that decision … it does not matter if the approved transcript adds to or differs from the actual words used by the judge at the time of giving judgment. What matters is only that it has been considered, revised if necessary, and then approved by the judge …"

82. In *Re L and B (Children)* [2013] UKSC 8, the Supreme Court found that a judge has the power to alter and reverse a decision at any time before the order is drawn up and sealed, and this power is not limited to cases where there are exceptional circumstances.

83. In *Space Airconditioning plc v Guy and another* [2012] EWCA Civ 1664 at [53]:

> " … if a judgment contains what the judge acknowledges is an error when it is pointed out, the judgment should be corrected, unless there is some very good reason for not doing so. A judgment should be an accurate record of the judge's findings and of the reasons for the decision."

84. Most recently, in *Mazhar v The Lord Chancellor* [2019] EWCA Civ 1558, this court [Master of the Rolls, Singh and Baker LJJ] held that it is the substance that determines the issue of whether a judge has or has not made an order:

> "57. Mr Tomlinson also submitted before us that a restrictive interpretation of section 9(1)(c) [of the Human Rights Act 1998] would lead to an undesirable gap emerging where some judicial acts could not be challenged under the HRA at all, because no appeal or application for judicial review is available and there would be no right to bring a claim by way of originating process.

> 58. We do not accept that submission. In our view, any exercise of judicial powers is an order that is in principle appealable or (where judicial review is available, as in the case of inferior courts) may be a decision which can be the subject of judicial review. The question is one of substance, not form. Even judicial acts done in excess of jurisdiction are orders. This is the rationale for section 9(2), which preserves the rule that courts of unlimited jurisdiction are not amenable to judicial review, because it is assumed that an appeal is available. Mr Tomlinson was unable to give us any realistic examples of a judicial act that would not be amenable either to appeal or judicial review.
>
> 59. Mr Tomlinson did suggest during the hearing before us that an example can be found on the facts of *Sirros v Moore* [1975] QB 118, in which a judge asked security staff to stop a person who was in court and who was subsequently detained by them. Mr Tomlinson submitted that there was no formal order in that case, none presumably having been drawn up by the court, and so there would have been nothing which could have been appealed. We do not accept that submission. In our view, an instruction by a judge which leads to a person being detained would be an order which could be appealed. It would not matter if no formal order was ever drawn up. What matters is the substance of the matter, not the form."

85. Drawing matters together, and looking at the substance of what occurred in the present case, the judge gave his full judgment in December 2018. Whether or not a formal order was drawn up on that day, as it should have been, that was the 'day' on which the decision took effect under CPR, r 40.7(1) and the time for appealing ran from that date. The judge was at liberty to alter the words of his judgment when correcting or perfecting the transcript; indeed, if the transcript was defective, he was obliged to do so. The later release of the corrected transcript was not, however, the 'day' on which the decision was made. The court's final order dismissing the application for judicial review should have been issued to reflect the decision taken in December 2018 and not July 2019. To hold otherwise, would be to contemplate the wholly unsatisfactory situation that occurred here to be replicated in other cases on a regular basis.

86. I have dealt with this issue in order to provide guidance for the future. For the reasons given by My Lady, even if the appellant had brought her appeal at an earlier stage it would not have succeeded in this case.