Neutral Citation Number: [2018] EWHC 2331 (Admin)

Case No: CO/5867/2017

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 5 September 2018

Before:

SIR STEPHEN SILBER
(Sitting as a High Court Judge)

- -

Between:

THE QUEEN ON THE APPLICATION OF ANNA HINSULL	**Claimant**
- and -	
NHS DORSET CLINICAL COMMISSIONING GROUP	**Defendant**

- -
- -

Jason Coppel QC and Joanne Clement (instructed by **Leigh Day**) for the **Claimant**
Fenella Morris QC and Annabel Lee (instructed by **Capsticks)** for the **Defendant**

Hearing dates: 17th and 18th July 2018
Further Written Submissions until 25 July 2018

- -

Approved Judgment

Sir Stephen Silber:

A. Introduction

(i) The Dispute

1. The Claimant seeks to challenge the decision of the Dorset Clinical Commissioning Group ("the CCG") of 20 September 2017 which made significant changes to the configuration of health services in the Dorset area. The CCG is responsible for commissioning and paying for NHS services in that area. Like many similar bodies, it had been facing pressure on its funds to continue providing healthcare in the way that had been provided previously because of changing health needs and because of an increasing demand for services. The Claimant's Statement of Facts refers to Dorset facing "a crisis of health and social provision".

2. After a consultation process which the Claimant contends is flawed, the CCG took a series of decisions ("the Decisions") which are the subject of the present application. The Decisions are of particular importance to the Claimant, who sadly has nineteen different health conditions and is heavily dependent on safe access to emergency health care at Poole General Hospital ("Poole Hospital") which is close to her home in Langton Maltravers. She frequently needs to be admitted to Poole Hospital as an emergency patient.

3. Before the Decisions were made, Poole Hospital was one of three hospitals in Dorset giving acute care which is short-term treatment for patients with any kind of illness or injury. The other two acute hospitals in Dorset were the Royal Bournemouth Hospital ("Bournemouth Hospital") and the Dorset County Hospital ("Dorset Hospital") in Dorchester.

4. The Claimant is particularly concerned about two aspects of the Decisions relating to Poole Hospital. First, it would no longer be an emergency hospital. Instead it would become a "planned hospital" and the Accident and Emergency ("A& E") Department would be downgraded to a GP-led '"urgent care centre" with emergency care only being available at Bournemouth Hospital and at Dorset Hospital. She is very troubled about the additional time required for travelling from her home to Bournemouth Hospital rather than to Poole Hospital. In the period from 2015 to 2017, she had 31 hospital admissions and there have been more occasions where ambulances were needed for her.

5. Second, Poole Hospital's Specialist Maternity Unit would be closed and its consultant-led maternity and paediatric services would be delivered only from Bournemouth and Dorset Hospitals. In addition, further consultation would take place on whether Dorset Hospital would share its consultant-led Maternity and Special Care Baby and Paediatric services with Yeovil District Hospital.

6. There are many other challenges to the Decisions as explained in paragraph 36 below. As I will explain, the CCG contends that it was entitled to make each of the Decisions under challenge and therefore that the Claimant's challenges should be rejected. It contends that decided cases show that the CCG had a broad discretion as to how it should have gone about making the Decisions under challenge. As I will explain, the CCG relies on various other reasons why the Decisions should not be quashed. The organisation of the judgment after the Introduction is as follows:

- The Statutory Framework is dealt with in paragraphs 30 and 31 below.
- The Issues are dealt with in paragraph 36 below.
- The Applicable Legal Principles are dealt with in paragraphs 40 and 41.
- Issue 1: The Sufficiency of Social Care Workforce Issue is dealt with in paragraphs 42 to 91 below.
- Issue 2: The Alternative Investigations Issue is dealt with in paragraphs 92 to 102 below.
- Issue 3: The New Bed Closure Test Issue is dealt with in paragraphs 103 to 125 below.
- Issue 4: The Travel Times Issue is dealt with in paragraphs 126 to 157 below.
- Issue 5: The Consultation Issue is dealt with in paragraphs 158 to 175 below
- Further Matters are dealt with in paragraphs 176 and 177 below
- The Conclusion is dealt with in paragraph 178 below.
- The Appendix contains a Summary of the SWAST Report.

(ii) Why Dorset needed to change the way its Health Services were provided

7. Dorset is a large and predominantly rural county but even within its urban areas, travel is problematic. Prior to the time of the Decisions, Dorset had (apart from 13 community hospitals all with some beds) three acute hospitals, with approximately 1,810 acute hospital beds available. First, Bournemouth Hospital is located in the far east of the county, not far from the Hampshire border. Prior to the Decisions, the hospital had 741 beds. Second, Poole Hospital is located in the eastern half of the county, but more centrally than the Bournemouth Hospital. Prior to the Decisions, it had 654 beds. Dorset Hospital, which is located in Dorchester to the west of the county, is a smaller hospital. Prior to the Decisions, it had 415 beds.

8. Prior to the Decisions, each of these three hospitals had A&E Departments. They all had maternity units, although Bournemouth Hospital's maternity unit was only midwife-led. It delivered 350 babies compared to over 4,500 babies at Poole Hospital last year. Each hospital offered planned services, although there was some degree of specialisation between the hospitals. For example, cardiac cases went to Bournemouth Hospital, while trauma and emergency maternity cases were dealt with at Poole Hospital. It was also the busiest county maternity unit delivering two-thirds of the county's babies born in hospital and providing Dorset's only neonatal unit offering high-dependency and intensive care.

9. By the early part of the present decade, Dorset, like the rest of England, had been facing, and was continuing to face, a crisis. This meant as was explained in the consultation document that "doing nothing is not an option because by staying the same our

healthcare would get much worse". Six causes of this crisis, which are particularly significant are that:

1. On a national level, the crisis in both the NHS and social care sector has been widely reported. Independent research had established that NHS funding was at least £4 billion lower than was needed in 2018/19.

2. Dorset's A&E capacity was described in the Claimant's Statement of Facts as "seriously over-stretched". A&E departments declared numerous OPEL alerts (diverting patients) last winter, waiting time targets had been missed on more than 200 occasions in December 2017 alone. The social care sector was facing unprecedented funding cuts with (a) Dorset having to make savings of £5.6 million from its adult social care budget; (b) Poole Borough Council projecting at least a £1 million shortfall in funding; and (c) Bournemouth Borough Council having to make savings of £4 million. In March 2017, BBC research placed Dorset in the top 30 areas of the country where discharge from hospitals was delayed by a lack of social care provision.

3. Demand for health and social care services within Dorset was, however, increasing with a population older than the national average. This placed particular demands on the health and social care system. More people were living longer, with more complex and long-term conditions. By 2023, the population of Dorset will have grown from around 750,000 to over 800,000 with older people making up much of this increase. Estimates predicted a 30% increase in demand for acute hospital beds by 2026. The Claimant's Statement of Facts observes that "Demand for hospital beds is predicted to grow significantly from the currently unsustainable levels due to demographic and other pressures".

4. There were also national and local shortages of staff with key specialist skills. Dorset faced particular challenges in recruiting staff employed in the health and social care sectors. Dorset also had a high number of staff approaching retirement age and difficulty in filling vacancies.

5. The CCG was spending more money than it received, and it was facing a shortfall of some £158 million each year by 2020/2021.

6. The CCG concluded as a result of its pre-consultation analysis that the current model of NHS care in Dorset could not continue as it would increasingly fall behind the needs of the people of Dorset and their carers as well as becoming increasingly unaffordable.

10. This growing crisis caused healthcare providers and commissioners in the UK to attempt to ensure that more care was delivered in the community rather than in acute hospitals. The CCG is the main healthcare commissioning body for the whole county of Dorset. It was, and is, responsible for the planning, development and purchasing of high-quality, safe and sustainable health services for local people. In keeping with other parts of England, the health economy had for a number of years been struggling to provide the very best quality of care for people in Dorset.

11. National evidence, particularly the comprehensive review of NHS emergency and urgent care published in 2014 by the NHS Medical Director, Sir Bruce Keogh, showed that many people, who then attended A&E Departments could achieve better outcomes and less disruption to their lives by receiving urgent care in community settings, while patients with more serious or life-threatening emergency care needs had to be treated in specialist emergency care centres so as to maximise the chance of survival and good recovery.

12. Dorset's population has, and has had, some unique characteristics which were likely to lead to an increase in the demand for health services and needs in that county. First, the age profile was older than the English average age profile. Second, the population over the age of 70 was expected to grow four times faster than the growth rate of the total Dorset population. Third, at the same time, the core working age population was expected to decline, whilst the part of the population who were children and young people below the age of 20 was also expected to grow.

(iii) Early stages of the Clinical Services Review ("CSR")

13. The Governing Body of the CCG recognised the future challenges facing the healthcare of Dorset in 2013 and it approved the initiation of the CSR programme in March 2014. The purpose of the CSR was to establish a clear commissioning plan for Dorset moving forwards by looking at the areas where there was a need for change. These areas were changing health needs, variation in quality of care, specialist treatments, clinical unsustainability, workforce unsustainability and financial pressures.

14. The CSR's in-depth review programme was publicly announced and was launched in October 2014. The overriding approach of the CSR to the design of healthcare in Dorset was to ensure that it was both clinically-led and evidence-based. Throughout the process, primary stakeholder partners and reference groups were engaged to inform the development of potential options for consultation. In particular, the NHS Commissioning Board ("NHS England") was involved in the CSR from the beginning and it has made a significant input in the development of potential options. In accordance with best practice guidelines, NHS England had undertaken an assurance process of the plans for consultation and models of care for the future, and continued to do so.

15. The CSR was led by doctors, nurses and other frontline workers from Dorset's health and care organisations. These professionals came together in a number of Clinical Working Groups to look in depth at a large number of options for how services could be organised. Each of the Clinical Working Groups considered current services, best practice care pathways and potential models of care for their service area and around the potential options for delivering these in Dorset. A strategic Clinical Reference Group was established to be the main clinical advisory group of the review.

16. In January 2015, the CCG published its "Case for Change". Through the CSR, Dorset CCG aimed to deliver five key ambitions which were:

    i) Services organised around people;
    ii) Supporting people to stay well and take better care of themselves;
    iii) Delivering more care closer to home;
    iv) Integrated teams of professionals working together;

v) Centralised hospital services.

17. On 10 April 2015, NHS England completed the first stage of the assurance process, "the Strategic Sense Check". This meant that the CSR programme could be entered onto the NHS England reconfiguration grid, and became subject to the full assurance framework.

18. As was explained in the consultation document, the CCG originally hoped to go to public consultation in August 2015. Extensive stakeholder and professional feedback, however, made clear that more work was needed to be done in a number of areas – in particular around community services, where 90% of services were provided, and with joint working between health and care providers. As a result, since August 2015, the CCG has placed significant focus on community health and care services as well as continuing to work on the options for acute hospital services.

19. In late 2015, the CCG conducted stakeholder engagement and worked on model design for acute services. In March 2016, the CCG launched a programme of engagement in order to seek views from the public on Integrated Community Services proposals. To arrive at the options for public consultation, the CCG used six evaluation criteria drawn up by doctors and other health professionals in conjunction with the Patient (Carer) and Public Engagement Group. These criteria were:

i) The quality of care and patient safety;
ii) Access to services (travel);
iii) Cost and affordability;
iv) The impact on staff (workforce);
v) Whether the changes would be delivered within the required timescale (deliverability); and
vi) Other factors such as research and education.

20. In order to maximise resources and to obtain the best possible outcome for patients, the CCG proposed that Poole and Bournemouth Hospitals (both located in the east of the county) should each have their own distinctive role*s*. One would be a hospital for major planned care. This would allow for the continuous delivery of treatment away from the disruption that urgent and emergency care can create. The other hospital would be a major emergency hospital with more consultants available more of the time to deal with urgent and emergency care. By specialising in this way, the evidence showed that outcomes for patients could be improved and more lives could be saved. In both scenarios, Dorset Hospital would remain a district general hospital serving the west of the county and providing planned and emergency care.

21. In November 2016, NHS England gave confirmation of Stage 2 Assurance which approved the proposals against the Government's "Four Tests of Reconfiguration". This meant that the proposals could then proceed to formal public consultation. This assurance incorporated inputs from the Wessex Clinical Senate, which provided independent clinical advice on the proposals.

(iv) The Formal consultation

22. The CCG launched its formal consultation on 1 December 2016, which lasted for 12 weeks, closing on 28 February 2017. Two options were put forward in respect of acute hospital services. Option A had Poole Hospital as the major emergency care hospital with Dorset Hospital as a planned and emergency care hospital and Bournemouth Hospital as the major planned care hospital. Under Option B, Poole Hospital was to be the planned care hospital with Dorset Hospital as a planned and emergency care hospital and Bournemouth Hospital as the major emergency care hospital.

23. Option B was the preferred option of the CCG. In most areas of evaluation, both options rated the same and so ultimately the decision between the two came down to access and affordability. In both of those areas, Option B was rated more highly than Option A.

24. The consultation responses were independently analysed and reported on by Opinion Research Services and quality assured by the Consultation Institute. The Consultation Institute awarded the CCG "best practice" accreditation for the CSR consultation.

(v) The Post-Consultation work

25. Initial feedback from the public consultation highlighted some areas where the CCG felt that further work was needed to enable the Governing Body to make their decision. These areas were:

    i) Transport / travel times (emergency and non-emergency);
    ii) Clinical risk;
    iii) Equality Impact Assessment;
    iv) Health and Wellbeing.

26. As a result, the CCG commissioned additional work (a) on emergency transport from South West Ambulance Service Trust ("SWAST"), (b) on non-emergency transport from Dorset County Council ("Dorset CC"), (c) a review of clinical risk by the CCG Deputy Director of Nursing and Quality, (d) a robust review of the Equality Impact Assessment; and (e) a review by Public Health Dorset (a partnership of Bournemouth, Poole and Dorset Councils) of concerns about health and wellbeing from a prevention perspective.

27. In addition, a detailed programme of events and workshops was organised between July and September 2017 to ensure that the consultation responses were shared with and considered by members of the CCG's Governing Body and key partner organisations during their detailed deliberations in preparation for the decision-making meeting on 20 September 2017.

(vi) The Decisions

28. The CSR set out the information required by the Governing Body to make their decisions as to the configuration of services for healthcare in Dorset in its Decision-Making Business Case ("DMBC") and made its recommendations. As a result of the feedback from public consultation, some of the recommendations for integrated community services changed from the proposals set out in the Consultation Document.

In respect of acute hospital services, the recommendation for Option B remained the same.

29. At a meeting on 20 September 2017, the Governing Body approved the recommendations and the Decisions were made. This meant that instead of the three main hospitals each providing many of the same services, under the new regime, they would each have different roles. Bournemouth Hospital, as the major emergency hospital would provide what is described in the DMBC as "the most rapid access and high-quality treatment across Dorset" and there would be more consultants available than under the existing regime. Poole and Dorset Hospitals would have significant roles as respectively "the major planned hospital" and the "planned and emergency hospital". Further there was to be a new regime to provide care closer to people's homes using teams based at local community hubs; this would enable many people to be treated without going to hospital, while many of those who were admitted hospital will be released earlier than under the previous arrangements because more treatment and care can be provided outside hospitals Following the Governing Body's decision on 20 September 2017, the CSR has moved towards the implementation phase and some implementation has now taken place.

B. The Statutory Framework

30. The CCGs were created by the Health and Social Care Act 2012 ("the 2012 Act") and they are bodies corporate established in accordance with Chapter A2 of Part 2 of the National Health Service Act 2006 ("the Act").

31. Section 3(1) of the Act sets out the core statutory duty of each CCG, which was to arrange for the provision of various services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility, including:

(a) hospital accommodation;
(b) other accommodation for the purpose of NHS services;
(c) medical, dental, ophthalmic, nursing and ambulance services;
(d) such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as the group considers are appropriate as part of the health service;
(e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the group considers are appropriate as part of the health service; and
(f) such other services or facilities as are required for the diagnosis and treatment of illness.

32. Section 3(1F) of the Act provides that in exercising their functions, a CCG must act consistently with:

(a) the discharge by the Secretary of State and NHS England of their duty under section 1(1) of the Act (to promote a comprehensive health service);
and (b) the objectives and requirements for the time being specified in the NHS Mandate published under section 13A of the Act.

33. By section 14L of the Act, each CCG must have a governing body. The general duties of CCGs are set out in sections 14P to 14Z1 of the Act. The most important of these for present purposes is that set out in section 14R, which states that:

"(1) Each CCG must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness.
(2) In discharging its duty under subsection (1), a clinical commissioning group must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services."

34. By section 14R (3) of the Act, the relevant outcomes include, in particular, outcomes which: show (a) the effectiveness of the services; (b) the safety of the services; and (c) the quality of the experience undergone by patients. In discharging its duty under section 14R (1), a CCG must have regard to any commissioning guidance published by NHS England under section 14Z8 of the Act: see section 14Z8 (2).

35. Other general duties of CCGs include requiring the CCG:

(1) in the exercise of its functions, to act with a view to securing that health services are provided in a way which promotes the NHS Constitution (section 14P(1)(a));
(2) to exercise its functions effectively, efficiently and economically (section 14Q)
(3) in the exercise of its functions, to have regard to the need to (a) reduce inequalities between patients with respect to their ability to access health services; and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services
(4) exercise its functions with a view to securing that health services are provided in an integrated way where it considers that this would improve the quality of those services, reduce inequalities between persons with respect to their ability to access those services, or reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services (section 14Z1).

C. The Issues

36. It is not disputed that there was a need for the CCG to make savings and changes to the configuration of health services in its area. Mr. Jason Coppel QC, Counsel for the Claimant, contends that the Decisions should be quashed because:

(1) The CCG failed to have regard to the relevant consideration of whether there would be a sufficient social care workforce to deliver its new integrated model of community service ("Issue 1-The Sufficiency of Social Care Workforce Issue")
(2) The CCG failed adequately to investigate and reach a conclusion on whether alternative community provision could be put in place, before deciding to close hospital beds, contrary to the Tameside duty of careful inquiry with its duty to make further inquiries as to (i) what alternative community provision would need to be put in place to achieve the reduction in demand for acute hospital care; (ii) how the workforce for this community provision would be recruited; and (iii) how it would be paid for ("Issue 2-The Alternative Community Provision Issue");
(3) The decision to cut the acute services fails to comply with the NHS England's "bed closure" test which stated that NHS entities would have to show that significant

bed closures can meet one of the three new conditions set out in the bed closure test. "…before NHS England will approve them to go ahead". It is contended that the CCG erred (i) in concluding that the bed closure test did not apply to the consultation process leading to the Decisions; (ii) failing to consult on the bed closure test; (iii) in that its consideration of the bed closure test was inadequate and was not provided to the Governing Body ("Issue 3-The Bed Closure Test Issue").

(4) The CCG failed to consider adequately the impact of increased travel times in emergency cases to Bournemouth Hospital, which was the major emergency hospital rather than Poole Hospital which was the more centrally located hospital ("Issue 4-The Travel Times Issue").

(5) The CCG failed to supply sufficient information to consultees in respect of 24/7 consultant care and/or the probability of large scale acute bed closures especially at Poole Hospital. In consequence, the CCG failed to conduct the consultation fairly. ("Issue 5-The Consultation Issue").

37. As I will explain, Ms. Fenella Morris QC, counsel for the CCG, submits that there is no merit in any of these claims for a number of reasons, including that the CCG had a broad discretion as to how the consultation should be carried out and that it was entitled to take the Decisions after its detailed assessment of the relevant factors. She also contends that even if the Claimant succeeds on some of the grounds, it would not be appropriate to quash the Decisions.

38. Permission was granted by HH Judge Walden Smith sitting as a Deputy High Court Judge for Issues 1 to 4 to be pursued, but she refused to grant permission on Issue 5. The Claimant seeks to renew her application on this ground. A rolled-up hearing took place to resolve that issue when I heard the remainder of the Claimant's grounds.

39. When counsel for the CCG completed her oral submissions in the later part of the afternoon of the second and the last day of the hearing, I was unfortunately unable to continue sitting for the remaining part of that day and it was determined that the Reply would be served in writing and not orally. After it was served, counsel for the CCG complained that the Reply contained many matters raised which they stated should not have been included in the Reply. I gave permission to the CCG to make the representations in writing on that point which they could have made orally if the Reply had been made orally. When the CCG produced this document, the Claimant's counsel objected to its contents on the basis that those points could not have been made orally in response to the CCG's Reply. I will limit my consideration to those matters which the Claimant would have been entitled to make in his oral Reply and the points which the CCG could then have made orally in response to the Claimant's Reply, together with many relevant matters which had been made in oral submissions or which I had noted from reading the papers.

D. The Applicable Legal Principles

40. The approach of the courts to a challenge to a decision such as that under challenge on this application is that:

(a) "The decision-maker has to balance the interests of several different groups, not simply those represented before the court". **R (on the application of Royal Brompton and Harefield Hospital NHS Foundation Trust v Joint Committee**

of Primary Care Trusts and another [2012] EWHC Civ 2986 (Admin) at paragraph 90 per Arden LJ.

(b) "The decision-maker may be in a better position to do this effectively and in such a way as to prevent the interests of one particular group receiving inappropriate precedence over the interests of other groups." **(ibid)**.

(c) "With the benefit of hindsight, it will almost invariably be possible to suggest ways in which a consultation exercise might have been improved upon. That is most emphatically not the test." **(R (Greenpeace) v. Secretary of State for Trade & Industry** [2007] Env. LR 29 at paras 62 per Sullivan J).

(d) "It must also be recognised that a decision-maker will usually have a broad discretion as to how the consultation should be carried out". **(ibid)**.

(e) "Parliament, wisely, does not attempt to limit the various ways in which CCGs could provide arrange for the provision of health care. It follows, in my view, that Parliament intended CCGs to enjoy a broad discretion when choosing how to commission." **R (Hutchinson) v Secretary of State for Health and Social Care** [2018] EWHC 1698 (Admin), at paragraph 94 per Green J.

(f) "…where a statute conferring discretionary power provides no lexicon of the matters to be treated as relevant by the decision-maker, then it is for the decision-maker and not the court to conclude what is relevant subject only to Wednesbury review. By extension it gives authority also for a different but closely related proposition, namely that it is for the decision-maker and not the court, subject again to Wednesbury review, to decide upon the manner and intensity of enquiry to be undertaken into any relevant factor accepted or demonstrated as such" **Khatun v Newham BC** [2005] QB 37 at paragraph 35 per Laws LJ.

41. In a judicial review application, the Court will only quash a decision in limited circumstances because:

(a) (a) "Not all objections to the accuracy of the consultation process will lead to a full reconsideration of provisional decisions. It is not enough, therefore, for a party seeking to quash a consultation exercise to point to some facts that are inaccurately presented. Their inaccuracy may on reflection lead only to a minor and immaterial scaling down of the case supporting the provisional proposal for change. The arguments for change will then not be as black and white as they appeared in the consultation document, but different shades of grey. Determining the strength of those shades of grey is generally not a matter for the court but the decision-maker. **R (on the application of Royal Brompton and Harefield Hospital NHS Foundation Trust v Joint Committee of Primary Care Trusts and another)** (supra) at paragraphs 90 per Arden LJ.

(b) (b) In short, it is inherent in the consultation process that it is capable of being self-correcting. This has to be borne clearly in mind, for the various reasons already indicated, the courts should therefore avoid the danger of stepping in too quickly and impeding the natural evolution of the consultation process through the grant of public law remedies and perhaps being led into areas for the professional judgment

of the decision-maker. It should, in general, do so only if there is some irretrievable flaw in the consultation process". **ibid** at paragraph 91

(c) "A consultation exercise which is flawed in one, or even in a number of respects, is not necessarily so procedurally unfair as to be unlawful" **R (Greenpeace) v. Secretary of State for Trade & Industry** [2007] Env. LR 29 at paragraph 62 per Sullivan J.

(d) "In reality, a conclusion that a consultation exercise was unlawful on the ground of unfairness will be based upon a finding by the court, not merely that something went wrong, but that something went 'clearly and radically' wrong." **Ibid** at paragraph 63.

E. Issue 1: The Sufficiency of Social Care Workforce Issue

(i) The Claimant's case on the Sufficient Social Care Workforce Issue

42. The thrust of the Claimant's case is that the Decisions will lead to significant cuts to acute hospital services which would be made without any adequate steps having been taken to ensure that there would be a safe transformation of care to the community in Dorset. This approach is said to be flawed by two fundamental public law errors of which the failure to have regard to the sufficiency of the social care workforce is Issue 1.

43. Mr. Coppel submits that the CCG failed to have regard to the relevant consideration of whether there would be a sufficient social care workforce to deliver its new integrated model of community service. This, according to the Claimant, was a mandatory relevant consideration, in particular, because first, the integrated health care was central to the new community services model; second, the CCG had been specifically warned by Dorset CC that it needed to consider social care workforce capacity before deciding on its proposals; and third, that CCG failed to listen to the concerns of Dorset CC.

44. Mr. Coppel contended that in spite of this, the Workforce and Capability Plan appended to the Decision Making Business Case excluded consideration of the social care workforce. Ms. Debby Monkhouse, who is "a local NHS activist and a member of Defend Dorset NHS Campaign Group", refers to post-decision developments, but Mr. Coppel correctly accepts that these matters are "not relevant to legality of [the Decisions]" and so I will not consider them.

45. The Claimant's case is that on the facts, first, that the proposed alternative configuration required substantial numbers of new staff; second, that the only workforce modelling that CCG carried out excluded consideration of the sufficiency of the social care workforce as did the Workforce Capacity and Capability Plan appended to the DMBC; third, that this issue of the sufficiency of the social care workforce was treated by the CCG not as a matter relating to whether the proposals should be adopted, but instead as a matter relating to implementation; and fourth, that although the CCG had been considering the workforce crisis for at least 2½ years before the Decisions, in September 2017, Mr. Tim Goodson, the CCG's Chief Officer could offer only a "vision" and high level aspirations, but not concrete evidence of the effect of the measures.

46. Mr. Coppel also contends that the CCG was unable to point to any document where the CCG had considered the capacity of the social care workforce in spite of the clear warning from Dorset CC, who were the employers of the social care workforce, that "the shortages in both health and social care create severe difficulties for providers".

47. The Claimant's case is that the local authorities, and not the CCG, were the employers of the social care workforce, but that the CCG could have obtained information from the local authorities in order to make calculations before the Decisions were made, but it failed to do so

48. In support of these submissions, Mr. Coppel points to various items of evidence. He refers to the slides for the CCG CSR in February 2015 in which the workforce is described as a "business critical issue". In addition, he contends that the significance of establishing that there was an adequate social care workforce is apparent from the extract from Our Dorset, Sustainability and Transformation Plan ("STP") for local Health and Social Care in March 2016 in which it was stated that:

> "…we have yet to understand the gaps in the social care workforce. We expect there will be a need for some recruitment, changes in the skill mix across staff groups and new ways of working, such as developing nursing and allied professional roles across community and primary care services, including community, pharmacy and pharmacists in a range of settings".

49. In April 2016, in the ICS Modelling Programme Provision of Community Services, it was stated that in respect of social care, assumptions were "TBD", (i.e. to be decided) for activity level and staffing mix in social care. In the 27 May 2016 Clinical Senate Council report on the CSR, it was noted that there was a national shortage of some staff required to run the reformed package of health services in the CCG's area and the inability to recruit staff particularly in the West of Dorset. The report also explained that "the successful delivery of patient-focused service changes, network working, enhanced skill mixes and the targeted implementation of telemedicine should all contribute to successful implementation".

50. Mr. Coppel contends that the consultation document of 1 December 2016 referred to the wish "to establish mixed teams of doctors, nurses and other health and social care professionals to provide well-coordinated care". He also refers to an undated document entitled "CSR-New Patient Care Test for Hospital Bed Closures" in which it is stated that the "New Patient Care Requisites", there will be a need to demonstrate that "the new workforce will be there to deliver it".

51. There were some concerns expressed concerning the shortages in relation to the health and social care workforce in the response of 17 March 2017 from Dorset CC to the Consultation document when it explained that:

> "the shortages in workforces in both health and social care, at all levels, create severe difficulties for providers. Whilst the reconfigurations of acute and community health sites may enable the NHS workforce, the County Council is concerned as to the impact of increased demand on the social care workforce".

52. Similarly, the Joint Health Scrutiny Committee ("JHSC") Minutes of 3 August 2017 referred to a statement made at the hearing by Phil Richardson of the CCG that:

> "workforce shortages are a big problem, but the hope is that a networked Health system would attract more staff, given the opportunities to build skills and work in integrated teams".

53. In a subsequent letter dated 29 August 2017, Dorset CC welcomed some work carried out by CCG and it:

> "noted that to successfully implement the proposals within both the [CSR] and the Mental Health Acute Care Pathway Review, there would have to be a **sufficient work force** in place. Whilst recognising the CCG's intentions to create networks to support and develop the workforce, it remains to be seen whether recruitment and retention can meet the demands of the services. **The Committee recommends that the CCG continues on workforce development, alongside partner organisations, to ensure that planned changes can be properly supported and recognises that this is the role of the STP partnership**". (Emphasis as in the original).

54. As I will explain in paragraph 79, Mr. Goodson replied setting out how the CCG would seek to satisfy the social care work requirements, but the Claimant's case is that this was too vague.

55. The DMBC referred to the challenges on workforce capacity caused by "a significant gap in terms of current versus future workforce numbers, a shortage of staff in key roles and an ageing workforce in a number of areas". Mr. Coppel attaches importance to the section on workforce in which there is a workforce model for integrated community and primary care services at March 2017 in which "mental health nursing, Social Care and Pharmacists [are] excluded as workforce assumptions for relevant activity".

56. This document explained that the aim of the Workforce and Capability Plan was to:

(a) "ensure we have the "right staff in the right places to deliver services across Dorset";

(b) "identify and address the work force challenges where there are existing gaps and shortages, as well as in areas where there is likely to be a future challenge in workforce supply".

(c) "work in partnership to address these challenges together, through recruitment, networking and development of skills".

57. Finally, the Integrated Community Services Review and Design: Outline Business Case of December 2017 stated that social care had been excluded from workforce assumptions addressing the workforce capacity "due to difficulty in establishing current output".

58. The case for the Claimant is that CCG did not consider the capacity of the social care workforce as it deliberately excluded it from consideration. That was because its only workforce modelling expressly excluded consideration of the social care workforce, while the Workforce Capacity and Capability Plan appended to the DMBC excluded consideration of the social care workforce and that it was left to be considered on implementation although it is argued that this was not made clear to the Governing Body. Mr. Coppel contends that the CCG had not had regard to the relevant

consideration of whether there would be a sufficient social care workforce to deliver its new integrated model of community service because the social care costs were excluded from various calculations and/or because there is no document which shows that the CCG had considered the capacity of the workforce.

(ii) The CCG's Case on the Sufficient Social Care Workforce Issue

59. Ms. Morris accepts that the issue of the adequacy of the social care capacity to support the NHS in delivering the model developed through the CSR was a relevant factor to be considered, but the CCG's case is that the Claimant is wrong to contend that the CCG failed to take account of the social care capacity. Ms. Morris contends that matters like the CCG's involvement and collaboration with the local authorities in Dorset, as well as the significant amount of work done by the CCG (including comprehensive modelling) in order to understand future demand for community services in the Dorset area, demonstrate that the CCG did take account of social care provision and the local authority's ability to provide it. The significance of the involvement of the local authority officials is that it was the local authorities, and not the CCG, which were responsible for providing social care. Therefore, they had a strong incentive to ensure that there would always be a sufficient social care workforce available to enable them to provide its social care services.

60. Ms. Morris points out that the CCG took reasonable steps to understand the social care sector and how it would meet the requirements of the new regime including having available a sufficient social care workforce. She refers to three interlinked ways in which this was achieved.

61. First, Ms. Morris contends that a crucial feature of the CCG's CSR was that there would be more collaborative working between health and social care as it involved "health and social care staff working in teams to support people with the most complex needs". Indeed, this is said to be a feature of many STPs. Therefore, in order to develop the proposals, local social care professionals had to be, and indeed, were intimately involved throughout the lengthy process of developing the proposals which were ultimately accepted.

62. In order to achieve this aim, Ms. Morris explained that the CCG developed a partnership known as the "Better Together" programme with the three local authorities in Dorset, as well as with Poole Hospital, Bournemouth Hospital, Dorset Hospital and Dorset Healthcare. It was supported by the Dorset and Bournemouth and Poole Health and Wellbeing Boards. This partnership was used to carry out what Mr Goodson describes as a *"sense check"* of the CCG's vision for community-based services, and to implement some initial changes to introduce jointly delivered services between health and local government. The importance of the involvement of the three local authorities was that as they were responsible for the social care, they would have had a strong incentive to ensure that there would be a sufficient social care workforce able to deliver the services required by the CCG's proposals, especially as it was replacing some of the hospital services.

63. The involvement of the three local authorities was very substantial, because they were also involved in the programme for developing "Integrated Community Services", and the development of "Better Care Fund" plans, which were the joint local authority and NHS plans. Ms. Morris contends that the STP for Dorset was developed in consultation

with all of the local authorities in the county and outlined the integrated programmes of work that would enable the authorities to better meet the health and social care needs of the local population.

64. The "Better Care Fund" plan was informed by and aligned with the STP and the CSR. Both the STP and the Better Care Fund plan were formally signed off by the local authority Health and Wellbeing Board, while the STP was also signed off by all of the NHS providers in Dorset. During the CSR process, the local authorities were identified as key stakeholders in the programme and an extensive programme of engagement with the local authorities was undertaken during the CSR. Therefore, as was stated in the DMBC, there has been extensive stake holder engagement including with local authorities and particularly with Dorset's three upper tier local authorities.

65. Another part of the CSR programme included a "Leading and Working Differently" portfolio which included social care professionals. This reviewed what would be the workforce requirements under the proposed regime on a system-wide basis as well as considering the skill mix that would be required within the workforce including the social care workforce. Ms. Morris stresses there was detailed analysis of workforce considerations and this formed one of the six criteria for decision-making. This analysis included specific consideration in a separate section of "workforce capacity" for "care services". A Workforce and Capability Plan was produced to consider these issues in detail and I have set out some aspects of it in paragraph 56 above.

66. Second, in addition, the CCG worked with and took account of the feedback of social care colleagues. This was to be expected because the CCG had a statutory duty to consult the local authority for the health service in the relevant area under rule 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.The local authorities formally responded to the CCG's consultation and Dorset CC's Cabinet agreed in principle with the case for change. It raised some points for consideration in a letter dated 17 March 2017 to which I have referred in paragraph 51 above. Details of the local authorities' responses were contained in the ORS consultation report which was made available to the CCG's Governing Body in advance of its decision-making.

67. An important role was played by the JHSC, which included representatives from each of the Bournemouth, Dorset and Poole local authorities as well as Hampshire County Council because it was specifically constituted to consider the CSR's proposals and consultation. The JHSC's tasks included reviewing and scrutinising matters relating to the planning, provision and operation of the health service in its area. Somerset Council later joined the JHSC due to the potential impact of the proposals on Yeovil Hospital. This meant that there were five local authorities formally scrutinising the CCG's proposals and the sufficiency of the social care workforce must have been an important issue for the authorities who would have had every reason to complain if the CCG had not made suitable plans for a suitable social care workforce.

68. In a letter dated 29 August 2017, the JHSC provided its comments and recommendations on the CCG's proposals. The JHSC considered that it remained to be seen whether recruitment and retention could meet the demands of the services and it recommended that the CCG continue to focus on workforce development alongside partnership organisations to ensure that the planned changes could be supported.

69. The CCG responded by letter dated 15 September 2017 giving assurance of continuing work with colleagues in partner organisations to ensure that the proposals were deliverable from a workforce perspective and stating that the JHSC's letter had been passed to the CCG Governing Body for consideration in advance of the decision-making meeting. The CCG's case is that the attachments to that letter contained an explanation of what Mr. Goodson describes as "[CCG's] continuing work with colleagues in partner organisations to ensure the proposals are deliverable from a workforce perspective". I will return to consider those significant proposals in paragraphs 79 and 80 when giving my conclusions on this issue.

70. The CCG were appreciating that the issue of the social care workforce was a relevant consideration because they considered the adequacy of the social care workforce as is apparent from the statement of Mr. Goodson that "our expectation is that [the proposed changes] will actually reduce the cost for social care [and] that the CCG's decisions are not dependent or reliant on an increase in social care expenditure or workforce".

71. Third, Ms. Morris submits that the CCG had undertaken extensive and comprehensive modelling to understand the future demand for community services, taking into account demographic growth over 5 years and the impact on reducing reliance on secondary hospital care. As part of the CSR programme, the Clinical Working Groups each chaired by a GP, were established. The Clinical Working Groups had the task of looking at how workable models of care to ensure high quality and efficient acute hospital and integrated community services could be applied across Dorset. This included the future increased capacity requirements for community beds and community teams. This work informed the development of the CCG's model for community services.

72. The workforce modelling specifically took into account the new integrated community and primary care services model of care which brought together the different sectors and workforce across the NHS and social care to deliver joined up services. This exercise drew on clinical research, UK and international reports. Assumptions on which community models were based were based on best practice and were tested, amended and agreed with clinicians and managers several times for validation. The evidence was that in developing its service model for the community, the CCG had sought regular external assurances from expert bodies including NHS England, the Clinical Senate and a Health Gateway Review. Specifically, the CCG engaged in a dialogue with the Wessex Clinical Senate regarding the proposals and, following receipt of their findings, NHS England provided assurance of the proposals as I will explain in paragraphs 97 and 98 below.

73. In addition to these assurance processes, there was evidence that the main healthcare providers – the NHS Trusts – had confidence in the proposals. The Chief Executive of Poole Hospital NHS Foundation Trust, Ms. Debbie Fleming, was very supportive as I will explain in paragraph 84 below.

74. The CCG relied on the decision of the local authorities not to refer matters to the Secretary of State in circumstances where it considers that local authorities have not been adequately consulted on proposals for the substantial development of the health service in the area or if the proposals are not "in the interests of the health service in its area".

75. Under rule 23(9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, the local authority has a specific power to make a reference to the Secretary of State in such circumstances. Significantly, in December 2017, the Dorset CC's Health Overview and Scrutiny Committee ("HOSC") resolved not to refer the matter to the Secretary of State. The JHSC also did not support a referral to the Secretary of State and none of the five constituent local authorities has made such a referral.

76. In conclusion, Ms. Morris submits that the CCG plainly took into account the social care sector and took reasonable steps to inform itself of issues relating to the sufficiency of the work force. Her case is that it is fanciful to suggest that the CCG has not taken into account social care provision or failed to make adequate inquiries about alternative community services in reaching its Decisions about future healthcare provision in both community and hospital settings, in light of the CCG's close collaboration with the local authorities in Dorset responsible for social care and the significant amount of work that has been done (including comprehensive modelling), in order to understand future demand for community services in the Dorset area. Ms. Morris submits that it is clear is that there had been much cooperation between the CCG, the local authorities and the Hospitals on how they could make proposals which became the Decisions work including in taking steps to ensure that there would be an adequate social care workforce.

(iii) Discussion and Conclusions on the Sufficient Social Care Workforce Issue

77. There are two matters to be considered in discussing this issue. The first is whether the CCG appreciated the significance of the need for a sufficient social care workforce, while the second matter is whether the way in which the CCG considered the sufficiency of the social care workforce was Wednesbury unreasonable or a breach of CCG's public law obligations.

78. As to the first matter, I am quite satisfied that the CCG appreciated the significance of the need for a sufficient social care workforce essentially for the reasons put forward by Ms. Morris and which I have explained. For example, the CSR programme included the "Leading and Working Differently" portfolio which reviewed all the workforce requirements of the new regime as well as the skill mix that would be required within the work force including the social care workforce. There was also a detailed analysis of workforce considerations which was one of the six criteria for decision-making. In addition to other matters set out in paragraph 65, the CCG had undertaken wide-ranging and comprehensive modelling to understand the future demand for community services and this would have included the social care workforce. Mr. Goodson had also clearly considered the social care workforce required under the regime envisaged by the CCG's proposals when he stated that "the CCG's decisions are not dependent or reliant on an increase in social care expenditure or workforce."

79. It is noteworthy that in CCG's response of 15 September 2017 to JHSC's letter of 29 August 2017, to which I have referred in paragraph 69 above. Mr. Goodson said in his witness statement that he had attached to his letter of 15 September 2017 a document setting out the CCG's response to the points in the JHSC letter. That important document stated that one of the five enabling portfolios within the STP is the "Leading and Working Differently" portfolio and that:

"the work streams within that portfolio include ….
recruitment and retention of staff: the vision is **to develop a system-wide approach to attract new staff and retain existing staff within the health and *social care sector* in Dorset**;

developing our staff: the vision is to improve the development opportunities for staff, **to ensure the future workforce supply**, to **improve retention and morale within health and social care organisations in Dorset**, and to work in greater partnership with education providers to **ensure future workforce supply** is available;

supporting our staff through change: the vision is to improve the working environment for staff by ensuring they are engaged and involved in changes that affect them;

workforce planning: the vision is **to ensure that a workforce with the required skills** and competencies to deliver new models of care is available". (emphasis added)

80. This shows the importance attached by the CCG to the adequacy of the social care workforce. I have also referred in paragraph 56 to the aims of the Workforce Capacity and Capability Plan which showed that an aim of the CCG was to "ensure that we have the right staff in the right places to deliver services across Dorset". In addition, in its letter of 29 August 2017, Dorset CC states that it "recommends that the CCG continues on workforce development, alongside partner organisations**"** and the used of the word "continues" shows that this was ongoing work. All this material shows that the CCG appreciated the significance of the need for a sufficient workforce, one part of which was the social care workforce. It also demonstrates that the Dorset CC was content with the CCG's work on workforce development as it wanted the CCG to continue with it is work "alongside partner developments." This is what happened.

81. Turning to the question of whether the way in which the CCG considered the sufficiency of the social care workforce was Wednesbury unreasonable or a breach of the CCG's public law obligations, it is important to bear in mind that as Laws LJ explained in **Khatun** (supra) that "where a statute conferring a discretionary power provides no lexicon of the matters to be treated as relevant for the decision maker …it is for the decision-maker and not the court, subject again to Wednesbury review, to decide upon the manner and intensity of enquiry to be undertaken into any relevant factor accepted or demonstrated as such". As the Act did not provide any "lexicon of the matters to be treated as relevant for the decision maker", the CCG, as the decision-maker in this case, had a wide discretion. An additional reason why it had a wide discretion was, as Green J explained in **Hutchison** (supra), that "Parliament intended CCGs to enjoy a broad discretion when choosing how to commission."

82. In order to ensure that there was an adequate social care workforce when the new regime came into force, the CCG was doing and was intending to do exactly what Dorset CC advocated in its letter of 29 August 2017 when it "recommend[ed] that the CCG continue… on workforce development, alongside partner organisations to ensure that planned changes can be properly supported". This entailed pursuing the aims set out in the portfolios within the STP entitled "Leading and Working

Differently" and which I have set out in paragraph 79 above as well as the contents of the "Workshop and Capability Plan" which I have quoted in paragraph 56 above and which was part of the DMBC. This important document sought to "ensure [that the CCG] have the "right staff in the right places to deliver services across Dorset" as well as to "identify and address the work force challenges where there are existing gaps and shortages, as well as in areas where there is likely to be a future challenge in workforce supply". I cannot accept Mr. Coppel's submission that it was not clear to the Governing Body that the sufficiency of the social care workforce was to be the subject of continuing work to be carried out after the Decisions were taken and this would be done in the words of the letter from Dorset CC "alongside partner organisations to ensure that planned changes can be properly supported".

83. After all, the DMBC made it very clear that the the "Workshop and Capability Plan" is "an iterative and developing document and will inform the development of a Workforce and Capability plan for each service area over the next 14 to 24 months, the pace at which will be dependent on "the readiness of the services and the timescales for changes in the CSR implementation plan". This showed that consideration of the sufficiency of the social care workforce would have to be considered after the Decisions were taken in the light of what the DMBC described as "a risk that there may not be available staff and resources in the system to deliver the future service models". These statements in the "Implementation of Recommendations" sections of the DMBC show clearly that the sufficiency of the workforce was to be the subject of continuing work after the Decisions were taken. The Governing Body was put on notice and it could have decided to pursue it in any way they wished, but they accepted the approach which I have explained and then made the Decisions with full knowledge of this approach. I cannot accept the criticism of Ms. Monkhouse that this policy amounts to "closing the door after the horse bolted" as there is nothing to suggest that the decisions relating to the workforce required would not be taken in advance of and in the light of proposed changes.

84. This supports my conclusion that the CCG was entitled to take the approach it adopted as does the positive evidence that the main healthcare providers, which were the NHS Trusts, had confidence in the proposals and there would be sufficient social care workforce to deliver the proposed new integrated model of community service. The Chief Executives of each of the three acute hospitals in Dorset expressed their support for the proposals. The Chief Executive of Poole Hospital NHS Foundation Trust, Ms. Debbie Fleming, states in her witness statement with which Mr. Tony Spotswood, the Chief Executive of the Bournemouth Hospital, agreed that:

> "Clinical staff were therefore extensively involved in the CSR process. Both Trusts, at both clinical and managerial level, were satisfied with the demand modelling assumptions that underpin the CSR which were tested and agreed with the clinicians at [Poole Hospital] and [Bournemouth Hospital] ... Confidence in the modelling has been gained from having the Trusts' staff involved in the development of the model."

.

85. There is no suggestion from any of the local authorities that at the date of the Decisions, the CCG had failed to give adequate consideration to the sufficiency of the social care

workforce which they required to comply with their duties. In the draft, I regrettably referred on two occasions to an obligation of the CCG to supply the social care workforce, but that was an error because the CCG did not have that duty. The remainder of the judgment is based on the need to consider the sufficiency of the social care workforce and not to supply it. I decided this issue on this basis and not on the basis on an obligation to supply that workforce.

86. I am further fortified in reaching my conclusion that the CCG adequately considered the sufficiency of the social care workforce because, if as is contended by the Claimant, there was inadequate consideration of the sufficiency of the workforce, there would have been every prospect that one or other of the local authorities would have been complaining or invoking its crucially important power under rule 23(9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 to which I have referred in paragraph 75 above. This very important specific power granted to a local authority enables it to make a reference to the Secretary of State where it considers either that local authorities have not been adequately consulted on proposals for the substantial development of the health service in the area, or that the proposals are not "in the interests of the health service in its area*"*. In this case, if the local authorities had concerns about whether there would be a sufficient social care workforce to deliver the CCG's new integrated model of community service, this would have been a matter of crucial importance to them as without a sufficient workforce, they would have been unable to comply with their obligations.

87. So it is highly likely that they would have at least complained to the CCG or made a reference to the Secretary of State if they had thought that they could not provide a sufficient social care service. The absence of such a reference or any complaint or other evidence showing or suggesting that as at the dates of the Decisions any of the local authorities was dissatisfied with the approach of the CCG is cogent evidence indicating that the local authorities did not regard that the Decisions (including the vital issue of the adequacy of the social care workforce) were not *"in the interests of the health service in its area"*.

88. This point has additional force as there is evidence that that Dorset CC considered this matter and in December 2017, the Dorset CC's HOSC resolved not to refer the matter to the Secretary of State. The JHSC also did not support a referral to the Secretary of State and none of the five constituent local authorities has made such a referral. It can be inferred from these matters that the Decisions were not regarded by the local authorities as not being *"in the interests of the health service in its area"* which would have been the position if there had been an inadequate workforce. This shows why I cannot accept Mr. Coppel's submission that the CCG failed to listen Dorset CC's concerns. Indeed, there is no evidence from Dorset CC or from any of the local authorities or the hospitals supporting this or any other challenge to the Decisions at or immediately after the time when the Decisions were reached.

89. In reaching that conclusion, I have considered, but rejected, Mr. Coppel's contention that the CCG had not had regard to the relevant consideration of whether there would be a sufficient social care workforce to deliver its new integrated model of community service because the social care costs were excluded from various calculations and/or because there is no document which shows that the CCG had considered the capacity of the workforce. I am unable to accept that submission first, because there was no

statutory or other obligation on the CCG to produce documents or calculations; second, because it is inconsistent with the wide discretion given to the CCG as to how to commission and on "the manner and intensity of enquiry to be undertaken into any relevant factor" for the reasons which I have explained in paragraph 40 (e) and (f) above; third, none of the health authorities, Hospital Boards or any interested party were asking for that information; fourth, because of the difficulties of making those calculations bearing in mind that the Integrated Community Services Review and Design: Outline Business Case of December 2017 states that social care cost were excluded due to "difficulty in establishing current input"; fifth, because as I have explained the DMBC stated that the workforce demands will depend on an uncertain matter which was "the readiness of the services and the timescales for changes in the CSR implementation plan". and sixth, because as Sullivan J explained in the **Greenpeace** case (supra):

> "With the benefit of hindsight, it will almost invariably be possible to suggest ways in which a consultation exercise might have been improved upon. That is most emphatically not the test."

90. Mr. Coppel says that the CCG could have obtained information from the local authorities needed to produce the calculations. I doubt if that information would have enabled the CCG to work out how, when and in what order the implementation of the new regime would occur, which were crucial matters for any calculations. In any event, even if that was wrong, it was not Wednesbury unreasonable or a breach of public law for the CCG not to have sought to have obtained this information for the six reasons set out in the previous paragraph.

91. Pulling the threads together, the CCG had considered all the material factors and had developed a clear strategy that it would "continue to work on workforce development alongside partner organisations" as Dorset CC recommended that it should do in its letter of 29 August 2017. The CCG was also quite entitled not to have prepared calculations bearing in mind that the workforce demands at different times would depend on an uncertain matter which was "the readiness of the services and the timescales for changes in the CSR implementation plan" and the other matters which I have set out in paragraph 89 above. The Governing Body was put on notice of this approach which entailed considering the sufficiency of the social care workforce in the light of what the DMBC described as "a risk that there may not be available staff and resources in the system to deliver the future service models". They adopted this approach of the CCG and no local authority has sought to invoke its critically important right to refer proposals to the Secretary of State on the grounds that the Decisions (including the vital issue of the adequacy of the social care workforce) were not *"in the interests of the health service in its area"*. For these reasons and the other matters to which I have referred, I reject this head of challenge as I do not consider that the approach of the CCG was Wednesbury unreasonable or a breach of the CCG's public law obligations the relevant factors relating to the the adequacy of the social care workforce had been considered.

E. Issue 2: The Alternative Investigations Issue

(i) The Claimant's Case

92. The case for the Claimant is that the CCG failed adequately to investigate and to reach a conclusion on whether alternative community provision could be put in place, before deciding to close hospital beds, contrary to the **Tameside** duty of careful inquiry, together with its duty to make further inquiries as to (i) what alternative community guidance would need to be put in place to achieve the reduction in demand for acute hospital care; (ii) how the workforce for this community provision would be recruited; and (iii) how it would be paid for. It is said that the CCG proceeded on the basis of untested assumptions and that no reasonable public body could have proceeded on the basis of the information before it and that it should have made further inquiries.

93. The approach of the CCG is said to be contrary to the **Tameside** duty of inquiry, which provides that:

> "… the question for the court is, did the Secretary of State ask himself the right question and take reasonable steps to acquaint himself with the relevant information to enable him to answer it correctly?" **Secretary of State for Education and Science v Tameside Metropolitan Council** [1977] AC 1014,1065 per Lord Diplock.

94. Mr. Coppel contends that the workforce was of critical importance in considering the options because the proposed alternative provision required a substantial number of new staff when there were 14% vacancies and 20% of staff within 5 years of retirement. He points out that the DMBC makes clear that the workforce crisis was only to be considered as a detail of implementation after the original decision had been taken. So the DMBC invited the Governing Body to adopt the proposed decisions and then proceeded to describe potential difficulties which had been identified in "high level implementation plans" which might arise at the implementation stages.

(ii) The Stance of the CGG

95. Mr. Goodson has explained that that during the CSR process, consideration was given to models of providing health care around the NHS and internationally in order to ascertain the appropriate model for the CCG with patients receiving the right care at the right place in the right location. I have referred to the way in which the local authorities and the health trusts were involved in developing the options. They also had a great interest in ensuring that there was adequate community care to compensate for the reduction in acute hospital care and that there would be adequate community provision. It must have been expected that they would have complained before the Decisions were taken if they believed that these matters were not being handled properly by the CCG because alternative and superior provisions could and should have been put in place, but there is no evidence of this.

96. In the Appendix to the Consultation document, it is explained that the CCG considered 65 potential options for acute hospitals and that "this process of elimination gave us two feasible options for consideration". Those options were the subject of the consultation. Before reaching the two feasible options, the very many options considered included considering examples of schemes where increased primary and community services had resulted in significant reductions in acute admissions and

lengths of stay. Comprehensive modelling to understand the future demand for services in Dorset and the workforce requirements was undertaken.

97. Very significantly, the CCG sought and obtained regular external assurance of its proposals. NHS England guidance, 'Planning, assuring and delivering service change for people" provides for two stages of formal assurance, a strategic sense checks and Stage 2 assurance. The strategic sense check examines the case for change and the level of consensus for change, including identifying and mitigating all potential risk. Stage 2 assurance is NHS England's formal assurance of proposed options for consultation involving input, not merely from the local NHS and external bodies, but also in this case from the Clinical Senate (via two external teams) and a Health Gateway Review.

98. The Clinical Senate was a source of independent strategic advice to make the best decisions about health care for the population they represent. The Wessex Clinical Senate made a number of comments. The Stage 2 assurance, which included the findings of the Wessex Clinical Senate, took place in June 2016. NHS England-South (Wessex) received sufficient assurances to recommend that the proposal could be taken to the National Oversight Group for Service Change and Reconfiguration. It accepted the proposed assurances which were then taken to the NHS England National Investment Committee which agreed that they were supportive of the CCG's proposals. The critically important confirmation of Stage 2 assurance was received from NHS England on 15 November 2016. This showed support for the consultation process, including the options considered.

99. As for the **Tameside** duty, Popplewell J explained in respect of the Tameside duty, that "the scope of investigation required for any given decision is context specific" (**R (on the application of Refuge Action) v The Secretary of State for the Home Department** [2014] EWHC 1033(Admin) paragraph 121). In this case, the scope is very limited. That was not merely because of the urgent financial problems facing the CCG to which I have referred in paragraph 9 above and because, as I have explained in paragraph 40 above, Green J observed in **Hutchinson's** case that:

> "94... Parliament, wisely, does not attempt to limit the various ways in which CCGs could provide arrange for the provision of health care. It follows, in my view, that Parliament intended CCGs to enjoy a broad discretion when choosing how to commission."

100. So it is said that there is no merit in this complaint.

(iii) Discussion and Conclusion on the Alternative Investigations Issue

101. This claim has to be considered in the context of various factors, first, the numerous judicial statements to which I have referred in paragraph 40 above that the CCG enjoyed broad discretion in choosing how to commission; second, the fact that the CCG had considered numerous models and 65 potential options before choosing the proposed options; third, it has not been shown that there was a particular alternative option which should clearly have been adopted; fourth, the critically important confirmation of Stage 2 assurance was received from NHS England on 15 November 2016; fifth, the confidence of the NHS entities in the proposals explained in paragraphs 97 and 98 above ; and sixth, the decision of the Dorset CC's HOSC not to refer the Decisions to

the Secretary of State on the basis that the CCG's Decisions were "not in the interests of the health service in its area". Seventh, neither the JHSC nor the five constituent local authorities had made such a referral or sought to suggest that the CCG should have carried out further investigations on whether alternative processes and procedures should have been adopted by the CCG before the Decisions under challenge were taken. Finally, the Claimant's case, if correct, would mean that in almost every case, it will be possible to think of some further inquiry that the decision-maker could have taken.

102. In those circumstances, the CCG was entitled to act as it did. Therefore, I must reject the contention that the CCG failed adequately to investigate and to reach a conclusion on whether alternative community provision could be put in place before deciding to close hospital beds.

F. Issue 3: The New Bed Closure Test Issue

(i) Introduction

103. This issue relates to the consequences of the introduction in 2017 by NHS England of the Bed Closure Test (which is described in paragraphs 108 and 109 below), and whether the proposals of the CCG were subject to it as well as the further issues of first, whether the CCG was obliged to consult in relation to it; second, whether the CCG took into account the requirements of the Bed Closure Test; and third, if not, what the consequences are.

(ii) The Statutory Landscape relevant to the Bed Closure Test

104. The background to the imposition by NHS England of the new Bed Closure Test is that the 2012 Act also created NHS England, which was a body corporate (see section 1H (1) of the Act). NHS England has the same duties as are imposed on the Secretary of State under section 1 of the Act, namely to continue the promotion in England of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England, and in the prevention, diagnosis and treatment of physical and mental illness: section 1H (2) of the Act.

105. For the purpose of discharging that duty, NHS England has the function of arranging certain health services itself. It must also exercise the functions conferred on it by this Act in relation to CCGs so as to secure that the services are provided for those purposes in accordance with the Act (section 1H (3)).

106. By section 14Z8 (1) of the Act, NHS England must publish guidance for CCGs on the discharge of their commissioning functions. Each CCG is under a statutory duty to have regard to guidance published under this section: see section 14Z8 (2) of the Act.

(iii) The Introduction of the Bed Closure Test

107. Prior to 2017, four tests of service change for NHS England had been stipulated in its published guidance and they related to:

(1) strong public and patient engagement;
(2) consistency with current and prospective need for patient choice;
(3) a clear, clinical evidence base; and

(4) support for proposals from clinical commissioners.

108. On 3 March 2017, the NHS England Chief Executive announced that as from 1 April 2017, a fifth test, which is the Bed Closure Test, would be applicable as the announcement stated that:

> "From 1 April [2017], local NHS organisations will have to show that significant hospital bed closures subject to the current formal public consultation tests can meet one of three new conditions before NHS England will approve them to go ahead."

109. This Bed Closure Test required that in any proposal including plans to significantly reduce hospital bed numbers, CCGs had to be able to show that they could meet one of the following three conditions, namely to:

(1) 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
(2) Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or
(3) Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with Getting It Right First Time programme).

(iv) The Contentions on the Bed **Closure** *Test Issue*

110. The case for the Claimant is first, that the CCG wrongly proceeded on the basis that the Bed Closure Test did not apply to its proposals; second, that the CCG failed to consult on the Bed Closure Test; and third, that if the Bed Closure Test did apply to the CCG's proposals, it was not complied with.

111. In response, the CCG contends first, that the Bed Closure Test did not apply to its proposals; second, that in any event, there was no need to consult on the Bed Closure Test; third, that the CCG took into account the requirements of the Bed Closure Test to the satisfaction of NHS England; and fourth, if it was obliged to comply with the requirements of the Bed Closure Test to the satisfaction of NHS England, but had failed to do so, then the Decisions should not be rescinded.

(v) Did the Bed **Closure** *Test apply to the CCG's proposals?*

112. CCG's case is that the Bed Closure Test did not apply to its proposals because before this test was announced on 3 March 2017 and introduced on 1 April 2017 the CSR had undergone the full NHS England assurance process including two assurance reviews from the Oversight Group for Service Change and Reconfiguration and two National Investment Committees and NHS England had approved the proposals against the "Four Key Tests" on 15 November 2016.

113. Ms. Morris contends that because NHS England has approved the CCG's proposals and permitted consultation which had taken place from 1 December 2016 to 28 February 2017 which was before the announcement of the Bed Closure Test on 3 March 2017,

this test did not apply to the CCG's proposals. She fortifies this contention by submitting that if there was any doubt about the applicability of the Bed Closure Test to the CCG's proposals, the case that the Bed Closure Test did not apply to those proposals was confirmed by letter from NHS England dated 5 April 2017 to the CCG'S local MP, Dr Andrew Murrison, which stated that:

> "Mr. Goodson is correct that the test being formally applied from 1 April 2017 will not apply, as the CCG's proposals had completed the NHS England formal assurance process prior to consultation" and that "the tests do not formally apply to the Dorset scheme".

114. Mr. Coppel's response is that this statement in that letter is clearly an error on the part of NHS England because it is contrary to the terms of the guidance published by that organisation. He also relies on the decision in **R (Cherwell District Council and Keep the Horton General) v Oxfordshire CCG** [2017] EWHC 3349 (Admin), in which Mostyn J rejected the defendant's submission that the Bed Closure test did not apply retrospectively to any consultation already underway. At paragraph 40, Mostyn J confirmed that the Bed Closure test would be operative, *"...at the time that any decision following the consultation was made."*

115. Accordingly, Mr. Coppel contends that before taking the Decisions, the CCG (a) was under a statutory duty to have regard to the Bed Closure test, as part of guidance published by NHS England under section 14Z8(1) of the Act; and that it (b) can only decide to depart from such statutory guidance if it gives clear reasons for doing so: see **Khatun v Newham LBC** (supra), paragraph 47.

116. Mr. Coppel submits that the remainder of the guidance makes clear that the NHS England assurance process is an ongoing one. It operates an "initial" two-stage assurance process (being the strategic sense check and an assurance "checkpoint"). NHS England will then continue to consider the project and may impose further assurance requirements before the decision in question is taken and throughout the implementation phase.

117. So he says that the NHS England assurance process was not completed before 1 April 2017, because although NHS England had given approval at stages 1 and 2, it still retained thereafter a role in assuring compliance certainly before the decision was taken. It is noteworthy that Mr. Goodson explained in his witness statement that NHS England continued to assess the proposals after the Bed Closure Test was introduced.

118. To my mind, the critical factor was that the entire NHS England assurance process was not completed before 1 April 2017 and therefore, I consider that the Bed Closure Test was applicable to the CCG's proposals. I do not consider that the views of an official of NHS England in his letter of 5 April 2017 can alter this legal position.

(vi) Did the CCG have to consult in respect of the Bed **Closure** *Test?*

119. The case for the Claimant is that the CCG was obliged to consult on whether the Bed Closure Test had been satisfied. I find it difficult to see why consultation on this test was necessary bearing in mind that it was NHS England that had to be satisfied that those tests had been satisfied. Indeed, if NHS England, the expert body, was satisfied

that those tests had been satisfied, I find it difficult to understand the role of a subsequent consultation on whether the tests had been complied with. A further reason is that the consultation period closed on 28 February 2017 and the notice relating to the introduction of the Bed Closure test was issued on 3 March 2017 and I assume that a further consultation would be called for on the Claimant's case.

120. It is true that the Oxford CCG decided of its own volition to consult in respect of the application of each of NHS England's "Four Key tests" in the **Cherwell District Council** case and so it was considered apt to consider the application of the bed closure test, but that does not show that there was an obligation to do so in that case or indeed in this case. It must not be forgotten that it was held in that case that in Mostyn J's words "the absence of consultation was not sufficiently material to lead to a finding that the consultation was unfair, let alone that it is vitiated".

(vii) Did the CCG take into account the requirements of the Bed **Closure** *Test to the satisfaction of NHS England?*

121. The complaint of the Claimant is that the CCG did not take into account the bed closure test as it is said that there is "not a shred of evidence to suggest that the decision-maker, the Governing Body of the CCG, considered this report when taking the Decisions on 20 September."

122. That is disputed by Ms. Morris who contends that although it was not necessary to apply it, the CCG did consider the "fifth test". The Governing Body of the CCG were informed in the DMBC, that in response to the Bed Closure Test "we prepared a report to provide assurance that our plans meet the requirements outlined within the new patient care test", which was the "fifth test", the Bed Closure Test. In addition, a report was provided to NHS England for further assurance that the requirements of the new patient care test were met in the report entitled "CSR –New Patient Care Test for Hospital Bed Closures".

123. The organization which had to decide if the Bed Closure Test had been complied with was the entity which imposed the test, namely NHS England. Crucially, it confirmed its satisfaction with the CCG's approach by letter dated 5 April 2017 when it stated that:

> "While the tests do not formally apply to the Dorset scheme, we are confident that the CCG have considered the new tests, and will continue to monitor the impact of proposed changes through implementation."

124. NHS England also noted and recognised in that letter that appropriate "steps were taken to ensure that sufficient alternative provision covering the Dorset CCG commissioning area as a whole, had been carefully considered.". Mr. Goodson also explained in a witness statement that the letter confirmed that the CSR plans would have satisfied the Bed Closure Test (Condition A) had it been in place at the time of the pre-consultation assurance approval. The Claimant has been unable to show that the CCG had not complied with the Bed Closure Test and so this claim fails.

(viii) Conclusion on the Bed Closure Test Issue

125. I have concluded that the Bed Closure test applied to the CCG's proposals, but that there was no obligation to consult on the Bed Closure Test. In any event, the CCG took into account the requirements of the Bed Closure Test to the satisfaction of NHS England, who were the crucial arbiters of whether the test had been complied with and that was determinative of the issue and I cannot understand why the Governing Body would be entitled or required to look behind it.Therefore, it is unnecessary for me to consider whether the Decisions would have to be quashed if the Claimant had succeeded on the Bed Closure Test issue or whether as in the **Cherwell District Council** case, the decision was not quashed when it had failed to comply with the Bed Closure Test provisions.

G. Issue 4: The Travel Times Issue

(i) Introduction

126. The Claimant's case is that the CCG failed to consider adequately the impact of increased travel times in emergency cases to Bournemouth Hospital, which was to become the major emergency hospital rather than Poole Hospital, which was the more centrally located hospital. The Claimant's complaint is that the CCG failed to equip itself with essential information which it required to apply the accessibility criterion, that it misdirected itself as to the conclusions which to be drawn from the information which it had acquired and failed to consider the mandatory consideration of accessibility to services for those in the more isolated areas. This issue has been a matter of particular concern to the Claimant and Ms. Monkhouse, who have both explained in clear and careful witness statements why they consider that a significant number of Dorset residents, including both of them, will be unable to obtain access to A&E, maternity and neonatal services within the "safetime guidelines" if Bournemouth Hospital was to become the major emergency hospital and Poole Hospital was to be downgraded. This issue has been the subject of consideration by the CCG.

127. In January 2015, the CCG published its "Case for Change" in which it developed a number of proposals including that the Poole and Bournemouth Hospitals would each have distinctive roles. The CCG commissioned Steer Davies Gleave ("SDG") to conduct an analysis of travel time in order to analyse the impact on them of the options for reconfiguration, and, in particular, whether to locate a major emergency hospital at Bournemouth Hospital or at Poole Hospital. SDG concluded that the "option evaluation for access to a major emergency hospital services rates [those services] provided at [Poole] higher than where [such] services are provided at Bournemouth Hospital".

128. In the consultation paper, for reasons which I will explain in paragraph 152 below, the preferred option was that Bournemouth Hospital should be the major emergency hospital with Poole Hospital becoming a planned hospital. During the consultation process, concerns were raised on matters including the travel times for patients and the risks to them if Poole Hospital's specialist Trauma A&E and maternity departments were to close.

129. As I have explained, in consequence, SWAST was asked by the CCG "to establish the potential impact of the proposed CSR reconfiguration on the emergency ambulance

services". The report, which was published in August 2017, is summarized in the Appendix to this judgment. It analysed 21,944 patient records covering all incidents when an ambulance attended and conveyed a patient to hospital during the period of 4 months from 1 January 2017 to 30 April 2017. The report considered maternity-related calls, adult and child emergencies. SWAST gave particular consideration to those cases in which the travel time of the patients would be extended under the new care model.

130. This exercise led to 132 cases (3 maternity cases, 125 adult emergency cases and 4 pediatric emergency cases) out of the 21,944 cases being identified where in the words of the SWAST report (with emphasis added) "extended journey times *may* increase the clinical risk". SWAST recommended in respect of the 132 cases that the CCG should "support the expert review of cases identified where extended journey times may increase the clinical risk". The 132 cases amounted to 0.6% of the 21,944 cases in which the possible additional clinical risk remained unquantified. The approach of SWAST and the conclusions that the CCG drew from it have been the subject of criticism by the Claimant's counsel and I will return to consider those criticisms.

131. Pursuant to the recommendation of SWAST, on 31 August 2017, a meeting took place attended by various experts to consider the potential additional risk cases which SWAST had identified as requiring further clinical review. The participants were unable to comment further on the risk posed to patients from the proposed CSR changes for a number of reasons. Those reasons included first, the fact that to reliably determine whether a patient would come to harm with the extended journey time would require hospital notes of the medical condition, injuries sustained and necessary treatment of the patient concerned; and second, that no consideration had been given to the time it would take for an ambulance to become available and to arrive at the patient's location bearing in mind that SWAST, like other ambulance services are under- resourced. So the meeting did not produce a conclusion on the risk posed to patients from the proposed CSR changes. No further meeting has taken place to review these cases.

132. The JHSC welcomed the additional work which the CCG had undertaken relating to the travel and transport issues and it recommended that work should continue with the local authorities and the ambulance services during the implementation phase to address these issues. The CCG and the local authorities set up a Transport Reference Group to develop an integrated transport plan for non-emergency health and social care across Dorset.

133. The DMBC, which was published on 1 September 2017, referred to the additional work in the SWAST report and it acknowledged that further work needed to be done during the implementation phase. It also referred to the proposals and that there will be "a minimum clinical risk" caused by any increased travel times.

(ii) The SWAST Report and the Decision

134. As many of the submissions on this issue relate to the SWAST report and its approach, it seems prudent to explain its reasoning. Mr. Goodson has explained that there were understandable concerns that changes to the location of treatment may lead to increased travel times and that this in turn could have a negative impact on the well-being of patients. He explained that national evidence - such as from Sir Bruce Keogh, NHS England's then Medical Director - supports the view that patients may have to travel further to receive specialist treatment, but that the outcomes for patients will be more

beneficial as a result of increased specialisation. Mr. Goodson said that this became the cornerstone in Dorset's CSR to improve outcomes and save lives. This was the way in which the CCG complied with its duty under section 14R of the Act which was to secure continuous improvement in the services provided to individuals. Mr. Goodson concluded that the CCG was:

> "… reassured by the extensive work undertaken that for most people the impact of changes on travel times would be negligible or shorter, and where people may be subject to longer travel times they would experience better outcomes"

(iii) Discussion and Conclusions on the Travel Times Issue

135. The first contention of the Claimant is that the conclusion reached by the SWAST report was misrepresented to the CCG's Governing Body in the DMBC and - according to the Minutes - by Mr. Adrian South, the Clinical Director of South Western Ambulance Trust, at the 20 September 2017 meeting. The case for the Claimant is that, contrary to what was stated in the DMBC and by Mr. South, SWAST did not conclude that there was a minimal clinical risk arising out of the increased travel times which may be caused if the Decisions were implemented.

136. I have concluded that the CCG was entitled to conclude that SWAST's statistics and analysis indicated that the additional clinical risk caused by the increased travel times as a result of implementing the proposed reconfiguration of medical services was "minimal". The SWAST report had been commissioned by the CCG to establish the potential impact of the proposed CSR reconfiguration on the emergency ambulance service. Therefore, it considered journey time and the potential additional clinical risk caused by the increased travelling time. In its detailed report running to 33 pages and containing 20 tables together with 13 graphs and maps, SWAST sought to identify cases in which the increased travelling time *might* cause additional risk for the patients concerned. The SWAST report made it clear that "no model can predict the future; it can only consider the potential impact of the Dorset CSR on historical data".

137. As I have explained, this analysis shows that there were only 132 cases for which additional clinical risk may be caused by increased travelling time as a result of implementing the proposed reconfiguration of medical services. These 132 cases amounted to 0.6% of the total 21,944 SWAST cases. The CCG with its broad discretion was quite entitled to conclude that the potential additional clinical risk quantification of 0.6% would indicate only a minimal clinical risk which *may* be caused by increased travel times. Indeed, if 0.6% does not show a minimal potential additional clinical risk, it is difficult to know what percentage the CCG would be entitled to regard as constituting "a minimal clinical risk". So, assuming that the figures in the SWAST report could be relied on as giving an accurate prediction of travel times, the CCG was entitled to state that there was minimal clinical risk arising out of the increased travel times if the Decisions were implemented. Support for that conclusion can be found in the evidence of Ms. Fleming, the Chief Executive of Poole NHS Trust, that some of the more seriously ill patients from Dorset - that is, those suffering from heart attacks or vascular problems - including residents of Purbeck, have been treated at Bournemouth Hospital and those arrangements have been deemed safe by Commissioners and Regulators and that those acutely ill patients receive treatment within an acceptable time period. So her evidence indicates that patients in Dorset requiring other types of

emergency care will be treated safely when services move to Bournemouth Hospital. I now turn to the contentions that those figures in the SWAST report cannot be relied on as giving an accurate picture.

138. The second contention of the Claimant is to challenge the reliability of the reasoning in the SWAST report by contending that there were unexplained and questionable steps used to reduce the total of adult cases from 1,636 cases to 696 cases. There is no merit in this point as SWAST was entitled to reduce those 1,636 patients so as to remove any incidents with a diagnosis code which were regarded as low risk such as, for example, anxiety risk or non-injury fall. The 696 cases were those with the most serious conditions classified by using what is called a NEWS score, which is a simple aggregate scoring system for identifying the sickest patients by taking account of certain specified risk factors, such as respiration and pulse rate, level of consciousness, oxygen saturation, systolic blood pressure and temperature. The SWAST report explains that "due to the time required to manually clinically review the remaining 696 cases, it would not have been possible to carry out the task within the time frame of the report". So a randomized sample of 22% of the 696 cases produced 150 cases. Mr. Goodson explains that random sampling is a recognized research methodology and "is the most straightforward probability sampling strategy". There was no reason why that approach was Wednesbury unreasonable or why it did not fall within the wide discretion given to the CCG to decide how to commission in the light of, in particular, the urgent need to find solutions to the serious and pressing financial problems facing the CCG. No expert or other cogent evidence was adduced to show that the SWAST approach was Wednesbury defective. Indeed, as I have explained, Sullivan J (as he then was) in the Greenpeace case (supra) explained that although:

> "…with the benefit of hindsight, it will almost invariably be possible to suggest ways in which a consultation exercise might have been improved upon. That is most emphatically not the test"

139. Third, the Claimant makes another challenge to the reliability of the reasoning in the SWAST report because of the absence of a proper expert review of the 132 cases in respect of which the report concluded that increased journey time could have resulted in harm to the patient. The only review which occurred took place on 31 August 2017, but it was unable to perform this task for the reasons such as those explained in paragraph 131 above. It is important to stress that the expert review recommended in SWAST's recommendations was for the CSR to consider the following recommendations which was to "support the expert review of cases identified where extended journey times may increase the clinical risk" (emphasis added).

140. It seems clear that the expert review was limited to considering the 132 cases which were "the cases identified where extended journey times may increase the clinical risk" (emphasis added). Indeed, as the meeting of experts was charged with considering only the 132 cases, they could not have increased the number of cases in which increased journey time could have resulted in potential harm to the patient. So the expert review could either have supported the finding of 132 cases or it might have resulted in reducing the 132 cases. Instead, CCG worked on the assumption that all those 132 cases remained as the only cases in which increased journey time could have resulted in harm to the patient. So by not holding the expert's meeting, the CCG lost the chance of reducing the number of such cases. So the failure to hold the meeting does not show

that the CCG was working on figures which underestimated the number of cases where the increased journey time could have resulted in harm to the patient.

141. In any event, even if that analysis was wrong, this head of claim would fail as the CCG had a broad discretion as to how to evaluate the risk caused by increased travel time. The CCG was entitled to rely on the figures in the SWAST report and not to carry out the extensive inquiries suggested at the expert's meeting held on 31 August 2017, particularly bearing in mind the need for the CCG to take urgent action to remedy the crisis in the health and social care provision for the reasons set out in paragraph 9 above. As I explained in paragraph 131, those extensive inquiries suggested by those who attended the review meeting on 31 August 2017 would have been very time-consuming including obtaining and analysing the hospital notes of the medical condition, injuries sustained and necessary treatment of the patients concerned to determine whether they would have come to harm because of the extended journey time. For similar reasons the CCG was entitled, in the light of the urgency, not to await a further review and so if it is suggested that the review meeting should have considered more than the 132 cases specified in the SWAST report I am unable to accept this head of criticism. I will deal in paragraph 153 with the issue raised at the meeting on 31 August 2017 of whether the time it takes for the ambulance to become available and to reach the patient would mean that it would not be safe for emergency cases in Dorset to be dealt with at Bournemouth Hospital.

142. Fourth, Mr. Coppel contends that the CCG did not consider "outliers" which were said to be "namely those patients who would be most seriously affected by increased journey times". I do not accept that criticism as the SWAST report refers to the maximum travel times for adult patients and children and that would include outliers. Nothing has been put forward to show that "outliers" were not considered in the SWAST report.

143. Fifth, although it was not raised in the application for judicial review or in the Claimant's skeleton argument for the present hearing, Mr. Coppel at the hearing contended that the CCG presented the decision-makers with a claim that their plan for reorganisation would save 60 lives per year. This point was raised during the oral submissions of Mr. Coppel and in the Reply. Ms. Morris contends that because this issue was not raised in the Claimant's judicial review application or even in the Claimant's skeleton argument, the evidence of CCG understandably did not address the correctness of the claim that 60 lives per year would be saved. I will return to consider how I should deal with this objection.

144. In any event, there is much evidence that lives will be saved by having specialist units as specified in the proposed regime. Mr. Goodson has explained that travelling further to receive specialist care will benefit the patient as it would provide a better health outcome. The consultation document explains that the rationale for the new proposed regime was, as seems sensible, that more lives would be saved when people are treated at a specialised site available for 24 hours every day.

145. Ms. Fleming, who, as I have explained, was and is the Chief Executive of Poole Hospital NHS Foundation Trust stated that between 17 and 29 lives might be saved each year through quick access for patients with heart problems to treatment for non-ST segment elevation myocardial infection for patients who, prior to the reforms in the Decisions, were admitted to Poole Hospital and then transferred to the Bournemouth Hospital for treatment.

146. She also stated that consolidation of acute stroke services at Bournemouth Hospital would lead to quicker access to stroke consultant reviews, higher nurse to patient ratios and improved specialist staffing levels and that these improvements would reduce patient mortality. Ms. Fleming also refers to higher quality care for A&E patients because of the availability of consultants at all time under the new regime even though they would not necessarily be present at hospital. She also explains that higher quality care for patients would be a consequence of better access to consultants and significantly improved facilities for maternity services under the regime set out in the Decisions. All these factors show that there would be many lives saved. I am not satisfied that that it was unreasonable for the CCG, who after all had the expert knowledge which I do not have, to predict that 60 lives would be saved each year.

147. I should add that, in any event, it would be wrong to allow the Claimant to succeed on this issue because Ms. Morris has explained that if the complaint about the representation by the CCG that 60 lives would be saved by the new regime had been made, as it should have been made in the judicial review application form, this would have led to the CCG adducing evidence on this issue. In my opinion, it would be wrong to allow the CCG to be very seriously handicapped by not having this evidence when there was no reason for them to be prepared for it. Therefore, I would not, in any event, have allowed the Claimant to succeed on this issue.

148. Sixth, it is contended that more of Dorset's population, including the Claimant, would be left without safe access to emergency services than was the position before the Decisions were made. Those living in West Dorset could obtain this at Dorset Hospital in Dorchester and the predicted additional travel time according to Mr. South was 9 minutes. As I will explain in the next three paragraphs, a greater proportion of the Dorset population would be able to reach these services at Bournemouth Hospital than at Poole Hospital within 20 or 30 Minutes. So I am unable to accept this claim of the Claimant.

149. Seventh, a complaint is made that, as I have explained in paragraph 127, SDG produced a report early in the evaluation process which rated medical emergency hospital services being provided at Poole Hospital higher than that provided at Bournemouth Hospital. Mr. Goodson has explained that the report also stated that if those services were provided at Bournemouth Hospital, this would mean that a higher proportion of Dorset's population would reach those services within 20 minutes. Ms. Monkhouse has stated in her witness statement that "according to independent research, the maximum travel times in acute stroke, major trauma and maternity emergency are set at 30-45 minutes".

150. In addition, if Poole Hospital was the major emergency hospital, 80% to 87% of Dorset's population would be able to access planned and emergency services within 30 minutes depending on peak or off-peak travel times, while if those services were provided at Bournemouth Hospital, 90% to 93% of Dorset's population would be able to access planned and emergency care services within 30 minutes. This analysis assumed that Yeovil and Shaftesbury would not provide major emergency services and so travel to those hospitals was excluded from this calculation

151. The present position is that Yeovil and Shaftesbury will now continue to provide general emergency services. That means according to Mr. Goodson that if Poole Hospital was the major emergency hospital,71% of the population of Dorset would

reach services in 20 minutes and 94% within 30 minutes with a maximum travel time of 40 minutes and that would be well within the period of 45 minutes referred to by Ms. Monkhouse. On the other hand, if Bournemouth Hospital was the major emergency hospital 78% of the population of Dorset would reach services in 20 minutes and 95% in 30 minutes with a maximum travel time of 40 minutes. So it seems that Bournemouth Hospital is more accessible to a larger proportion of the population than Poole Hospital. It was also noted that Bournemouth Hospital was easier to reach by a larger proportion of the population by blue light while Poole Hospital was better placed for public transport and that suited a planned site there.

152. The consultation document sets out a whole variety of additional reasons why Bournemouth Hospital (and not Poole Hospital) was the proposed major emergency site for a number of reasons including first, that there is better access at Bournemouth Hospital as more of the population live in the east of the county and it is better for patients living in West Hampshire, a considerable number of whom use Bournemouth Hospital; second, Bournemouth Hospital would be cheaper and easier to develop and expand than Poole Hospital; third, it has lower running costs than Poole Hospital; fourth, unlike Poole Hospital, it has emergency access for helicopters on site. None of those factors have been effectively challenged in this judicial review application.

153. Eighth, it is said that there is a fault in the SWAST report as it focuses on the *increased* journey time rather than on the *total* journey time to Bournemouth Hospital from the time when the ambulance was called. I have explained that at the meeting on 31 August 2017, the point was made that SWAST, like ambulance services nationwide were under-resourced and no consideration during the CSR process was taken of the time it takes for the ambulance to become available and to reach the patient. It is true that the SWAST report only considers increased time rather that the total time but there is evidence that the total journey times do not endanger life. As I have explained, Ms. Fleming, the Chief Executive of Poole NHS Trust, has reported in a witness statement that some of the more seriously ill patients from Dorset - that is, those suffering from heart attacks or vascular problems - including residents of Purbeck, have been treated at Bournemouth Hospital and those arrangements which take account of total journey time have been deemed safe by Commissioners and Regulators and that those acutely ill patients received treatment within an acceptable time period. So her evidence, with which Mr. Tony Spotswood, the Chief Executive of Bournemouth Trust, agreed indicates that patients in Dorset requiring other types of emergency care will be treated safely when services move to Bournemouth Hospital taking into account the total journey time. If this evidence was not taken into account before the Decisions were taken, on the Claimant's case, this might show that adequate inquiries had not been made about the total journey time. The response to that would be that if such inquiries had been made, the evidence of Ms. Fleming would have shown that those requiring emergency treatment in Dorset, including residents of Purbeck, would be able to obtain treatment in Bournemouth within an acceptable period. This is powerful evidence that the total journey times to Bournemouth Hospital will be deemed safe from different parts of Dorset, including residents of Purbeck. I fortify this point by repeating, as I explained in paragraph 87, that Dorset CC and the other local authorities had the rule 23(9) power to make reference to the Secretary of State if the proposals were "not in the interests of the health service in its area". A system by which critically ill patients could not reach a hospital for treatment would be an obvious case to use such a power,

but as I explained in paragraph 88, Dorset CC resolved not to refer this matter to the Secretary of State and none of the five constituent authorities have made such a referral.

154. Ninth, Mr. Coppel complains that the SWAST report and the CCG failed to consider the effect of increased travel time for self-presenting patients who form the majority of paediatric and obstetric cases. I assume that if they were emergency cases, they would go to hospital by taxi or car. In that case, it is difficult to see why the effect of the new regime would be different for them than it would be for people who go by ambulance as they would both be going by road. Nothing has been put forward to show why this is incorrect.

155. In conclusion, I agree with Mr. Goodson that the Decisions would lead to improvements in outcomes and save lives which would having the effect of satisfying section 14R(1) of the Act which requires the CCG to "exercise its functions with a view to securing continuous improvement in the quality of services provided". There is national evidence - such as from Sir Bruce Keogh, NHS England's then Medical Director – which supports the view that patients may have to travel further to receive specialist treatment, but that the outcomes for patients will be more beneficial as a result of increased specialisation.

156. Ms. Fleming has reported, as stated in paragraphs 145 and 146 above, the benefits of having the to those suffering from strokes, heart illnesses and other life-saving illnesses. As for the difficulties of access to Bournemouth Hospital, she has also explained in paragraph137 that that some of the more seriously ill patients from Dorset - that is, those suffering from heart attacks or vascular problems - including residents of Purbeck, have been treated at Bournemouth Hospital and those arrangements have been deemed safe by Commissioners and Regulators and that those acutely ill patients receive treatment within an acceptable time period. I do not accept any of the Claimant's grounds of challenge under this head for the reasons which I have explained.

157. I have concluded that contrary to the Claimant's case the CCG equipped itself with the appropriate information that it required to apply the accessibility criterion. It also reached conclusions open to it on the information which it had acquired and considered appropriately the issue of access to services for those in the more remote and isolated areas. After all, it was open to the CCG to conclude that the advantages of improved health services under the proposed regime outweighed any problems caused by increased journey times. In addition, I am fortified in coming to these conclusions by the additional matter that if the Decisions would lead to more than a minimal increase in additional risks to critically ill patients as a result of increased journey times to A&E and maternity departments, the attitude of the local authorities in Dorset is more than surprising. They each had, and have, a strong interest in ensuring that the health of those living in their areas was not jeopardized by choosing Bournemouth Hospital and not Poole Hospital as the major emergency hospital. As I have explained in paragraph 87, the authorities had the rule 23(9) power to make reference to the Secretary of State if the proposals were "not in the interests of the health service in its area". A system by which critically ill patients could not reach a hospital for treatment would be one of the most obvious cases in which to use such a power, but as I explained in paragraph 88, Dorset CC resolved not to refer this matter to the Secretary of State and none of the five constituent authorities have made such a referral. I should add that the Claimants have said that the Dorset Health Scrutiny Committee is currently considering whether to make a referral almost one year after the Decisions were made. The critical time for

determining the legality of the Decisions was when they were made in September 2017 and not one year later.

H. Issue 5: The Consultation Issue

(i) Introduction

158. The Claimant's application for permission to pursue this issue was refused when considered on paper by the Deputy High Court Judge. The Claimant seeks to renew this application and this is a rolled-up hearing to consider this application. The case for the Claimant is that the CCG was under a statutory duty set out in s14Z2 (2) of the Act to consult its service users in respect of the matters covered in the Decisions. In addition, having decided to consult, the CCG was under a common law duty to conduct the consultation fairly.

159. It is said that the CCG failed to provide sufficient information to consultees and the consultation was therefore misleading in respect of 24/7 consultant care and/or the probability of large scale acute bed closures particularly at Poole Hospital. The approach to a challenge to the fairness of a consultation, as I have explained in paragraph 41 (b) and (d) will only succeed "if there is some irretrievable flaw in the consultation process" or that there is a finding by the Court "not merely that something went wrong, but that something went 'clearly and radically wrong'".

(ii) 24 Hour Consultant Care

160. The Claimant's case is that the consultation documents stress the benefits of 24/7 consultant care and that these documents suggest that one of the benefits was that the new regime would bring this about in Dorset. Reliance is placed on three matters.

161. The first matter is the statement in the consultation document that:

> "National clinical evidence shows that more lives are saved when people are treated in the specialist centres with senior specialist staff on site 24 hours a day, 7 days a week. At the moment, none of Dorset's hospitals offer 24/7 consultant care on site."

162. The second matter is that the table in the consultation document sets out "at a glance" the services that would be available at each of the types of hospital. Under the heading "Major emergency care hospital", it is stated that there would be "consultant delivered" A&E with major trauma and "consultant delivered" emergency surgery. It is also stated that there would be "inpatient consultant delivered services for very sick children". The glossary in the consultation document defines the term "consultant delivered service" as meaning, "the consultant will be present in the hospital at all times (24/7) to deliver that service".

163. Third, the consultation questionnaire stated that:

> "National and international evidence show that more lives are saved if people are treated in specialist centres with senior staff available on site 24 hours a day 7 days a week; however, none of the hospitals in Dorset currently provide this".

164. This statement is true and certainly cannot be understood as constituting a promise that there will always be 24/7 consultant care on site in the major emergency hospital.

165. All these statements on which the Claimant relies have to be read in the light of the clear statements in the consultation document, that 24/7 consultant cover is an "ambition" which the CSR aims to achieve and so it is not a warranty. First, the consultation document explains clearly (with emphasis added) that:

> "Patients needing emergency care would benefit by being taken to a hospital with specialist consultant-led services where the **ambition** is to have these available 24 hours a day, seven days a week"

166. Mr. Coppel contends that any reasonable reader would have understood the consultation document as a whole to be saying that consultants would be present on site at the new major emergency hospital on a 24/7 basis. In other words, his case is that the statement about the services has to be read as if the word "ambition" means "warranty". I cannot accept that submission.

167. A second reason why I reject the Claimant's case on this is that in Chapter 3 of the consultation paper in a section headed "Vision for change" it is said that one of "the five key ambitions" is "having highly trained consultants available 24 hours, seven days a week". I stress that this is described as one of the "five key **ambitions"** (emphasis added). Again, this shows that statements in the consultation paper about 24/7 consultant availability have to be considered in the light of the fact that they were ambitions.

168. Mr. Goodson has explained in his second witness statement of April 2018, that "we are well on track to realise the **ambition** described in the consultation document for 24/7 consultant-led emergency services" (emphasis added). In the consultation paper, "consultant-led services" are defined in the glossary to the consultation paper as meaning that "the consultant will be available at all times to deliver that service but will not be present at the hospital at all times to do so (e.g. they may be on call at home)". Mr. Goodson has explained that this statement was repeated in the "Frequently Asked Questions" section on the Dorset vision website and in the DMBC.

(iii) Acute Bed Closure

169. The complaint of the Claimant is that the CCG's consultation document did not explain to readers that there would be large scale acute bed closures especially at Poole Hospital. The consultation document made clear, as it was required to do, what services were being proposed on each site by the CCG and the views of consultees were sought on that issue.

170. This complaint fails to appreciate that first, the CCG in the words of the Introduction to the consultation document is "the organisation responsible for commissioning –or

planning and securing- healthcare in Dorset", and second that the CCG does not commission beds. Therefore, it was not concerned with the issue of how many beds were provided. Indeed, it was for the provider NHS Trusts, and not for the CCG, to decide how many beds were provided. So the CCG could not be expected to deal with acute bed closures in the consultation document, as it was a matter outside their control. So the CCG was not under a duty to provide information on this issue and if readers of the consultation paper were in any doubt, they could have requested further information.

171. Mr. Goodson has explained that it was clear which services would be provided from each site. There was a slide deck in an Appendix to the PCBC which showed the bed movements between the hospitals under two acute service scenarios and this was available to members of the public on the dorsetvision.nhs.uk. website. The DMBC shows clearly that 41,650 cases will transfer from Poole Hospital to Bournemouth Hospital and 42,691 will go in the opposite direction.

172. Mr. Goodson states that it was clear from the responses to the consultation that were received from members of the public and others that "they were well aware of the implications of our proposals in terms of bed movements." He explains that the consultation report noted that the Dorset Echo ran a campaign of "Hands off our wards" and the petition "Please don't axe Poole A & E" included a statement "a poor service if wards move to RBCH". Indeed, Ms. Monkhouse in her witness statement complains of the scale of the bed cuts proposed by the CCG, but significantly, she does not suggest that this was not known to those reading the consultation document.

(iv) Conclusion on the Consultation Issue

173. I grant permission for the Claimant to pursue the Consultation Issue, but dismiss the complaint for the reasons which I have stated. I am fortified in coming to that conclusion to some extent by four additional factors.

174. First, the consultation process itself was subject to independent scrutiny by the Consultation Institute's Independent Quality Assurance process and initially the process was deemed to be of Good Practice. Second, this was later "upgraded" to Best Practice Status. Third, the CCG's approach to consultation was also commended by Opinion Research Services, an independent research company.

175. Fourth, I have noted that, as I explained in paragraph 75 above, Dorset CC's Health Overview and Scrutiny Committee resolved not to exercise its right under rule 23(9) of the Local Authority (Public Health, Health and Wellbeings Boards and Health Scrutiny) Regulations 2013. This is, as I have explained, an important right as it enables local authorities to refer matters to the Secretary of State where it considers that they have not been adequately consulted on proposals for the substantial development of health services in the area or if the proposals are not "in the interests of health service in the area". The JHSC did not support a referral to the Secretary of State and none of the five constituent local authorities have made such a referral. Finally, a further difficulty for the Claimant is that a consultation document "which is flawed in one, or even in a number of respects, is not necessarily so procedurally unfair as to be unlawful" (***Greenpeace*** (supra) para 62).

I. Further matters

176. I should record that the skeleton arguments of the parties both dealt with the approach that I should adopt if I were to hold that the Claimant succeeds on any issue. The hearing proceeded on the basis that this matter would only be argued and would only be considered if and when there was a finding in favour of the Claimant on any ground. There has been no such finding and the matter has not been the subject of oral submissions, but it is appropriate to set out some of the submissions.

177. The Claimant's case was that if it succeeded on any ground, then the Decisions should be quashed. The CCG, on the other hand, set out a series of reasons, why in that event, the Court should not quash the decision such as that it is highly likely that the same decision would have been arrived at if the error had not been made. Another factor was that as Sullivan J observed in the **Greenpeace case** (supra):

> "A consultation exercise which is flawed in one, or even in a number of respects, is not necessarily so procedurally unfair as to be unlawful" [and] "a conclusion that a consultation exercise was unlawful on the ground of unfairness will be based upon a finding by the court, not merely that something went wrong, but that something went 'clearly and radically' wrong."

J. Conclusion

178. For the reasons I have explained, I grant permission to pursue the Consultation Issue, but dismiss that claim and all the other claims for judicial review. I appreciate that some residents of Dorset will be disappointed by this decision, but it might be some compensation for them to know that the Claimant's case has been very well argued as has the case for the CCG.

APPENDIX

Summary of the SWAST Report

1. The SWAST review analysed 21,944 patient records covering all incidents when an ambulance attended and conveyed a patient to hospital during the period of 4 months from 1 January 2017 to 30 April 2017.

2. There were 236 maternity cases. Of these 60 patients had no difference in journey time, 53 had a shorter journey and 41 had to travel further. All the 41 cases were reviewed by the SWAST Consultant Paramedic lead for Obstetrics and Maternity to establish if any may present an additional clinical risk. Of those, 3 cases were identified for further review.

3. There were also 20,246 adult cases and of those 16,113 patients had no difference in journey time, 650 patients had a shorter journey and 3,067patients had to travel further.

The data for all 3,067 cases with an extended travel time was reviewed. Only cases with a NEWS score of greater than 7 and or where medications were administered, cannulation attempted or where an airway adjunct was required were considered.

4. This led to a reduced total of 1,636 patients which were further reduced to 696 cases to remove any incidents with a diagnosis code which was regarded as low risk such as, for example anxiety risk or non-injury fall. The 696 cases were those with the most serious condition by using what is called a NEWS score and this is a simple aggregate scoring system for identifying the sickest patients by taking account of certain specified risk factors, such as respiration and pulse rate, level of consciousness, oxygen saturation, systolic blood pressure and temperature. The remaining 696 cases were reduced by an established manner of random sampling to a sample of 22% of 150 cases. A random sample of 150 cases was therefore selected for further review. An experienced Paramedic (Quality Improvement Paramedic and Clinical Development Officer East) reviewed all cases to establish if any had the potential to pose an additional clinical risk.

5. From the sample of 150 cases, 27 cases were highlighted and it was proposed that each case would be reviewed by the SWAST Acute Care Medical Director (Consultant in Emergency Medicine and Critical Care) to review the potential additional clinical risk. It was necessary to scale up from 27 of 150 random cases to the total number of 696 of adult cases where potential additional clinical risk remained unquantified. So the calculation was 696 divided by 150 multiplied by 27 and this gives a total of 125 adult cases for further review.

6. There were also 1,462 children cases and of those 1,337 were direct admissions to hospital and 125 cases were inter-hospital transfers. Of those 1,337 cases, 832 had no difficulty in journey time, 214 had a shorter journey and 291 had to travel further. In order to establish the potential clinical risk, the data for all the 291 cases was reviewed by the SWAST Clinical Director. This review identified 22 cases which were reviewed by the Quality Improvement Medic who identified a total of 4 cases where an extended journey time had the potential to impact on the patient.

7. The number of cases for further review was 132 comprising 3 maternity cases, 125 adult cases and 4 children cases.

8. The CSR team were asked to consider recommendations which included “Support the expert review of cases identified where extended journey times may increase the clinical risk”