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CO/2930/2013

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 31 July 2013

Before :

MR JUSTICE SILBER

- -

Between :

THE QUEEN (on the application of (1) LONDON BOROUGH OF LEWISHAM and (2) SAVE LEWISHAM HOSPITAL CAMPAIGN LIMITED)	**Claimants**
- and -	
(1) SECRETARY OF STATE FOR HEALTH (2) TRUST SPECIAL ADMINISTRATOR APPOINTED TO SOUTH LONDON HOSPITALS NHS TRUST	**Defendants**
LEWISHAM HEALTHCARE NHS TRUST LEWISHAM CLINICAL COMMISSIONING GROUP AND OTHERS	**Interested Parties**

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Elisabeth Laing QC (instructed by **Lewisham Council**) for the First **Claimant**
David Lock QC and Jeremy Hyam (instructed by **Leigh Day**) for the Second **Claimant**
Rory Phillips QC and Ivan Hare (instructed by **Treasury Solicitor**) for the **Defendants**
The Interested Parties were not represented

Hearing dates: 2-4 July 2013

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Approved Judgment

MR JUSTICE SILBER:

Introduction

1. There are few issues which prompt such vociferous protest as attempts to reduce the services at a hospital which is highly regarded and which is much used by those who live in its neighbourhood. One such hospital is University Hospital Lewisham ("LH"). The present applications for judicial review relate to first a recommendation to reduce the services at LH made by the Trust Special Administrator ("TSA"), and second to a subsequent decision made by the Secretary of State for Health ("the Secretary of State") to also reduce the services offered at that hospital but in a different way.

2. There are specified and detailed procedures for reconfiguring services offered by a hospital which aim to ensure that the procedures are fair and that they satisfy the requirements for adequate consultation. The most recent arrangements were introduced by the Coalition in 2010, and they require detailed consultation with many interested parties. Therefore by their nature, these arrangements are lengthy and very time-consuming. The evidence was that the normal process of consultation involved in the conventional application to reconfigure health service "*could take up to two years to reach a decision [and] in some circumstances it could take even longer*" (page 204 of TSA's final report).

3. There are also procedures available to improve the performance of NHS organisations so as to ensure that they provide adequate quality of care within sustainable resources, but on occasions it has proven impossible to improve speedily the performance of a failing NHS organisation sufficiently to secure an adequate quality of care for its patients within sustainable resources. For that reason, an exceptional bespoke procedure was introduced to deal with situations which arise, in the words of a senior official of the Department of Health, Dr. Shaleel Kesevan, "*where very occasionally it proves impossible to improve the performance of an NHS organisation sufficiently to secure adequate quality of care within sustainable resources*". This regime is entitled the "Unsustainable Providers Regime" ("the UPR"), which as its name shows was intended to deal with failing NHS organisations.

4. This UPR regime entails the appointment of a TSA to run, among other entities, an NHS trust. It was introduced by the Health Act 2009 which inserted Chapter 5A into the National Health Services Act 2006 ("the 2006 Act"). The actual statutory provisions in Chapter 5A, which were in force at the relevant time, are set out in the Appendix to this judgment. The key stages of this Chapter 5A regime as it applies to NHS trusts are that:-

    (a) The Secretary of State decides, after consulting prescribed parties, to make an order authorising the appointment of a TSA to an NHS trust (having taken the view that it is appropriate in the interests of the health service to do so (section 65B(1) to (6) of the 2006 Act);

    (b) The Secretary of State then appoints the TSA on the terms and conditions he thinks fit. At that point the chair and directors (non-executive and executive) of the trust board are suspended from office and the TSA takes control of the trust (section 65B(7) of the 2006 Act);

(c) The TSA then has 45 working days to provide to the Secretary of State and publish a draft report stating the action which the TSA recommends the Secretary of State should take in relation to the trust (section 65F(1) of the 2006 Act);

(d) Publication of the draft report is followed by a period of 30 working days during which the TSA must consult on the draft report with those prescribed in section 65H and whoever else the TSA considers it appropriate to consult (section 65G of the 2006 Act);

(e) The TSA must then provide the Secretary of State with a final report within 15 working days from the close of the consultation stating the action he recommends that the Secretary of State should take in relation to the trust (section 65I(1) of the 2006 Act);

(f) The Secretary of State must take a decision on what action to take in relation to the trust within a further 20 working days (section 65K(1) of the 2006 Act); and that

(g) The Secretary of State is therefore required to make a decision speedily. In the present case, it was given within a period of a little longer than 6 months from the appointment of the TSA which means that the TSA process took about a quarter of the time taken by the conventional process.

5. This case concerns the first TSA to be appointed under those provisions, who was Mr. Mathew Kershaw, who on 16 July 2012 was appointed TSA of South London Healthcare Trust ("SLHT"), which was an NHS trust.

6. Until 1 April 2013 when they were abolished, the PCTs had an important role in the Health Service because under section 1 of the 2006 Act in force at the date of the decisions under challenge, the Secretary of State has the duty of continuing the promotion in England of a comprehensive health service. Section 3 of the 2006 Act stipulated the Secretary of State's duty which is to provide or arrange the provision of a wide range of services (including hospital accommodation and services) to such extent as he considers necessary to meet all reasonable requirements. Section 2 gave the Secretary of State the power to provide other services as he considers appropriate for the purpose of discharging any duties conferred on him by the 2006 Act.

7. The Secretary of State had delegated the majority of his functions under that Act to Strategic Health Authorities and Primary Care Trusts, including his functions under section 2 and 3 of the 2006 Act.

8. The TSA duly produced a draft report on 29 October 2012 ("the Draft Report"), on which he then consulted between 2 November 2012 and 13 December 2012. He then produced his final report entitled "*Securing Sustainable NHS Services: The TSA's Report on South London NHS Healthcare Trust and the NHS in South-East London"* ("the Final Report") and which was given to the Secretary of State on 7 January 2013.

9. The Secretary of State commissioned Professor Sir Bruce Keogh, the NHS Medical Director, to review the TSA's recommendations. On 31 January 2013, the Secretary of State accepted the TSA's recommendations with the modifications suggested by

Sir Bruce Keogh ("the Decision"). Many of the recommendations concerned hospitals within the SLHT, which was to be dissolved, with its hospitals to be moved to the control of adjoining trusts and these provisions are not the subject of any challenges.

10. Those recommendations and the Decision also concerned LH, which falls under the auspices, not of the SLHT, but of a completely different trust, namely Lewisham Healthcare NHS Trust ("LHT") and which, unlike SLHT, was not a failing NHS entity, and is an entity over which no TSA has been appointed. It is only the part of the recommendations of the TSA and the Decision of the Secretary of State which sought to reduce the services offered by LH which is the subject of the present judicial review applications. The Claimants seek to quash these Recommendations of the TSA and the Decision relating to services at LH.

11. These two separate judicial review applications, which have been heard together, have been bought in the first case by the London Borough of Lewisham Council ("Lewisham") represented by Ms. Elisabeth Laing QC and in the second case by Save Lewisham Hospital Campaign Limited ("the Campaign") represented by Mr David Lock QC and Mr Jeremy Hyam. Both claims have been brought against the Secretary of State for Health and the TSA for SLHT, who have been represented by Mr Rory Phillips QC and Mr Ivan Hare. I am grateful to all Counsel for their admirable written and oral submissions, which enabled the hearing to be completed in three days.

12. Both the Claimants seek judicial review of the Secretary of State's decision dated 31 January 2013 ("the Decision") to accept (with modifications) the TSA's Report so far as it relates to LH. The First Claimant ("Lewisham") also seeks review of the TSA's decision dated 8 January 2013 to make recommendations to the Secretary of State concerning LH.

13. The Claimants both contend that:-

    (i) the Decision is *ultra vires* because the powers of the TSA and the Secretary of State set out in Chapter 5A of the 2006 Act are confined to the particular NHS Trust in relation to which the TSA was appointed ("the *vires* argument"). The significance of this is that the TSA procedure is an abridged process which circumvents the more elaborate and time-consuming process of engagement and consultation which would normally apply to a major configuration of services; and

    (ii) in the alternative, that the Secretary of State erred in stating that his tests for reconfiguration were met in whole or in part.

14. In addition, Lewisham argues that the TSA's Final Report is *ultra vires* Chapter 5A for the same reasons as it relies in respect of the Decision. Lewisham also criticises the extent of the TSA's engagement with local authorities as "*superficial and limited*", although this is not one of Lewisham's grounds of review.

15. In addition, the Campaign submits that:-

(i) the Secretary of State has acted in breach of its legitimate expectation that the TSA regime would not be used to impose a "*back-door reconfiguration*" on the NHS in South-East London; and

(ii) the Decision was so different from the TSA's original recommendations that no proper consultation has taken place.

16. The Defendants' response is that:-

(i) On their true construction, the Secretary of State's powers in Chapter 5A of the 2006 Act are not confined to the particular NHS Trust in relation to which the TSA was appointed;

(ii) In the alternative, the Secretary of State had the power to make the Decision under provisions of the 2006 Act other than Chapter 5A and as the Decision can be justified under these provisions, it should not be quashed;

(iii) The reconfiguration tests are not legal requirements and they were not designed for decisions under Chapter 5A of the 2006 Act. In any event, the reconfiguration tests are met which is a question which goes to the merits of the Decision and not its legality;

(iv) The Campaign had no legitimate expectation that the Decision would not amount to a "*back-door reconfiguration*". In any event, the Decision is not a "*back-door reconfiguration*"; and

(v) The Decision was made after compliance with all the relevant duties to consult.

17. A rolled-up hearing was ordered and at the outset of that hearing, I gave the Claimants permission to pursue the *vires* argument and then I proceeded to hold the substantive hearing of that issue as well as the applications for permission in respect of the other claims.

What this case is not concerned with

18. It is necessary to stress five matters with which this case is not concerned. First, all parties accept that it was appropriate for the Secretary of State to appoint the TSA. He was entitled under different statutory provisions to dissolve the Trust and to move the hospitals in SLHT including Queen Elizabeth II Hospital, Woolwich, which was moved from the control of SLHT to the control of LHT. What is in dispute is the issue of whether the TSA could recommend and then the Secretary of State could make directions under the exceptional TSA regime so as to reduce the facilities in a hospital in a totally different area as a result of the decision to move Queen Elizabeth from the SLHT to the LHT. So, it is the recommendation of the TSA and the Decision of the Secretary of State to reduce the services at LH which are the decisions being challenged.

19. Second, my role on this application is limited as this is not an appeal on a question of fact. Indeed, this was pointed out by Richards J (as he then was) in *Bradley v The Jockey Club* [2004] EWHC 2164 QB in a passage which was expressly approved on appeal in that case by Lord Phillips MR. [2005] EWCA Civ 2164, [17] when, giving the judgment of the Court of Appeal, he observed that:-

> *"37 ... The function of the court is not to take the primary decision but to ensure that the primary decision-maker has operated within lawful limits…the essential concern should be with the lawfulness of the decision taken: whether the procedure was fair, whether there was any error of law, whether any exercise of judgment or discretion fell within the limits open to the decision maker, and so forth . . ."*

20. Third, I am neither required nor qualified to comment on the merits or otherwise of the proposals concerning the future of LH and indeed will not do so.

21. Fourth, I will ignore changes in the statutory provisions which came into effect after the Secretary of State made the Decision.

22. Finally, it was suggested that even if I dismissed the applications and upheld the Decision of the Secretary of State, the changes set out in that Decision could not be implemented, I was asked not to deal with that issue, and I have not done so.

The Facts

23. SLHT was formed on 1 April 2009, as the result of a merger of three NHS trusts and it operated largely out of three sites; apart from Queen Elizabeth Hospital in Woolwich, its other sites were Princess Royal University Hospital and Queen Mary's in Sidcup. There is no doubt that SLHT had considerable problems. It had large and unmanageable obligations under five PFI schemes, which cost £89m a year. The merger of the three trusts had not achieved the savings and efficiencies which it should have done. In the 12 months to March 2012, SLHT reported a deficit of £65 million making it the most financially challenged Trust in the NHS and it was forecast to have an accumulated deficit of £196 million for the five years from 2012/2013 to 2016/2017. I have taken much of the subsequent chronology which I will now set out from Lewisham's pleaded case.

24. As I have explained, against that background, the Secretary of State decided to exercise his powers under Chapter 5A of the 2006 Act in relation to SLHT and so he appointed the TSA pursuant to "*The South London National Health Service Trust (Appointment of Trust Special Administrator) Order 2012*" (2012 SI No 1806), which was made on 11 July 2012. Article 2(1) provided that "*a trust special administrator is authorised to be appointed to exercise of the functions of the chairman and directors of the trust*". "*The trust*" was defined by article 1(2) of order as "*the South London National Health Service Trust*".

25. Subsequently, *The South London National Health Service Trust (Extension of Time for Trust Special Administrator to Provide a Draft Report) Order 2012* (2012 SI No 1824) extended the period within which the TSA was to provide his draft report to 75 working days beginning with the date of the TSA's appointment.

26. A Written Ministerial Statement dated Thursday 12 July 2012 stated that:-

    (a) the Secretary of State had made an order to appoint a TSA to SLHT, and that an order would shortly be laid with a report setting out the basis of decision, in accordance with the UPR;

(b) the decision to appoint the TSA was based on a recommendation of the NHS Chief Executive, and on responses to recent statutory consultation with the Trust board, with the local strategic health authority and with local NHS commissioners;

(c) the Secretary of State had decided that it was in the interests of the health service, and, in particular, of the patients the SLHT served, to put the Trust in the TSA's regime;

(d) the TSA would be appointed with effect from 16 July 2012, and would then assume full control of SLHT, replacing the functions of the trust board and assuming the role of the accountable officer as well as being responsible for maintaining services for patients, and developing recommendations to secure a sustainable future for the services provided by Trust for the Secretary of State to consider;

(e) the TSA's regime is "*not a day-to-day performance management tool for the NHS, or a back-door approach to reconfiguration*". This repeats the Secretary of State's own Statutory Guidance for Trust Special Administrators Appointed to NHS Trusts ("the TSA guidance") "*The regime does not provide a back-door approach to reconfiguration*". These statements are the subject of the claim that there was a legitimate expectation that the defendants would not act contrary to that;

(f) the Secretary of State would not make "*a final decision about **an organisation** within a short period*" [emphasis supplied]; and that

(g) there was the guidance "*to which they must have regard in the undertaking their legal duties*".

27. The Secretary of State relies on other matters in the Statement to which I will return later including statements that the recommendations needed to be prepared "*for a sustainable solution for [SLHT] as part of the South-East London health economy*".

28. The two Orders were laid before Parliament on 13 July 2012, together with an explanatory memorandum and the reasons for making the orders in "*South London Hospitals NHS Trust: The Case for Applying the Unsustainable Provider Regime*". The Department of Health wrote to third-party trade creditors and suppliers of SLHT on 13 July 2012, explaining that one of the possible outcomes was the dissolution of SLHT. The letters referred also to section 70 of the 2006 Act, which imposed a duty on the Secretary of State to deal with all the liabilities of a dissolved trust.

29. On 19 July 2012, the Secretary of State issued a direction to the TSA. This required him, "*when preparing the draft report*" for the Secretary of State, to consult with ten named commissioning primary care trusts ("PCTs"), but it did not require him to consult with any other bodies at all such as LH. I will return to consider the TSA's consultations as well as how and whom he consulted.

The Draft Report

30. On 29 October 2012, the TSA published his Draft Report. It included recommendations which affected only SLHT (such as that it should be dissolved), but there were also recommendations which purported to affect LH, namely that:-

(a) it should no longer provide emergency care for critically ill patients,

(b) it might lose its obstetrician-led maternity unit, and that

(c) it should acquire an elective centre for non-complex inpatient procedures such as hip and knee replacements.

31. On the same day, the TSA wrote to Councillor Muldoon of Lewisham, who was also Chair of its Healthier Communities Select Committee, introducing his draft report, and summarising his draft recommendations. The TSA explained that Councillor Muldoon was "*someone whose views I am keen to hear and consider in order to inform my final recommendations*" and he was invited to provide a formal written response to this "*consultation*", which was to close at midnight on 13 December 2012.

32. Lewisham commissioned consultants, "Frontline", to analyse the TSA's draft report. On 12 December 2012, it accepted the TSA's invitation to respond to the draft report, by sending representations to him, and attaching a report prepared for it by those consultants. Lewisham criticised the TSA's recommendations about LH on their merits.

33. Lewisham explained to the TSA that he only had power and authority to make recommendations to the Secretary of State about the NHS Trust to which he had been appointed. If that was wrong, and the TSA had power to make recommendations which affected a different NHS Trust, then recommendations of the type made by the TSA for LH triggered the public involvement and consultation duties in section 242 of the 2006 Act, which were supplemented by Guidance from the Secretary of State.

34. Lewisham asked whether the TSA accepted that this was the position. It proceeded to say that if the TSA were to make *ultra vires* recommendations to the Secretary of State, and the Secretary of State were to decide to implement them without the necessary public involvement and consultation, Lewisham would then have to decide whether or not to apply for judicial review. At that time, such an application would have been premature, as there was no certainty that either the TSA, or the Secretary of State, was proposing to act unlawfully.

The Final Report

35. The TSA's Final Report was published on 8 January 2013. It included recommendations which affected SLHT and which were not disputed. It also included recommendations which affected LH which were that:-

(a) LH's A&E department be closed, and replaced with a non-admitting urgent care centre;

(b) LH's obstetrician-led maternity unit be closed, and replaced with a down-graded "*stand-alone midwife-led birthing centre*";

(c) LH's emergency and in-patient paediatric unit be closed, so that only urgent paediatric care would continue to be provided at LH; and that

(d) LH would become a centre for "*non-complex elective procedures such as hip and knee replacements*" for the whole of South East London.

36. It was explained in paragraphs 96 and 97 of that Report that the normal process of consultation without using Chapter 5A procedures "*could take up to two years to reach a decision [and] in some circumstances it could take even longer*". The TSA's procedure would lead to a shortened procedure. Nonetheless, Paragraph 204 of the Report acknowledges that it may not be possible to implement these changes immediately, if agreed, "*as they involve change across the whole of the healthcare system in South East London*".

37. On 8 January 2013, Dame Joan Ruddock, the Member of Parliament for Lewisham, Deptford, asked the Secretary of State a question in Parliament about the TSA's recommendations. The Secretary of State's response acknowledged that the TSA's recommendations about LH, if implemented, would have to satisfy the four test "*with respect to any major reconfigurations*".

38. On 9 January 2013, Dame Joan Ruddock MP referred in the House of Commons to the proposals relating to LH, and she recalled the Coalition's promise to end forced closures of A&E and maternity services. The Prime Minister said:-

> *"What the Government and I specifically promised was that there should be no closures or reorganisations unless they had support from the GP commissioners, unless there was proper public and patient engagement and unless there was an evidence base. Let me be absolutely clear: unlike under the last Government when these closures and changes were imposed in a top-down way, if they do not meet those criteria, they will not happen."*

39. On 22 January 2013, Lewisham delivered written representations about the TSA's report to the Secretary of State and it attached its response to the TSA's Draft Report to those representations. The representations explained both the Council's objections to the merits of the TSA's recommendations, and its case that the TSA had no power to make, and that the Secretary of State had no power to implement, the recommendations about LH. Those proposals could only lawfully be implemented if they were the outcome of the process which applies to local reconfigurations.

40. On 31 January 2013, the Secretary of State's written decision was presented to Parliament in which he explained that he accepted all the TSA's recommendations about SLHT. He went on to say "*As a consequence, [the TSA] recommended that services be reconfigured beyond the confines of [SLHT], across all of South East London*". The decision then summarised the "*main points*" of that recommended reconfiguration.

41. The Secretary of State said that he "*respected and recognised"* the sense of "*unfairness people feel because their hospital has been caught up in the financial problems of its neighbour*". He had therefore asked the NHS Medical Director, Professor Sir Bruce Keogh, to review the TSA's recommendations, and he then summarised Professor Keogh's views. They were that the TSA's recommendations should be changed somewhat. For example, LH would retain "*a smaller A&E service with 24/7 emergency cover*", but he accepted that the midwifery unit should be replaced with "*a free standing midwife-led unit"* at LH. He also made

recommendations on paediatric care which I will have to consider in due course in paragraph 151 below.

42. The Secretary of State went on to say that, as at the day before, as no viable alternative plan had been put forward, he had decided to accept the TSA's recommendations, but subject to the amendments suggested by Professor Sir Bruce Keogh. The Secretary of State stated that he believed that the four tests "*for local reconfigurations*", which I explain in paragraph 107 below, were met by the amended proposals.

43. On 7 February 2013, Lewisham sent a Pre-Action Protocol Letter to the TSA, asking him to withdraw the recommendations in his report about LH. Lewisham also wrote to the Secretary of State, asking him not to implement those recommendations. Those letters made suggestions for the further conduct of any proceedings, and they asked the Secretary of State for an undertaking not to take any steps to implement his decision, so far as it affected LH, pending the outcome of an application for judicial review.

44. On 22 February 2013, DWP/DH Legal Services replied on behalf of the TSA and of the Secretary of State explaining that the Secretary of State did not accept Lewisham's interpretation of Chapter 5A of the 2006 Act. The Secretary of State accepted that the powers of the TSA and those of the Secretary of State are "*coincident*". The Secretary of State contended, however, that:-

> *"the TSA's inquiry and the subsequent decision by the Secretary of State does not have to be - indeed could not sensibly be - confined to a particular Trust."*

45. His reasoning was that:-

a. The words "*In relation to*" have a naturally broad meaning. There was no reason unnaturally to narrow that meaning, and "*compelling reason*" not to;

b. The powers were enacted to enable "*a full and proper inquiry*" into problems, and decisions to be made to deal with them, "*constrained only by an appropriate connection or relation to the Trust in question*". It was "*hard to see why Parliament ...should have wished to confine the inquiry and thus the potential solution, simply...to the Trust itself*";

c. The Secretary of State already has powers to dissolve Trusts; the Chapter 5A powers must have been intended to be used for a wider purpose, or there would have been no reason to enact them;

d. Trusts do not exist in isolation. Problems with one Trust are "*overwhelmingly likely to involve neighbouring Trusts. Parliament will have been well aware of that... A Parliamentary intention positively precluding the TSA from examining such solutions, and the Secretary of State from deciding to implement them cannot coherently be squared with the evident purpose of the legislation. Moreover to treat each NHS Trust in isolation would produce the absurd result that the Secretary of State would be required to appoint a different TSA (thereby suspending its Chairman and directors) to all the Trusts which surround the SLHT,*

however the surrounding Trusts were performing".

e. To treat each Trust in isolation would mean that the Secretary of State would have to appoint a TSA to each, "*however the surrounding Trusts were performing*"; and that

f. The Secretary of State would have had power to do what he did without the involvement of the TSA; he could have dissolved SLHT under Paragraph 28 of Schedule 4 to the 2006 Act, and can give directions to NHS bodies under section 8(1). The Secretary of State could properly have regard to the TSA's report in doing so, even if (which the Secretary of State denied) the TSA exceeded his powers in producing the report.

The Issues

46. The major issues raised on these applications are whether the TSA acted *ultra vires* in making recommendations concerning LH and also whether the Secretary of State made the same error when making the Decision concerning services at LH. If the recommendations from the TSA were *ultra vires*, then the Decision of the Secretary of State must be also ultra vires insofar as he seeks to rely on the Chapter 5A regime because the same critical statutory words "*in relation to the Trust*" relate to the powers of the TSA to recommend and then of the Secretary of State to make a decision. Thus, there is no need at this stage for separate consideration of the *vires* of the TSA to recommend and the Secretary of State's decision-making in relation to altering facilities at LH.

47. In those circumstances, the issues which have to be considered are:-

(a) Whether the Decision is *ultra vires* because the TSA's powers and those of the Secretary of State in Chapter 5A of the 2006 Act are confined to the particular NHS Trust (including its hospitals) in relation to which the TSA was appointed ("The Vires Issue") (Paragraphs 48-92);

(b) Whether the Secretary of State had acted in breach of a legitimate expectation that the TSA regime would not be used to impose a "*back-door reconfiguration*" on the NHS in South-East London ("The Legitimate Expectation Issue") (Paragraphs 93-105);

(c) Whether the Secretary of State erred in stating that the appropriate tests under Chapter 5A of the 2006 Act for consultation on reconfiguration were met in whole or in part in respect of the reduction in services at LHT ("The TSA Consultation Issue") (Paragraphs 106-170);

(d) The decision of the Secretary of State was so different from the recommendations of the TSA that no proper consultation had taken place ("The Further Consultation Issue") (Paragraphs 171-172); and also

(e) Whether the Secretary of State had the power to make the decision under section 8 of the 2006 Act ("The Alternative Decision Route Issue") (Paragraphs 172-207).

ISSUE A: The Vires Issue

48. It is common ground between the parties that:-

(a) The powers of Secretary of State under Chapter 5A of the 2006 Act must be construed in the context of the 2006 Act read as a whole;

(b) The decision of the Secretary of State under section 65K can be to dissolve the Trust under paragraph 28 of Schedule 4 of the 2006 Act which provided that;

> "*(1) The Secretary of State may by order dissolve an NHS trust.*
>
> *(2) An order under this paragraph may be made–*
>
> ….
>
> *(b) if the Secretary of State considers it appropriate in the interests of the health service.* and

(c) If an NHS trust is dissolved under paragraph 28, then *"the Secretary of State may by order transfer, or provide for the transfer, to himself or an NHS body of such of the property and liabilities of the NHS trust which is dissolved as in his opinion is appropriate; may by order transfer, or provide for the transfer, to himself or a NHS body of such of the property and liabilities of the NHS Trust which is dissolved as in his opinion is appropriate"*. (paragraph 29(i) of Schedule 4 to the 2006 Act).

49. Both Lewisham and the Campaign accept that the TSA could recommend and the Secretary of State could decide, on the dissolution of a Trust to which a TSA has been appointed, and as a result of the dissolution, transfer property rights or liabilities (such as a hospital in that Trust) to a second Trust to which no TSA has been appointed. The Defendants regard this as an important concession which I will have to consider later. The real dispute between the parties on this *vires* issue is on the next issue which arises sequentially which is whether if this transfer takes place, the TSA is then empowered to make recommendations, and whether the Secretary of State is empowered to reduce services offered by a hospital, which has never been in SLHT but which is in another completely different NHS Trust over which the TSA has not been appointed but to which the TSA wishes to transfer one of the hospitals in the Trust over which he has been appointed as a TSA.

50. This issue entails consideration of the words "*in relation to the Trust"* in three different statutory provisions in Chapter 5A of the 2006 Act. The first such provision is to be found in section 65F(1) of the 2006 Act, which concerns the TSA's draft report and it provides that:-

> *"Within the period of 45 working days beginning with the day on which a Trust special administrator's appointment takes effect, the administrator must provide to the Secretary of State and publish a draft report stating the action which the administrator recommends the Secretary of State should take* ***in relation to the Trust****"* (emphasis added).

51. The second provision is Section 65I(1) of the 2006 Act which relates to the TSA's obligation to produce a final report and which provides that:-

> *"Within the period of 15 working days beginning with the end of the consultation period, the Trust special administrator must provide to the Secretary of State a final report stating the action which the administrator recommends that the Secretary of State should take* ***in relation to the Trust****"* (emphasis added).

52. Finally, there is section 65K(1) of the 2006 Act which relates to the Secretary of State's obligation to produce a Decision and it states that:-

> *"Within the period of 20 working days beginning with the day on which the Secretary of State receives a final report under section 65I relating to an NHS Trust, the Secretary of State must decide what action to take* ***in relation to the Trust****"* (emphasis added).

53. The case for Lewisham and the Campaign is that there is nothing in the words of the relevant provisions which shows that a TSA is entitled to recommend or that the Secretary of State in response to a report from the TSA is empowered by statute to make recommendations or decisions which affect hospitals which at all material times were not part of the NHS Trust over which the TSA had been appointed. In other words, they advocate what I will describe as a "*narrow interpretation*". On the facts of the present case, this would preclude any recommendations or decisions being made by the TSA and the Secretary of State about the services which would be provided by LH which is in the LHT, which is different from the Trust, to which the TSA was appointed, namely SLHT.

54. The case for the Defendants is that their powers in Chapter 5A of the 2006 Act are not confined to the particular NHS Trust in relation to which the TSA was appointed; they advocate what I will call "*a wide interpretation*". This entitles the TSA to make recommendations and the Secretary of State to make decisions about the services provided by a hospital which is in a different trust from the Trust over which the TSA has been appointed, but is instead in a NHS Trust to which the TSA has moved one of the hospitals in his NHS Trust.

The Case for the Defendants on the vires issue

55. It is said by Mr Phillips that the Claimants' narrow interpretation of the words "*in relation to a Trust*" is undermined by a number of matters, the most prominent of which I will now summarise.

56. First, he submits that the use in sections 65F(1), 65I(1) and 65K(1) in Chapter 5A of the phrase "*in relation to the Trust*" indicates that a naturally broad meaning is intended by Parliament. Mr. Phillips' contention is that if Parliament had intended that the TSA's report and the subsequent decision of the Secretary of State should be confined as narrowly as the Claimants suggest, then different words would have been chosen by Parliament so that the legislation would have stated that the recommendations of the TSA and the decision of the Secretary of State would be "*confined to the Trust*" or "*as to the dissolution or otherwise of the Trust*". In other

words, the Defendants' case is that the fact that Parliament has not used those words indicates that the narrow interpretation is incorrect and that their wide interpretation is the correct one.

57. The second point made by Mr Phillips is that the phrase "*in relation to*" in the 2006 Act has to take its meaning from the statutory context in which it is used. That context was that the powers conferred in Chapter 5A are exceptional because they are intended to deal with organisations which were unsustainable on a clinical performance or financial basis. The exceptional powers, are, as I have already explained, that:-

(a) The Secretary of State is obliged to make and lay before Parliament an order to appoint a TSA and then explain his reasons for doing so (section 65B(5));

(b) The effect of the appointment of the TSA is that the Trust's Chairman and Executive and Non-Executive Directors are suspended from office (section 65C(1));

(c) The TSA is independent of the Secretary of State in relation to the advice contained in his report with the powers of the Secretary of State confined to directing the TSA to undertake consultation in certain circumstances (section 65F(2)(b) and 65H(10));

(d) The Secretary of State and the TSA had to comply with strict time limits which could only be extended in very limited circumstances (sections 65F(1), 65I(1), 65K(1) and 65J);

(e) Unlike the normal procedures for changes in the NHS, the regime in Chapter 5A is expressly exempt from the consultation requirements set out in Part 12 of the 2006 Act, namely section 242(6) of the 2006 Act and regulation 4(3A) of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 ("The 2002 Regulations");

(f) When the Secretary of State received the report from the TSA, he has to publish it and lay it before Parliament (section 65I(3));

(g) The Secretary of State then has to publish a notice of its own decision and the reasons for it as well as displaying a copy of the notice before Parliament (section 65K(2)); and

(h) These powers are also exceptional because the time schedule for Chapter 5A cases is tight.

58. Mr. Phillips submits that in determining the powers of the TSA and the Secretary of State, due regard has to be given to first, this exceptional nature of the Chapter 5A regime; second, the fact that this exceptional regime is intended to deal with organisations which are unsustainable on grounds of clinical performance and/or financial basis; and third, that there should be broad powers vested in the TSA and the Secretary of State to remedy these problems.

59. So it is said by Mr. Phillips that the words "*in relation to the Trust*" have to be construed widely so as to cover changes that will be made as a result of the dissolution of the SLHT and the decision to move Queen Elizabeth Hospital from the

SLHT into LHT. Mr. Phillips submits that it would be absurd to suggest that all these very serious problems of the SLHT could sensibly be resolved by measures which did not include changing services provided by hospitals in neighbouring Trusts.

60. The next point made by Mr Phillips is that, as I have explained, the Secretary of State has power to decide to dissolve the Trust and to ensure that the liabilities of those Trusts be transferred to another NHS body and so he contends that in consequence, it must have been envisaged and anticipated that the consequences of the exercise of the powers of the Defendants might have substantial impact on other NHS bodies such as their neighbouring Trusts. Indeed, he stresses first that the NHS Trusts do not exist in isolation, but that they provide inter-dependent services under the auspices of the Secretary of State, and second that Parliament must have realised this and the duties of the Secretary of State. It is said that if the TSA failed to take into account the position in the neighbouring Trust, he would be causing problems for it.

61. All these matters have to be considered against the background that under Section 1 of the 2006 Act, the Secretary of State has the duty of continuing the promotion in England of a comprehensive health service. Section 3 of the 2006 Act specifies the Secretary of State's duty to provide or arrange the provision of a wide range of services (including hospital accommodation and services) to such extent as he considers necessary to meet all reasonable requirements. Section 2 gives the Secretary of State the power to provide other services as he considers appropriate for the purpose of discharging any duties conferred on him by the 2006 Act.

62. Mr Phillips reminds me that the interdependence of these Trusts in the light of the Secretary of State's powers shows why a broad interpretation of the Secretary of State's powers is called for and is the correct approach.

63. The next point made by Mr Phillips is that Chapter 5A provides at section 65B (2) that the Secretary of State may only appoint a TSA where "*he considers it appropriate* **in the interests of the health service**" (emphasis added). Thus, this shows that the TSA would have been concerned to make recommendations "*in the interests of the health service*" and not merely in the interests of the relevant Trust with the consequence that his powers and those of the Secretary of State must be construed widely. This approach would enable the Secretary of State to change the services in hospitals in other Trusts into which hospitals from the dissolved SLHT have been moved. I will return to consider this point because the Claimants rely on these provisions to make a contrary argument to support their narrow interpretation. The case for the Defendants is that if Parliament had wished to provide that the Secretary of State could appoint a TSA where he "*considers it appropriate in the interests of the relevant Trust*", it could, and indeed would, have said so, but that it has failed to do so.

64. It is also said that the Statutory Guidance issued in relation to Chapter 5A, which has not been subject to challenge, supports the Defendants' wide interpretation of Chapter 5A as it states that:-

> *40. Possible recommendations by the Trust Special Administrator include merging with another NHS organisation or that the organisation stops providing services altogether with the transfer of services and staff to another NHS provider*

> *61. It is the duty of the Trust Special Administrator to make final recommendations to the Secretary of State. Possible outcomes include*
>
> *. . .*
>
> *ii. acquisition by, or merger with another NHS Trust or Foundation Trust;*
>
> *iii. dissolution and the transfer of services and staff to another NHS Trust or Foundation Trust.*"

65. Mr Phillips also stresses that the Claimants made crucial concessions in relation to the power of the TSA to recommend, and the Secretary of State to decide, to dissolve the Trust to which the TSA is being appointed and to transfer its property, rights or liabilities to another Trust, such liabilities including SLHT's three hospitals.

66. His argument is that these concessions (which are based on the powers in sections 65L(1) and 65M(1) as well as in paragraphs 28 and 29 of Schedule 4 to the 2006 Act, which I have set out in paragraph 48 above) fundamentally undermine the Claimant's case and the weight placed by the Claimants on the status of NHS Trusts as separate legal entities. Indeed, it is said that these concessions show that NHS Trusts are all part of a greater whole and that they provide a matrix of inter-dependent services with a responsibility for the whole NHS remaining with the Secretary of State. As I will explain, I am unable to accept this argument because there are express statutory provisions which enable a Trust subject to a TSA to be dissolved and its assets transferred. What is of crucial importance on this application is the separate issue of whether there are provisions entitling the TSA to make recommendations relating to hospitals in a Trust other than the one over which he had been appointed as a TSA.

67. A further point made by Mr Phillips is that Lewisham appears to challenge only those decisions affecting the LHT with which it disagrees. So he says that while there is a challenge to the reduction in services of LH, there is no challenge to other decisions concerning the LHT such as the merger of the Queen Elizabeth Hospital with it and the substantial transitional funding for the new organisation which will place this hospital within the Lewisham Trust. So it is said that this really is a merits-based challenge and not a vires challenge. I cannot accept that submission as there is a robust statutory basis for the decision of the Secretary of State to dissolve the SLHT set out in Schedule 4 Paragraph 28 of the 2006 Act, but as I have explained those specific provisions do not also provide a statutory basis for altering the facilities at LH and the Defendants' recommendations and decision are based on the provisions in section 65F(1), I(1) and K(1).

68. Mr Phillips says that the fact that the Secretary of State required the TSA to have regard to the reconfiguration tests shows that the Chapter 5A regime can involve reconfigurations where the exceptional circumstances are made out. I am unable to see how this helps on the statutory interpretation issue with which I am concerned.

The case for the Claimants on the vires issue

69. Ms Laing contends that the provisions in Chapter 5A of the 2006 Act only enable a TSA to make recommendations, and the Secretary of State to implement such recommendations, if they relate to the NHS Trust to which the TSA has been appointed and its constituent parts. She further submits that there is nothing in the words of the relevant statutory provisions, which suggests that a TSA or the Secretary of State in response to a report from a TSA can make decisions which affect any entity other than the NHS Trust to which the TSA has been appointed. Thus, in the present case it is said that the TSA could not make any recommendations which affected LH nor could the Secretary of State make any decision in relation to it.

70. In support of her submissions, Ms Laing stresses that the word "*the Trust*" can only apply to the Trust in respect of which the TSA is appointed, namely SLHT and that the use of the words "*in relation to the Trust*" in Section 65F(1), 65I(1) and 65K(1) relate to the SLHT and to no other Trust.

71. Ms Laing fortifies the point by pointing out that there are frequent references to "*the Trust*" in Chapter 5A such as the requirement for the Secretary of State to consult "*the Trust*" before making the TSA order relating to it, while Section 65C relates to the suspension of the Directors of "*the Trust*" and Section 65H requires the TSA to hold at least one meeting to seek responses from staff of "*the Trust*". Her submission is that in each of those cases, the use of the word "*the Trust*" in its singular form shows that it can only relate to the Trust to which the TSA has been appointed.

72. Ms Laing proceeds to submit that the words "*in relation to*" like the closely linked phrase "*relating to*" is "*capable of a broader, or a narrower meaning, as the context requires*" as was explained by Moore-Bick LJ giving the judgment of the Court of Appeal in *Svenska Petroleum Exploration AB v Government of the Republic of Lithuania (No.2)* [2006] EWCA Civ 1529; [2007] QB 886 [137]. Her case is that the context here requires a direct link between the action and Trust to which the TSA is appointed, but that direct link does not include action and recommendation "*in relation to*" a distinct legal entity to which a TSA has not been appointed.

73. Ms Laing says that the Defendants are seeking to rewrite Chapter 5A of the 2006 Act so that instead of what is stated in sections 65F(1), 65I(1) and 65K(1) (which I have set out above) concerning recommendations and actions "*in relation to the Trust*", those recommendations and actions should be instead expressed to be "in relation to the Trust *and any other Trust*", with the words in italics being the additional words which Ms Laing contends are the basis of the Defendant's reliance on the broader construction.

74. Mr Lock on behalf of the Campaign adopts the submissions made by Ms Laing and he makes a number of additional submissions. He points out the 2006 Act provides that an NHS Trust must not be treated as the servant or agent of the Crown or as enjoying any status, immunity or privilege of the Crown and that its property is not Crown property. Mr Lock then submits that the decision-making powers of a NHS Trust should not be removed from its Board save by very clear wording. The Secretary of State cannot remove powers from the LHT without clear words to that effect.

75. Mr Lock also attaches importance to the contrast between the wide expression "*in the interests of health service*" in section 65B(2) and the narrow provisions of "*in relation to the Trust*" which is used in Section 65F(1), 65I(1) and 65K(1).

Discussion

76. It is clear that each NHS Trust is a separate entity, and this issue raises questions of statutory interpretation. My starting point is first, that the words "*the Trust*" in the critical provision in section 65F(1), 65I(1) and 65K(1) which I have quoted can only mean one single Trust, and second, that this single Trust must be SLHT as there is no other Trust over which a TSA has been appointed or any other Trust being referred to in these provisions. Indeed, for example the term *"the trust"* clearly has that meaning in section 65C(1), which states that "*when the appointment of the TSA takes effect, the trust's chairman and executive and non-executive directors are suspended from office";* it is clear that *"the trust"* referred to there is the one over which the TSA has been appointed and no other trust.

77. So the next issue is whether the words "*in relation to*" extend that meaning to include other Trusts such as LHT or as has also been suggested any Trust in South East London. They will have to be considered against the background that the Chapter 5A regime, which is set out in the Appendix to this judgment, is a clearly thought-out comprehensive regime, which explains, for example, precisely who the TSA has to consult and it is supplemented by the rights given to the Secretary of State to dissolve an NHS trust and transfer parts of it as I have explained in paragraph 48(c) above. There are a number of reasons which individually and cumulatively show why the words "*in relation to*" do not extend the meaning of the words "*in relation to the Trust"* so as to include not merely SLHT but also other Trusts such as LHT or, as has also been suggested, any Trust in South East London. I will now set out those reasons in no particular order of importance.

78. First, a construction of "*in relation to*" so as to include these other Trusts would give the words "*in relation to*" an unreasonably and an incorrectly wide meaning. The TSA explained of his proposals that they *"seek to address the challenges across the whole of South East London",* but insofar as such proposals relate to hospitals outside SLHT, they do not fall within the words "*in relation to the Trust*". Indeed there were many trusts in South East London, namely Bexley Care Trust, Bromley PCT, Greenwich PCT, Lambeth PCT, Southwark PCT and LHT, but recommendations in relation to their services would not be "*in relation to the Trust*". Crucially to this case, LH was, of course, not in SLHT but was in a totally separate Trust, LHT, over which the TSA had not been appointed. Therefore, the extent of its services and any reduction of them were matters "*in relation to*" LHT, but they were not matters "*in relation to*" SHLT.

79. Indeed if the Secretary of State's interpretation was correct so that "*other Trusts*" (such as LHT) were covered, it is difficult to see why those words "*in relation to the Trust*" were inserted. Clearly, if they were not there, the obligation of the TSA would relate to "*the action which the administrator recommends the Secretary of State should take*" without any words limiting such action and this would be consistent with the Defendants' wide interpretation. It is a clear rule of statutory construction that the words in a statutory provision must be presumed to have some meaning and in this case, the meaning of those words "*in relation to the Trust*" must be regarded as

limiting words so as only to relate to the Trust over which the TSA had been appointed.

80. Second, the construction put forward by Mr Phillips would be giving the words "*in relation to*" far too wide a meaning. They cannot have a wider meaning than "*concerning*" or "*relating to*", while the Defendants' case must be that their meaning is wider. The words "*in relation to*" are used frequently in the 2006 Act. Mr Lock says these words appear on 243 occasions. They clearly mean "*concerning*" when used elsewhere in the 2006 Act and so the ordinary rules of construction would lead to them having the same meaning in the provisions in Chapter 5A, which was added later. There are in the 2006 Act examples of the use of the words "*in relation to*" as limiting it to a particular person or period and nothing else. Examples are Section 276(1) of the 2006 Act which provides that "*relevant health services, accommodation or facilities in relation to a person*" and section 166(3) provides "*indemnity cover in relation to a person included in a pharmaceutical list…*" This wording in both provisions must limit the scope to such a person and nobody else. Similar reasoning applies to the critically important operative words in sections 65F(1), 65I(1) and 65K(1).

81. Third, the Parliamentary draftsman chose to distinguish between "*the interests of the Health Service*" and those of the Trust. As I have explained, section 65B(2) provides that an order may be made authorising the appointment of TSA "*only if the Secretary of State considers it appropriate in the interests of the Health Service*". There is a marked and deliberate contrast between, on the one hand, the reference to the "*interests of the Health Service*" in that provision and, on the other hand, the obligation of the TSA's recommendations to be "*in relation to the Trust*" and the Secretary of State's obligation to make a decision "*in relation to the Trust*" in sections 65F (1), 65I (1) and 65K (1).

82. To my mind, this clear difference in wording shows that the TSA has no obligation or power to consider the wider interests outside the Trust with which he is concerned, but significantly no obligation to consider the interests of the Health Service, because the draftsman has elected not to use such a provision in Sections 65F (1), 65I (1) and 65K (1). In other words, he or she has distinguished between "*the interests of the Health Service*" and matters "*in relation to the Trust*". This distinction is important and is supportive of the narrow construction of the Claimants because recommendations of the TSA and the decision of the Secretary of State are deliberately not expressed in Chapter 5A to be in "*the interests of the Health Service*" but only "*in relation to the Trust*".

83. Fourth, there are clear statutory obligations imposed on the TSA to consult only some entities which are connected to the Trust over whose affairs he is appointed before producing his draft report. These are important as they show what actions it was envisaged. Section 65F(2) requires the TSA to consult:-

> *"(a) any Strategic Health Authority in whose area the Trust has hospitals, establishments or facilities, and (b) any other person to which the Trust provides goods or services under this Act and which the Secretary of State directs the administrator to consult".*

84. It is noteworthy that the TSA has no obligation to consult any different Strategic Health Authority or any other Trust. It would be expected that if the TSA had power to recommend changes to services provided by a hospital in another Trust, then it would be expected that the Health Authority of that Trust and indeed the Hospital affected itself, would also be compulsory specified consultees especially as Chapter 5A is a carefully drafted regime in which all powers and duties are set out.

85. Fifth, the obligations imposed on the TSA to consult after publishing his draft report during the consultation period are defined. For example, section 65 H(4) requires a TSA to hold at least one meeting to seek responses from staff of the Trust and from such persons as the TSA may recognise as representing staff of the "*Trust*". There is, however, no suggestion there that this consultation obligation should extend to the staff of any other hospital, which might be outside the area of the Trust, but who might on the Secretary of State's wide rule be affected by the TSA's proposals. Similarly, the TSA has an obligation to require a written response from certain specified entities and any other person within a certain category falling within the provisions of section 65H(8).

86. Those entities to be so consulted do not include the staff at adjoining hospitals, although it is correct that the Secretary of State is entitled to direct a TSA to request a written response from any specific person or hold a meeting to seek a response from any such person (section 65H(10)). What is important is the absence of any specified and defined obligation to consult people and the staff of hospitals in adjoining areas affected by the proposal made by the TSA or the decision of the Secretary of State, as might be expected if the TSA had power to make recommendations that affected the services provided at those hospitals.

87. Sixth, the Statutory Guidance, which was issued by the Secretary of State in accordance with his obligation under Section 65M of the 2006 Act, supports the narrow interpretation. As Ms Laing submits, in the section of that document beginning with the purpose of the regime for unsustainable NHS providers, it is explained that the purpose of the regime is to "*provide a rapid resolution to problems within a significantly challenged NHS* ***organisation***" (with emphasis added), which in this case must be SLHT (which is the only challenged organisation) and no other Trust falls in that category. The LHT, which has no such problems, could not fall into that category, Paragraph 15 of the Statutory Guidance states that the TSA has to make recommendations to the Secretary of State:-

> *"about what should happen to the* ***organisation*** *and the services it provides. The objective is so that high-quality, sustainable services are delivered to the local health economy."* [emphasis added].

I agree with Ms Laing that the reference to "*the organisation*" must be to SLHT and not to LH.

88. Seventh, there are frequent references in the case for the Defendants to the need of the TSA and the Secretary of State to make recommendations and decisions respectively in the light of the interests of the South East London Health economy. I am unable to understand why those interests fall within the critical words of "*in relation to the Trust*", which is the SLHT. There is no reference in the Chapter 5A provisions to the

interests of any other Trust. In any event, I do not understand why on the Defendants' case, the TSA and the Secretary of State would not be entitled and empowered to make respectively recommendations or Decisions regarding the interests of the entire South East London economy or any other trust.

89. Eighth, when a NHS Trust is dissolved, the Secretary of State is given the power to transfer or provide for the transfer to himself or to an NHS body of the property and liabilities of the NHS Trust which is dissolved as in his opinion is appropriate (Schedule 4 Paragraph 29(1) which is set out in paragraph 48(c) above). What is noteworthy about these provisions, which, of course, relate to Chapter 5A orders, is that they do not then proceed to include any consequential power given to the Secretary of State to make an order pursuant to Chapter 5A relating to hospitals in other NHS Trusts which might have been affected by recommendations of the TSA and the decision taken in relation to it by the Secretary of State. This is a very significant omission in this carefully drafted regime and it supports the narrow interpretation.

90. In reaching my conclusions, I have not overlooked the submissions of Mr Phillips to which I have referred or to any of his submissions.

91. I must comment further on what Mr Phillips regards as the "*crucial concessions*" of Lewisham and the Campaign which are that they accepted that the TSA might recommend, and the Secretary of State might decide to dissolve the Trust to which the TSA has been appointed and to transfer the property, rights and liabilities to another Trust. I do not regard these matters as being relevant to the determination of the vires issue as (a) these were all "*actions*" that the Secretary of State had statutory authority to take in relation to the Trust as set out in Paragraph 29 of Schedule 4 to the 2006 Act; and (b) in any event, I am concerned with the proper construction of the provisions in Chapter 5A. In carrying out that exercise, I am not assisted by the approach of the Campaign and Lewisham, who for their own quite genuine reasons might welcome the break up of SLHT and the decision to move the Queen Elizabeth into the LHT.

92. I do not accept Mr Phillips' contention that the narrow interpretation of the words "*in relation to the Trust*", which I have accepted, does lead to absurd results because the Secretary of State would not be empowered to ensure that the reduction of services at LH could be implemented. So it is said that if the TSA failed to take this into account, he would be producing an incomplete or partial solution which could not have been Parliament's intention. I cannot accept that submission because first it is inconsistent with the wording used in the legislation which must have been taken to show the intention of Parliament; and second the Secretary of State does in any event have additional powers under Section 8 of the 2006 Act to reconfigure the services at LH, but that would entail a consultation programme that has to be complied with and to which I will return in paragraph 173 ff. Those drafting the Chapter 5A regime had to decide in what circumstances the usual rights of an individual to be consulted should be greatly reduced and that there would be this expedited process. They had to balance this important interest. The narrow construction is consistent with this.

93. After all, Parliament intended that the special Chapter 5A procedure would be an exceptional procedure in order to produce an expedited solution avoiding the established need for the conventional level of involvement and consultation because

the conventional requirements for consultation are expressly excluded (see, for example section 242 (6) of the 2006 Act which states that the normal rules of public involvement are excluded). This shows that the Chapter 5A remedy was exceptional and took away those rights of consultation with the consequence that it should be used sparingly, especially as it enables important decisions relating to hospital services to be made having "*regard*" to the four tests for reconfiguration services rather than having the more onerous and conventional task of complying with those requirements which I set out in paragraph 185ff. So the rights of patients to influence decisions relating to their hospitals were greatly reduced and so this remedy of almost the last resort for non-performing hospitals should be used in limited cases to deal with underperforming trusts and not solvent and successful ones like LHT.

94. For all those reasons, I have reached the conclusion that the narrow interpretation advocated by Lewisham and the Campaign is correct with the consequence that neither the recommendations of the TSA nor the decision of the Secretary of State reducing the facilities at LH fell within their powers. It has been suggested that the Secretary of State's Decision cannot be quashed as when he made it, the Recommendations of the TSA had not been quashed and so he was entitled to rely on them. I am unable to accept this because the Secretary of State's power to make the Decision was pursuant to section 65K(1) and therefore it had to be "*in relation to the trust*", but for the reasons which I have sought to explain, that part of the Decision relating to LH did not fall within that definition. The Decision will therefore have to be quashed but only if the Secretary of State cannot rely on his fall-back position which is that he would have been entitled to reach the Decision by relying on his powers under section 8 of the 2006 Act which is an issue to which I will return in Section E below in paragraph 173ff. This fall-back position, even if valid, cannot assist the TSA and although it might help the Secretary of State, it will not prevent the recommendations of the TSA from being quashed.

Issue B: The Legitimate Expectation Issue

95. This issue is only relevant if I am wrong and the Secretary of State did have vires under the Chapter 5A regime to make a decision relating to services beyond those provided by the Trust over which the TSA had been appointed, and in particular, in relation to LH.

96. The case for the Campaign on the legitimate expectation issue is that the Secretary of State by allowing the TSA process to be "*a back-door reconfiguration*" process in respect of services provided by LH acted unlawfully as he had promised that this would not happen and in consequence there was a legitimate expectation by the recipients of that representation to that effect.

97. The basis of this contention is that the Secretary of State had made a clear promise to Parliament that the TSA process in relation to the SLHT would not amount to a "*back-door reconfiguration*" when he stated in his Written Ministerial Statement of 12 July 2012 with emphasis added that:-

> *"The Trust Special Administrator's Regime is not a day-to-day performance management tool for the NHS or* ***a back-door approach to reconfiguration****. The purpose is to deliver a rapid and robust process when the widest range of other solutions to*

> *improve and maintain sustainability had been tried, implemented and not delivered the results required."*

98. In support of the contention that this gave rise to legitimate expectation, Mr Lock relied on the statement of Laws LJ in *R (Bibi) v Newham London Borough Council* [2001] EWCA Civ 607 [2002] 1 WLR 237, 244 at paragraph 19 that:-

> *"In all legitimate expectation cases, whether substantive or procedural, three practical questions arise. The first question is to what has the public authority, whether by practice or by promise, committed itself; the second is whether the authority has acted or proposes to act unlawfully in relation to its commitments; the third is what the court should do".*

99. In this case, the Secretary of State was merely saying that he intended to rely on the Chapter 5A regime which is a rapid decision-making process in which services can be properly configured, but only provided that certain requirements were met. Indeed in his statement, the Secretary of State was saying nothing more than that he proposed to rely on the statutory regime which included certain requirements to consult. This was uncontroversial and does not alter what the Secretary of State was obliged to do.

100. In my view, the Minister's statement relied on by the Campaign cannot give rise to a legitimate expectation because as a matter of general principle the undertaking or promise which gives rise to the alleged legitimate expectation must be, in the words of Bingham LJ, "*clear, unambiguous and devoid of relevant qualification*" (*R v Inland Revenue Commissions, ex parte MFK Underwriting Agencies Limited* [1991] WLR 1545 at 1569).

101. In my opinion, what the Secretary of State was stating falls a long way short of indicating anything other than that he will act in accordance with the established rules.

102. A further reason why I do not consider that a legitimate expectation arose in this case is that the Secretary of State cannot by Written Ministerial Statement fetter the powers which Parliament has given him under Chapter 5A of the 2006 Act.

103. The Campaign seek to answer this point by relying on the decision in *R (Majed) v London Borough of Camden* [2010] JPL 621 in which it was held that a statement made by a local authority regarding community involvement did give rise to a legitimate expectation that the consultation set out in it, which was additional to the statutory minimum under the relevant procedural order, would be carried out. In that case and on those facts, the Court of Appeal held that a legitimate expectation arose.

104. That case merely shows that a public authority can be bound by *additional* procedural requirements beyond those imposed by statute where it has created a legitimate expectation that it will do so. It is a different position here because the point is that the Secretary of State is not further seeking to fetter the substantive powers given to him by Parliament.

105. For those reasons, I reject the contention that there is any legitimate expectation and I refuse permission to pursue this point but in case I am wrong, I will consider in paragraph 170 below whether the Secretary of State has acted in breach of it.

Issue C: The TSA Consultation Issue

106. The case for the Claimants is that the appropriate requirements to be satisfied under Chapter 5A for consultation about reconfiguration were not met in respect of the reduction in services at LH. These submissions are only of critical importance if I am wrong and the TSA and the Secretary of State had powers under Chapter 5A of the 2006 Act to make recommendations for the reduction of services at LH. As I have explained, I do not consider that they had those powers.

107. After the Coalition Government came to power, Sir David Nicholson, the Chief Executive of the NHS in England, wrote a letter on 20 May 2010 to all NHS Chief Executives and to various other bodies explaining that the Secretary of State had identified four key areas in which the reconfiguration processes needed to improve as plans for significant service change were developed and consulted upon. Those four key areas or requirements were that:-

> *"1. support from GP Commissioners will be essential*
>
> *2. arrangements for public and patient engagement including local authorities should be further strengthened;*
>
> *3. there should be greater clarity about the clinical evidence base underpinning proposals;*
>
> *4. that proposals should take into account the need to develop and support patient choice"*

108. In his letter, he also explained that *"given the complexity and scale of the change issues in London",* he had asked NHS London to make separate recommendations about how service change in the capital should be taken forward to meet those requirements.

109. In an article in the Daily Telegraph on the following day, Mr Andrew Lansley, M.P., who was then the Secretary of State, explained the new principles stating that they "*will not merely be another tick-box exercise – it will be a tough test which every proposal must pass if it is to succeed*".

110. These four requirements were also set out in a document published in June 2010 entitled "*Revision to the Operating Framework of the NHS in England 2010/2011*".

111. On 29 July 2010, Sir David Nicholson wrote a further letter in respect of the four requirements in order to "*provide further information on the application of those tests*". It was stated in the letter that the Secretary of State had also made it very clear that:-

> *"GP commissioners will lead* ***local change*** *in the future. With that in mind, I am asking* ***local GP commissioners****, in conjunction with PCTs, to lead this process locally and assure themselves, and their SHAs, that proposals pass each of these tests"* (emphasis added).

112. The four reconfiguration requirements were designed for local service reconfigurations and not for decisions under Chapter 5A of the 2006 Act, which is, as I have explained, an expedited and emergency procedure. Paragraph 39 of the Statutory Guidance states that:-

> *"In assisting the Secretary of State to make a final decision on the future of the organisation, [the TSA]* ***should have regard t****o the Secretary of State's four key tests for service change in developing his or her recommendations i.e. local reconfiguration plans must demonstrate support from GP commissioners, strengthened public and patient engagement, clarity on the clinical evidence base and support for patient choice."*. (Emphasis added)

113. Both the TSA and the Secretary of State have correctly in my view accepted that the proposed changes to services provided at LH were a reconfiguration of services. So on the basis of the Statutory Guidance, the TSA was not obliged to ensure that the reconfiguration requirements were satisfied but instead that he merely had to have "*regard*" for them.

114. Dr Shaleel Kesevan, who is an official in the Department of Health, has, however, explained in paragraph 52 of his witness statement that Ministers made "*statements in Parliament of their expectation for a solution by the TSA at SLHT involving reconfiguration to satisfy the tests"*. Indeed, the Secretary of State's statement was that *"any solution would need to satisfy the four tests"* (Hansard, 8 January 2013, col 169). The Prime Minister's statement on the following day must be read in the light of this statement and the Secretary of State did conclude that "*the amended proposals meets the four tests required for local reconfiguration*". The TSA stated in his Final Report in Appendix K that it "*sets out how regard has been paid to each of these tests, along with how they are assessed,* ***on balance****, to have been met"* (emphasis added). There seems to be an expectation that the four requirements will be met. I will deal with the requirements on the alternative bases that the TSA "*should have regard"* to them and that they should be complied with.

The Approach to the Four Requirements for Reconfiguration

115. Before considering the requirements, it is appropriate to recall that Ms Laing drew attention to the fact that the approach of the Courts to policies and guidance was considered recently in the planning context by the Supreme Court in *Tesco Stores Limited v Dundee City Council* [2012] PTSR 983 in which Lord Reed JSC (with whom other members of the Supreme Court agreed) noted [18] at page 991 that Counsel had:-

> *"…referred to a number of judicial dicta which were supposed to support the proposition that the meaning of a development plan was matter to be determined by the planning authorities as "the court, it was submitted had no role in determining the meaning of the plan unless the view taken by the planning authority could be characterised as perverse or irrational"*.

116. His statement on the correct approach to those matters appears in the same paragraph at page 992 when he explained that:-

> *"18...As in other areas of administrative law, the policies which it sets out are designed to secure consistency and direction in the exercise of discretionary powers, while allowing a measure of flexibility to be retained. Those considerations point away from the view that the meaning of the plan is in principle a matter which each planning authority is entitled to determine from time to time as it pleases, within the limits of rationality. On the contrary, these considerations suggest that in principle, in this area of public administration as in others (as discussed, for example, in R (Raissi) v Secretary of State for the Home Department [2008] QB 836), policy statements should be* ***interpreted objectively*** *in accordance with the language used, read as always in its proper context"*. (Emphasis added)

117. Lord Reed went on to say that:-

> *"19.That is not to say that such statements should be construed as if they were statutory or contractual provisions. Although a development plan has a legal status and legal effects, it is not analogous in its nature or purpose to a statute or a contract. As has often been observed, development plans are full of broad statements of policy, many of which may be mutually irreconcilable, so that in a particular case one must give way to another. In addition, many of the provisions of development plans are framed in language whose application to a given set of facts requires the exercise of judgment. Such matters fall within the jurisdiction of planning authorities, and their exercise of their judgment can only be challenged on the ground that it* ***is irrational or perverse*** *(Tesco Stores Ltd v Secretary of State for the Environment[1995 1 WLR 759 ,780 per Lord Hoffmann). Nevertheless, planning authorities do not live in the world of Humpty Dumpty: they cannot make the development plan mean whatever they would like it to mean".* (Emphasis added).

118. It has not been suggested that these principles do not apply to the reconfiguration tests. So it becomes necessary in the case of each requirement to decide how they should be applied. Ms Laing contended that the challenges would have to be on grounds of irrationality. The Campaign put it more broadly and considered that some of the tests could be challenged if they were wrong as a matter of law.

The First Requirement: - "Support from GP Commissioners"

119. As I have explained in the letters from Sir David Nicholson, it was said that "*support from GP commissioners is essential*" but there is a dispute as to who the appropriate commissioners were in respect of the changes at LH. At the relevant time when the TSA was preparing his recommendations, the NHS Commissioners for services at LH

was Lewisham PCT which led on all commissioning at LH. Decision-making responsibility had been devolved by Lewisham PCT to GP Commissioners who were acting as a committee at the PCT.

120. On that basis, Mr Lock contends, and it does not appear to be disputed, that Lewisham PCT was the lead commissioner for services at LH and the Lewisham GP Commissioners were the only GP Commissioners who entered into commissioning contracts with LHT. It also does not appear to be disputed that over 70% of the services at LH were provided to NHS patients who were the responsibility of LHT.

121. Lewisham GP Commissioners were joined in their opposition to the proposed changes at LH by the Bexley GP Commissioner. Thus it is said by the Claimants that by the time the Secretary of State made his decision, GP Commissioners representing substantially more than 70% of the patients were opposed to the proposals, although well under half of the Commissioners in the South East London area took the same view. Indeed, the only commissioners supporting the changes at LH were those not commissioning any substantial services at LH and they were NHS Dartford, Gravesham and Swanley CGG, NHS West Kent CCG, NHS Bromley CCG, NHS Greenwich and NHS Lambeth CCG as well as NHS Southwark CCG, who later opposed the scheme. Three of these groups did not fall with the South East health regime but were in Kent.

122. The issue in respect of this first requirement ("*Support from GP Commissioners will be essential*") is whether the essential support that was required to come from the GP Commissioners (a) in the area where the reconfiguration was intended to take effect and from those who commissioned the services in LH, or (b) the GP Commissioners from a larger area, such as South East London. I will consider it both on the basis that it raises a question of construction which in Lord Reed's words "*should be interpreted objectively in accordance with the language used, read always in its proper context*", and a balancing issue which could only succeed on an irrationality basis.

123. The case for the Claimants is that option (a) represents the correct approach, while the Defendants contend that option (b) should be adopted with the relevant area being those in South East London. The Claimants point out that after his initial letter of 20 May 2010, Sir David Nicholson wrote again to all NHS Chief Executives on 29 July 2010 referring again to these four new requirements explaining that "*the Secretary of State has also made it clear that GP Commissioners will lead local changes in the future*".

124. The letter also attached a document entitled "*Applying the Reconfiguration Test*". Under the heading entitled "*Support from GP Commissioners*", the process is defined in this way and with emphasis added:-

> "***Local commissioners and consortia*** *should review the current evidence of engagement with GPs and the level of support and consensus for a proposed service change. As GP/practice based commissioning structures vary across the country,* ***local commissioners*** *will need to take an appropriate view as to how best to gather this evidence, with PCTs supporting this process where required. Commissioners will*

> *need to consider the engagement that may need to take place with practices whose patients will be significantly affected by the case for change, inviting views and facilitating a full dialogue were necessary".*

125. The answer to the question as to who would be the "*local commissioner*" is then set out in that document in tabular form stating that:- the test "who leads".

This test is in a section which is headed:-

> *Who Leads?*
>
> *GP Consortia supported by their PCT, where majority of patients will be most affected by the proposed service changes. Where necessary PCT to identify relevant GP commissioners (or organisations as proxies). Consortia may ask PCTs to support the process*

126. It is noteworthy that special and crucial importance is attached to "*the GP Consortia …where majority of the patients will be most affected by the proposed service changes*" and in the case of the proposed changes at LH, it would be the Lewisham consortium whose patients would be most affected by the changes at LH. It is then stated in this enclosure to the letter of 29 July 2012 that there would be a dialogue between local consortia to review evidence (including clinical evidence base, support from patients and impact on patient choice) and address any issues or concerns. This would show that the focus would be on the Lewisham GP consortium as otherwise I am not clear how this test could be regarded as satisfied.

127. The next heading in the same Table is entitled "Threshold" in which it is stated with emphasis added that:-

> *Threshold*
>
> *Lead GP consortia (or where appropriate PCTs) to apply a test of reasonableness and consider on balance whether they can demonstrate to their SHA that they have GP commissioner support.*

128. The Lead GP consortia, in my opinion, would be Lewisham as its patients would be most affected by the proposed service changes at LH. It is then said that if substantial issues remain unresolved, the consortia or PCT would have to hold further local dialogue to seek resolution or seek informal advice from the IRP or NCAT against agreed timetables. The next stage would be for the SHA to review evidence and if not assured, they would refer the matter to GP Consortia (or PCT) for further resolution.

129. In deciding how to approach this issue, the TSA explained that all general practices had to be members of a Clinical Commissioning Group ("CCG") and "*on this basis, meeting this test would require the recommendations within the report to be supported, on balance, by the relevant CCGs*". The TSA stated that the recommendations had an impact on the whole South East London health economy, and it was on that basis that CCG support should be gauged, with six

recommendations to be regarded as a package to address the challenges in South East London, and they should not be viewed as a "*menu*" to choose from.

130. The TSA noted that the NHS Lewisham CCG which "*is arguably the CCG whose population is most affected by the proposed changes, it recognised the financial and services challenges facing the local National Health Service and the need for a change*". The view of NHS Lewisham CCG was that a service change should be developed by the new trust at a later date, but the TSA did not agree and he explained that:-

> *"As part of their response, the CCG raises some concerns particularly around the service change recommendations, which should be highlighted here. Specifically, that proposals for A&E services "would lead to more expensive, complicated and longer journeys for Lewisham residents", and the changes, "will result in less integration than currently". The CCG challenges the number of current attendees at the Lewisham Hospital A&E who would appropriately be seen at the proposed Urgent Care Centre suggesting, "less than 50% and possibly as few as 40%." The CCG is concerned that, "there is a risk that acutely ill children who are seen at an urgent care centre will not receive the same quality of care currently offered by the paediatric A&E [currently at Lewisham Hospital]." The CCG also has concerns regarding the impact of the changes to A&E services [currently at Lewisham Hospital]." The CCG also has concerns regarding the impact of the changes to A&E service on training and attracting quality staff"*

131. Turning to maternity care, the TSA stated that:-

> *"With regards to the options for the maternity models, the CCG that, "the dispersal model would have a significantly damaging effect on…Lewisham women requiring maternity services," and prefers an obstetric-led unit, with community midwifery service at Lewisham hospital if the other TSA recommendations go ahead.*
>
> *The CCG also describes its concerns, "that even this [elective] element…which has the appearance of supporting a vibrant Lewisham site is unlikely to be deliverable".*
>
> *The CCG does stress that, "we recognise the need for change to achieve the London-wide clinical quality standards over time in an affordable way."*
>
> *Lewisham CCG's concerns are somewhat understandable due to the significant impacts the recommendations, if implemented, would have on services on the Lewisham hospital site and their perception that this would be detrimental. Similarly, the concerns and reassurances sought form the other seven CCGs*

> *are legitimate and have been considered in coming to the final report. However, they have all expressed the unequivocal view that changes must be made, and standards, which are described in more detail under test 3 below."*

132. The conclusion of the TSA was that:-

> *"It is fair to say that support for the recommendations consulted on have the broad support of GP Commissioners with the exception of those regarding service change, which are supported by all bar Lewisham. Considering the proposals seek to address the challenges across the whole of South East London, it would not be appropriate to give undue weight to any particular locality. On this basis, it seems a reasonable assessment that taking the views of the CCGs across this area and those in Kent who would be impacted, the proposals consulted upon, on balance, have the support of GP Commissioners."*

133. I am unable to agree on the identity of the relevant group of GPs was those whose "*support*" was needed as I believe it should have been Lewisham's GPs. I reach that conclusion because of the references to the role of local commissioners while Sir David Nicholson's document states that they should be "*GP Consortia supported by their PCT where majority of patients will be most affected by the proposed service changes*". This must be the Lewisham GP consortium because, as I have explained, it is not disputed that over 70% of the services at LH were provided to NHS patients who were the responsibility of Lewisham PCT. Therefore their patients will be the patients "*most significantly affected by the case for change*". So support was required from Lewisham GP Commissioners as otherwise this requirement would be disregarded.

134. The TSA in not regarding the views of the Lewisham GP Commissioners in relation to the changes at LH as being the crucial matter means that the views of those GP Commissioners most affected by the changes did not have the importance which they should have had. This undermines the underlying rationale of the essential need for local GP support for such changes. Indeed, after I reached this decision, I appreciated that if this was not so, it would always be possible to close a popular hospital in a particular area and transfer all its facilities to neighbouring areas, and the local GPs in that area might well be supportive as their patients would obtain additional services and would therefore outvote those in the area of the hospital which is to be closed who would be most affected by it.

135. In reaching the conclusion that support was required from Lewisham GP Commissioners, I have not overlooked the evidence of the TSA that in the case of Barnet, Enfield and Haringey Clinical Strategy in 2010, those closest to Chase Farm Hospital were opposed to service reductions there. Nevertheless, this requirement was regarded as satisfied by the Secretary of State because of broader support across the wider population. This merely shows how the Secretary of State construed the requirement, but that is not determinative of this issue and does not bind me. In my view, for the reason I have sought to explain, support was required from the Lewisham GP commissioners.

136. The use of the words "*support from GP Commissioners*" does not mean unanimous support but it does entail some appreciable form of support. Mr. Phillips contends that these relevant commissioners do not have a right of veto, but nevertheless some support from them is a condition precedent to this test being satisfied as otherwise the test is meaningless. In the present case, there was no such support from the Lewisham GP consortium.

137. In those circumstances, it seems to me that for the proposals relating to LH, there was not the essential "*support from the GP commissioners*" in the light of the views of the crucial views of the Lewisham GP commissioners, who were hostile to the changes at LH. Indeed even if there was only a need to *have regard to* the need for support from the GP commissioners, the decision to ignore the views of the Lewisham GP commissioners, showed that he did not comply with that requirement and I would say that was irrational.

138. So I consider that that the Claimants succeed on this point.

The Second Requirement: Strengthened public and patient engagement

139. This requirement has to be considered in the light of the facts that:-

i) The usual duties of broad public involvement and consultation in section 242 and 244 of the 2006 Act and in the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 ("the 2002 Regulations") do not apply to the TSA regime (section 242(6) of the 2006 Act and regulation 4(3A) of the 2002 Regulations);

ii) Chapter 5A lays down express provisions for limited consultation in preparing the Draft Report, extensive consultation within a limited time frame on the Draft Report itself and no specific further duty on either the TSA or the Secretary of State to consult between the Final Report and the Secretary of State's decision; and that

iii) The urgent nature of the TSA regime is very different from the usual reconfiguration scheme as it, unlike the usual scheme, takes place over a period strictly limited by statute.

140. In the Final Report of the TSA, there was evidence of stakeholder engagement across South East London between 17 July 2012 and 13 December 2012 as there was a very busy programme comprising of a very large number of meetings not merely with clinicians, but also with groups of patient, members of the public and others interspersed in the health service. There was also the launch of the Stakeholder Bulletin with workshops in August and September 2012 to look at clinical issues with representatives of interested groups, including the voluntary sector attending each one.

141. The engagement with patients and the public also occurred through patient and public advisory groups as well as in individual meetings with representatives of many local involvement networks and focus groups. There was also formal consultation on the draft recommendation with 27,000 full consultation documents and 10,000 summary documents distributed through 2000 locations across South East London.

142. In addition, there were also 14 publicised public consultation meetings held across six boroughs, while the TSA also attended several additional public meetings organised by local authorities, local involvement networks and community groups. The TSA worked with other groups to identify communities who did not ordinarily attend public meetings and events, and meetings were then held with some people who fell into that category.

143. Further, there was a Workshop in early October 2012 with a representative sample of members of the public from six South East London boroughs and others from the Public and Patient Advisory Group in order "*to elicit their views on the emerging thinking and proposed clinical standards*".

144. Mr. Lock also made some specific complaints to which I now turn.

Accident and Emergency Services

145. Mr. Lock contended that there was a failure to strengthen public and patient engagement relating to the changes made in the Final Report and "*the potential effects and opportunities for the delivery of additional other services at [LH] upon the subsequent changes to accident and emergency services*".

146. The TSA started with the proposal that emergency care should only be provided in four hospitals across South-East London, but the final decision departed from the model because the Secretary of State decided after consulting Sir Bruce Keogh that "*LH should retain a smaller A&E service with 24/7 senior emergency medical ward cover*". The Final Report stated in paragraph 52 that:-

> *"a significant number of responses to the consultation opposed the draft recommendation that [LH] should no longer provide emergency care".*

147. There was, according to the TSA, consideration of the options by means of evaluation criteria, which were tested and agreed with the TSA Advisory group, the Clinical Advisory Group, the External Clinical Panel, and the Patient and Public Advisory Group. Those evaluation criteria related to quality of care, affordability, and value for money, deliverability, and the impact of local research. The TSA explained that the options were evaluated against these criteria by the Clinical Advisory Group for non-clinical criteria, while the Financial, Capital and Estates Advisory Group assessed them against the financial criteria.

148. The TSA explained convincingly in his witness statement that as a result of this process, the final solution was reached as set out in his recommendations. It clearly had been tested and agreed through consultation including with those groups referred to in the last paragraph. The Secretary of State asked Sir Bruce Keogh to review these recommendations and with the benefit of his views, the Secretary of State agreed that LH should retain a smaller A and E service with 24/7 emergency cover.

Paediatric Care

149. Mr Lock submits that paediatric care was not covered in the Draft Report and reasons were not given for any proposals so as to permit intelligent consideration and an

appropriate response. The TSA explains that that there were concerns about this omission expressed in the consultation exercise.

150. He explained that prior to the preparation of the Draft Report, there had been discussions between the Clinical Advisory Group and the External Clinician Panel and there had also been a workshop on 24 September 2012 with a specific focus on maternity and children's services. There was further consideration provided by and at meetings with the Clinical Advisory Group and the external Clinician Panel respectively on 10 October and 6 December 2012.

151. The TSA explained that in his Final Report, he highlighted the importance of careful planning to ensure that "*effective pathways are maintained for the services that remain at [LH]*". The Secretary of State received advice from Sir Bruce Keogh and he recognised the high quality of paediatric services at LH so that any replacement would have to offer even better clinical outcomes and patient experience. He considered that this was possible but it was dependent on very clear protocols on a number of matters but that it would "*require careful pathway planning and need to be a key focus of implementation*".

Maternity Services

152. It is said by Mr. Lock that the changes to maternity services were made without strengthened public and patient consideration. He submitted first that there was strong opposition to the proposal to remove maternity services from LH in the Draft Report, and second that the decision in the Final Report to recommend a midwife-led birthing unit had not been the subject of proper consultation or of strengthened public and patient.

153. The decision to have a midwife-led maternity unit was not considered financially viable at the Draft Report stage, but as a result of consultation, it was stated in the Final Report that during the consultation, the focus sessions for maternity services users held at locations in Lewisham came out in support of maternity services being retained at LH with participants at those sessions being particularly positive about the model for midwifery-led birth unit.

154. The Final Report explained that this prompted the External Clinical Panel to consider whether this would work at LH. The Royal College of Midwives representative and other members of the Panel supported this. This shows that the recommendation was the direct result of public and patient engagement and which led to the ultimate solution.

155. Pulling the threads together in respect of all these matters, it was a matter of judgment as to how this second requirement was to be satisfied. In the light of the matters to which I have referred, I am satisfied that it was complied with and so it also follows that regard was had to this condition.

The Third Requirement: Clarity on the clinical evidence base

156. I agree with Mr Phillips that this is an area where the expertise of the TSA and the Secretary of State and those on whom they relied, such as the Clinical Advisory

Group, make it particularly difficult to challenge the recommendations of the TSA and the advice of Sir Bruce Keogh on this ground.

157. Mr. Lock contends that the processes of the TSA and the Secretary of State show a distinct lack of clarity on the evidence base to support the final shape of the assessment of acute NHS services for South East London.

158. The TSA has explained that the Statutory Guidance stressed the importance of strong clinical evidence to support recommendations that would deliver safe and effective care and the early engagement of the medical Royal Colleges. The Statutory Guidance recommended that the TSA should "*engage senior clinical expertise at an early stage*".

159. The TSA stated that he complied with these obligations through the work of his own clinical adviser (Dr. Jane Fryer), the Clinical Advisory Group (which comprised of clinicians from each Hospital Trust) the Expert Clinical Panel and the clinical team within the SLHT, the Clinical Commissioning Groups and the Royal Colleges. He also held a series of clinically-led workshops in August and September 2012 which were each attended by around 60 to 80 clinicians, commissioners and managers at which the financial and other challenges facing the local health system in South East London were considered. There were also discussions about community-based and hospital-based acute case in the area.

160. Mr. Lock's submission fails to take account of the matters set out in the responses to the consultation form the Royal Colleges, such as the Royal College of Physicians, the Royal College of Gynaecologists, The Royal College of Midwives, the Royal College of Nursing, and the College of Emergency Medicine.

161. The TSA also referred to clinical quality standards for hospital-based acute emergency (both adult and paediatric) and maternity services developed over 2011 and 2012 across London and other reports.

162. I will not lengthen this judgment by going through each of the points relied on by Mr Lock especially as this was one of the issues which the Secretary of State asked Sir Bruce Keogh to confirm which he duly did.

163. In his skeleton argument, Mr. Lock attaches importance to the fact that Sir Bruce Keogh cannot give precise figures to support his conclusions but that instead he relies on estimates based on the best available information available. This material, according to Mr. Lock, cannot constitute evidence. I am unable to accept this argument which appears to be based on there being a requirement that where the Secretary of State seeks the opinion of the NHS Medical Director, each aspect of his advice has to been supported by an independent clinical base and that is not correct. The opinion of Sir Bruce and his reasons showed that this requirement was satisfied.

164. I have no doubt that the TSA not merely had regard to this factor but also that the way he complied with it was not irrational.

The Fourth Requirement: Consistency with current and prospective patient choice

165. Mr. Lock complains that as long as the Secretary of State has the policy that reconfiguration should demonstrate consistency with patient choice, it is not open to the Secretary of State to reduce the maternity services so that only 10% of those now able to do would be able to do so if the changes of the Secretary of State came into effect. His point is that on consultation there was support for comprehensive maternity services being retained at LH.

166. Mr Phillips submits correctly that this requirement to be "*consistent with*" in this requirement cannot and does not mean "*the same as*". The Secretary of State was quite entitled to accept the view that concentrating clinical sites to drive up clinical quality so that although it inevitably reduces patient's choice, it still increases choice between high quality services.

167. In connection with this requirement, there was the Equality and Health Impact Assessment commissioned by the TSA to understand the impact of the proposals on patient choice. It noted that the reduction of maternity facilities meant that patients would benefit from centres with a large number of consultant surgeons and multidisciplinary team and a wide choice of surgeons. In addition the midwife-led maternity unit would increase choice.

168. The TSA concluded that concentrating clinical sites to drive up clinical quality inevitably reduces patient choice, but significantly it increases choice between high quality services. All this shows that the TSA not merely had regard to this requirement but that he also complied with it. There is nothing irrational about the way he did it.

Conclusion

169. I grant permission to pursue these complaints and have explained why the Claimants succeed on the complaint concerning "*support from GP commissioners*". Apart from that, I reject the other complaints from the Claimants.

170. I should add that if I was wrong and the Claimants had a legitimate expectation that there would not be any "*back-door reconfiguration*", I do not consider that it has occurred.

Issue D: The Further Consultation Issue

171. Mr. Lock contends that the Decision contained conclusions which were different from what was said in the Final Report relating to the A&E care, maternity service and paediatric services to be provided at LH and so the Secretary of State should have consulted on these changes which were the result of Sir Bruce's recommendations. Mr. Phillips' response is that the TSA regime is carefully structured and it contains provisions for consultation prior to, but crucially he says not subsequent to, the production of the Final Report.

172. That is correct but I doubt if this allows the Secretary of State to produce a decision containing totally new solutions which have never been the subject of any form of consultation or prior consideration. I need not come to a conclusion on this point as the Decision allowed more services to stay at LH, than were set out in the Final Report. I do not consider in those circumstances that a Court should require further

consultation especially as the Claimant wanted more services at LH, which is what they got. My provisional view is that if this requirement of support from GP Commissioners was satisfied in respect of the TSA's final proposals, it is highly unlikely that they would not give support for the improved services which are based on the suggestions from Sir Bruce Keogh. I refuse permission on this issue.

Issue E: The Alternative Decision Route Issue

Introduction

173. As a fall back position if he cannot succeed on the vires issue, the Secretary of State contends that he can justify the Decision in relation to LH by relying on his powers in the 2006 Act, other than those set out in Chapter 5A, and, in particular, those set out in Section 8 of the 2006 Act which provides that:-

> *"(1) The Secretary of State may give directions to any of the bodies mentioned in subsection (2) about its exercise of any functions.*
>
> *(2) The bodies are—*
>
> *(a) Strategic Health Authorities,*
>
> *(b) Primary Care Trusts,*
>
> *(c) NHS trusts, and*
>
> *(d) Special Health Authorities.*
>
> *(3) Nothing in provision made by or under this or any other Act affects the generality of subsection (1)"*

174. It is said by Mr. Phillips that the TSA did actually engage in substantial consultation with Lewisham, which was sufficient to comply with its duties under common law and so the Decision cannot be quashed.

175. The Claimants contend that the Secretary of State cannot justify the Decision so as prevent it being quashed by relying on his powers under Section 8 of the 2006 Act because: -

(a) He did not say, or even think, that he was using any powers other from those under Chapter 5A in making the Decision relating to LH and so he cannot now rely on having unconsciously used other powers;

(b) He is unable to justify the Decision by relying on the consultation and the recommendations of the TSA in the Draft Report and in the Final Report as they were *ultra vires* and therefore void in relation to the proposed changes to LH; and

(c) Even if the Secretary of State was able to rely on the recommendations of the TSA, he could not properly invoke his Section 8 powers with the

consequence that his Decision will have to be quashed because it failed to comply with:-

(i) The four reconfiguration tests; and

(ii) the public involvement process set out in the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 ("the 2002 Regulations"); and

(iii) the London Configuration Guide, which was published in 2011.

Can the Secretary of State rely on other powers under section 8 of the 2006 Act to justify the Decision even though he was not intending to use those powers when he made that Decision?

176. The Claimants contend, as is not disputed, that the Secretary of State was not purporting to use his Section 8 powers when he made his Decision and so it is said that he cannot now seek to rely on that provision. I am unable to agree as the Courts would refuse to quash the Decision which the Secretary of State was entitled to make under Section 8 even though he relied on other statutory provisions when he made the Decision provided that two conditions were satisfied which would ensure that the Claimants are not prejudiced by the fact that they were not informed that the Secretary of State was relying on his Section 8 powers. After all, the Claimants are entitled to be put in the same position as would have occurred if it had been disclosed to them that the Section 8 route was being used.

177. The first condition that would have had to be satisfied before the Secretary of State could rely on section 8 was that he had complied with all the consultation and other requirements that would have had to have been satisfied if Secretary of State had told the parties that he was adopting the section 8 route. As I have explained, Chapter 5A set out an abridged procedure with limited obligations to consult.

178. The second condition which would have had to have been satisfied before the Secretary of State could rely on section 8 was that other parties, who would have had to be consulted under that regime, were not prejudiced by the fact that they did not know that section 8 powers were being used. In other words, it is necessary to consider in the event that Lewisham and other parties had known that the Secretary of State was using section 8 provisions, what steps they would have taken, but which they have not actually taken.

179. I will consider what those steps were and then decide if it can be shown that the Secretary of State would still have made the Decision and so the test is whether it would have made no difference to the decision which would have been taken if the appropriate consultation steps had been taken.

180. It must be stressed it is not enough to show that if these steps warning the Claimants that the Secretary of State was using the section 8 route had been taken, then in that event the Decision would *probably* have been the same. As May LJ explained in *R (Smith) v North Derbyshire Primary Care Trust* [2006] 1 WLR 3315; [2006] EWCA Civ 1291 [10] that he had:-

> *"… already noted that neither [counsel] contended that the judge's second reason, that is that the decision would probably*

> *have been the same, anyway, was alone sufficient to sustain his conclusion. That is a proper concession. Probability is not enough. The defendants would have to show that the decision would inevitably have been the same and the court must not unconsciously stray from its proper province of reviewing the propriety of the decision making process into the forbidden territory of evaluating the substantial merits of the decision".*

181. I add that if those two conditions were satisfied, then there would in those circumstances have been nothing wrongful about the Secretary of State's Decision. So there would be no reason to quash it.

182. In my view, the Secretary of State cannot satisfy these two conditions because if the Claimants had known that the Section 8 route was being adopted, they would still have been very unhappy about the reduction of the services at LH. In consequence, they would have invoked the consultation provisions in the 2002 Regulations and in the London Configuration Guide as I will explain. I will have to consider whether that would have led to a different or the same decision as the Secretary of State actually made.

Can the Secretary of State justify the Decision by relying on the recommendations of the TSA in the Draft Report and in the Final Report even though they were ultra vires and void in relation to LH?

183. The Claimants contend that the Secretary of State cannot rely on the TSA's consultation and recommendations because they were ultra vires and void. This submission fails to appreciate that the reason why the Secretary of State cannot rely on the recommendations of the TSA is not because what was said in them was incorrect, but instead because the TSA did not have the vires to make them. So that does not preclude the Secretary of State relying on the TSA's consultation insofar as what has been said by the TSA was accurate and that it assists in satisfying one of the requirements of Section 8 for making the Decision insofar as it affects LH.

Was there a failure to comply with the four reconfiguration tests?

184. Mr. Phillips accepts that in this case, the Secretary of State had to comply with the four reconfigurations tests to which I have referred in Section C. I have already explained that there was a failure to comply with the requirement for support from GP Commissioners. Thus the Secretary of State cannot rely on Section 8 to justify the Decision.

If the Secretary of State had been pursuing the section 8 route, what decision would he have made in the light of any duty imposed by the 2002 Regulations?

185A. At the relevant time, section 242 of the 2006 Act provided that those PCTs, NHS trusts and other similar bodies had to make arrangements to ensure that the users of their services were involved in the planning, the development and consideration of proposals for change in the provision and the operation of health services. They had to have regard to any guidance given by the Secretary of State about the discharge of those duties but the recommendations of a TSA were expressly excluded (section 242

(6)). So there was no consideration of section 242 by the TSA or the Secretary of State before making the Decision as there was no requirement to do so.

185B. Chapter 3 of Part 12 of the 2006 Act is headed "Overview and Scrutiny Committees" and section 244 (2) enabled regulations to be made for various matters. Such functions could not be discharged by the executive of a local authority but were to be discharged by an overview and scrutiny committee ("OSC") of the local authority (section 242(2ZD) and (2ZE) of the 2006 Act. The regulations in force at the relevant time were the 2002 regulations.

186. Regulation 2(1) of the 2002 regulations entitles the OSC to review and to scrutinize any matter relating to the planning, provision and operation of health service in the area of its local authority. In carrying out its function, the OSC shall invite interested parties to comment and keep the referrer informed of any action taken in respect of it (regulation 2A (b)), but otherwise the procedure is to be determined by the OSC (regulation 2(3)).

187. Regulation 3 enables an OSC to make reports and recommendations on any matter reviewed or scrutinized by it under regulation 2 to the local authority and local NHS bodies.

188. To whom it has made a report or recommendation, that body shall respond in writing to the OSC within 28 days of the request (regulation 3 (3)).

189. There are also provisions, which enable an OSC, which considers proposals not to be in the interests of the health service in the area of the committee's local authority to report to the Secretary of State who may make a final decision (regulation 4(7)).

190. In order to decide how Lewisham would have reacted if it had been told that the Secretary of State was using the section 8 route, it must not be forgotten that any proposals to reduce services at LH were likely to be vehemently opposed by Lewisham and its citizens. As Ms Nicholson, the Head of Law at Lewisham has explained, there has been and continues to be massive opposition to the proposals for reduced services at LH with demonstrations attracting 15,000 people in November 2012 and 25,000 people in January 2013.

191. In addition it is important to bear in mind that it was not stated or implied until long after the Decision was made that the Secretary of State could have reached his decision by the section 8 route or any route other than Chapter 5A.

192. I have no doubt that if Lewisham had been told that the Secretary of State was relying on section 8 powers, the OSC would have considered the proposal very critically and with great care. It is difficult to believe that they would have done other than what Lewisham has done in these proceedings and that is to oppose the proposal very forcefully putting forward every possible argument. The matter would then have been considered by the Secretary of State.

193. It is difficult to predict with total certainty what he would have decided but it seems that he would not have reached his decision in January 2013 when the actual decision was made. As I have explained, the evidence was that the procedures take up to two years and sometimes longer. So it is likely that the procedure might have meant that

the Secretary of State might not yet have made a decision if he had just gone down the section 8 route.

194. More importantly, the Secretary of State cannot show that he would have reached the decision which he did as much more material would have been in front of him. This is especially true as there were many component parts to his Decision. Indeed I have been unable to find any assertion let alone detailed reasoning from the Secretary of State showing why he would have reached the same decision as he did by using the totally different process involved with Section 8.

195. I have been fortified in reaching that conclusion because there had been very limited (if any) consultation with Lewisham's OSC by the TSA when he was taking the Chapter 5A route. As to that there is a witness statement from Mr. John Muldoon who is the Chair of Lewisham's Healthier Communities Select Committee which exercises all the OSC functions in Lewisham in relation to the provision of services by and performance of health bodies providing services for local people. He stated that he and his Vice Chair, Councillor Jeffrey, met the TSA twice with the first meeting taking place on 16 October 2012. Councillor Muldoon explained that on that occasion, the TSA was not requesting input from him and his colleague as would have been expected at a consultation meeting but that instead the TSA was reporting progress. What is important was that Councillor Muldoon observed that "*there was no suggestion that a major downgrading of LH was in contemplation"* and "*there was no statement that the TSA was seeking the views of the Council on a substantial downgrade of [LH]"*.

196. At his second meeting with the TSA when he was accompanied again by Councillor Jeffrey, Councillor Muldoon said that the TSA gave a general update and he explained that "*in parallel to carrying out the consultation they have been preparing the final report to the tight time scales*". If the Secretary of State was proceeding down the Section 8 route, I would agree with the conclusion of Councillor Muldoon that both of these meetings "*fell far short of the consultation required in respect of a proposal to downgrade services at [LH] as was proposed by the TSA"*.

197. I have considered the statements of the TSA on his dealings with Councillor Muldoon as well as the witness statements by Mr. Barry Quirk and Sir Steve Bullock who were respectively the Chief Executive and the Mayor of Lewisham as well as other witness statements adduced by Lewisham. They show that the communications between Lewisham and the TSA were very different from the regime advocated in the 2002 regulations. That is not surprising as neither the TSA nor the Secretary of State were considering or anticipating the use of section 8 powers.

198. There is no evidence that the basic requirements for ordinary consultation were satisfied. The most commonly cited statement of the key features of a lawful consultation process is that laid down by Hodgson J in *R v Brent LBC, ex p Gunning* (1985) 84 LGR 168, 189 when he said that the features were that:-

(a) Consultation is undertaken at a time when the relevant proposal is still at a formative stage;

(b) Adequate information is provided to consultees to enable them properly to respond to the consultation exercise;

(c) Consultees are afforded adequate time in which to respond; and

(d) The decision-maker gives conscientious consideration to consultees' responses.

199. I am therefore faced with the task of deciding what would have happened if the Secretary of State had gone down the section 8 route when there has been no meaningful consultation with Lewisham or at best such consultation as there was of a minimal nature. As I have explained, the only ground on which the Secretary of State could seek to argue that Decision should not be quashed on the basis of lack of consultation, or inadequacy in it, is that it would have made no difference to the result but the onus of proving that must be on the Secretary of State and he would have to show he would have made the same decision as he made.

200. In this case, I cannot say that the Secretary of State would have made precisely the same decisions on each of the services as he made in the Decision. He is likely to have received different evidence and his decisions on each of the facilities at LH which were reduced might have been different.

If the Secretary of State had been pursuing the section 8 route, what decision would he have made in the light of any duty imposed by the London Reconfiguration Guide?

201. The NHS London Reconfiguration Guide was published in December 2011 and it provided a guide for PCTs, Clusters, CCGs and Trusts in London. It was produced at a time when changes were expected to be made in the Health and Social Care bill which meant that commissioning was to move from PCTs to CCGs and that SHAs were to be abolished. The purpose of the Guide was to ensure that those responsible are clear how changes can continue to be delivered during the transitional period.

202. Section 1.1 defines "*reconfiguration*" as meaning "*major service changes and service improvement*". It explains that "*the goal of any change for services must be to ensure that patients receive the best care possible, delivered to the highest standards in the most effective, efficient and personalised way*".

203. It is also explained in paragraph 1.1 that "*any reconfiguration of service provision needs to be based on a deep and evidence based understanding of the need for service change, a clear understanding of the benefits to patients, a robust patient plan and a comprehensive communication and engagement strategy*." It also goes on to state that "*good preparation in the understanding of the reconfiguration process (pre-consultation, post-consultation and implementation) is crucial*". The purpose of the Guide was to describe the process and the actions required to "*navigate*".

204. The Guide sets out requirements for service changes which are a substantial variation. It explains in paragraph 3.1 that "*NHS London will not support organizations to proceed to the next stage in their reconfiguration scheme without successful completion of the assurance process through.. three stages of reconfiguration*". Those three stages are pre-consultation, consultation and post-consultation.

205. The actual process is complicated and section 3.2 sets out fifteen principles which are:-

- Proposal for substantial service change
- Pre-reconfiguration discussion with SHA, OSC and stakeholders
- Development of programme brief
- NCAT review and Health Gateway review
- Develop full pre-consultation business case, consultation document and evidence against the four tests.
- Business case and consultation document agreed with SHA
- Proceed to consultation
- 12 week minim formal consultation period.
- Analysis of consultation responses
- Preferred option drawn up and submitted to PCT board(s)
- PCT board(s) make final decision
- OSC meet to discuss PCT board's final decision
- OSC content
- Proceed to implementation

206. There are in sections 4-6, which are 26 pages long, much detail about the three stages of the process namely, pre-consultation process which sets out matters such as public consultation documents and other matters, the formal consultation process and finally the post-consultation process. These are all immensely detailed. I do not consider there is any need to go through them because it has not been suggested by the defendants that they have been complied with. That is not surprising because it was considered at all times by the Secretary of State that he could rely on the Chapter 5A process.

207. Again applying the reasoning in the *Smith case*, which I quoted in paragraph 180 above, the Secretary of State would have been unable to show that he would have reached the same decision on each of the services reduced in his Decisions as he arrived at in the Decision under challenge.

208. My conclusion is that the Secretary of State cannot show that if he had adopted the section 8 route, he would have come to the same conclusion as he did in the Decision.

Conclusion

209. For the reasons which I have endeavoured to set out, I have concluded that notwithstanding the admirable arguments of Mr. Phillips:-

i) The TSA did not have *vires* to make his recommendations relating to LH;

ii) The Secretary of State did not have *vires* to make his Decision relating to LH;

iii) The Claimants succeed on the complaint concerning "*support from GP commissioners*", as support from the GP Commissioners of Lewisham should have been obtained as they used most of the services at LH. This support was

not given and regard was not given to this duty to obtain it. The statement that they had this support was irrational; and

iv) The Secretary of State cannot justify the Decision by showing that if he had adopted the section 8 route, he would have come to the same conclusion.

210. The other grounds of the Claimants are rejected.

211. Therefore the Decision of the Secretary of State insofar as it relates to LH must be quashed as must the recommendations of the TSA also insofar as they relate to LH.