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

Claim No: C0/1968/2018

BEFORE HIS HONOUR JUDGE MARK RAESIDE QC
Sitting as a Judge of the High Court

BETWEEN:

RACHEL NETTLESHIP

and

(1) NHS SUNDERLAND CLINICAL COMMISSIONING GROUP
(2) NHS SOUTH TYNESIDE CLINICAL COMMISSIONING GROUP

and

(1) SOUTH TYNESIDE COUNCIL
(2) SUNDERLAND CITY COUNCIL
(3) SECRETARY OF STATE FOR HEALTH

VIKRAM SACHDEVA QC and ANNABEL LEE appeared on behalf of the Claimant
ELEANOR GREY QC appeared on behalf of the Defendant

JUDGMENT
(Approved)

HH JUDGE MARK RAESIDE QC:

This is the judgment for which I have belatedly received a transcript and due to its poor quality, I had to correct on several occasions and chase up those corrections all of which unfortunately has taken a very long period of time to finalise. I apologise for this delay which has been largely outside my control.

Introduction

1. In this judicial review claim Rachel Nettleship ("Miss Nettleship") who is in receipt of a legal aid certificate seeks a declaration that the decision of 21 February 2018 ("The Decision") to approve the reconfiguration of services by NHS Sunderland Clinical Commissioning Group and South Tyneside Clinical Commissioning Groups, ("The NHS Sunderland and South Tyneside Clinical Commissioning Groups") was unlawful and should be quashed and a mandatory order requiring them to take a new decision to meet their obligations should be imposed by this court.

2. There are now seven grounds which, when considered, take the shape of what may be described as a bowtie, in that at one end, (Ground 1), the main ground is where the real argument lies and at the other end, Ground 7 is the new ground relying on changed circumstances after the Decision which have latterly been added and in between are grounds 3 to 6 which essentially are narrow and grounds which have not been developed by counsel for Miss Nettleship. As this is the largest court in the Leeds District Registry and over the three days of this hearing this court has been full of members of the public, I have considered it appropriate to give this *ex tempore* oral judgment on the last day sitting before Christmas vacation so the parties know the decision when they leave this court. I apologise for its length but this is a fact sensitive case.

Procedural Background

3. On 18 May 2018 Miss Nettleship issued a Judicial Review Claim Form against NHS Sunderland and South Tyneside Clinical Commissioning Groups together

with three interested parties, South Tyneside Council, Sunderland City Council and the Secretary of State for Health, in which she wished to review the extraordinary meeting which made the Decision.

4. The Claim Form and the Claimant's Statement of Facts and Grounds dated 17 May 2018, settled by Vikram Sachdeva QC and Annabel Lee, at that time only raised six grounds. Ground 1, which was the most important submits that the consultation process was unlawful and relied upon the NHS Act 2006 Section 14Z2(2) and *Moseley v London Borough of Haringey* [2014] UKSC 56 per Lord Wilson at paragraph 27 (and the Gunning Criteria) and asserts (a) failing to consult at a formative stage, (b) failure to provide sufficient information and (c) failure to conscientiously take into account the product of consultation.

5. On 14 June 2018 NHS Sunderland and South Tyneside Clinical Commissioning Groups acknowledged service of the Claim Form and attached the Defendant's Summary Grounds of Defence, also dated 14 June 2018, settled by Eleanor Grey QC. In defence to Ground 1 the defendant assert that they had met these obligations and relied upon the statement of Dr David Hambleton and in response they say (a) there was a consultation and it was proper to identify options provided they kept an open mind, (b) extensive information was in fact provided, and (c) considerable work was done to collect and analyse the public concerns. This of necessity requires a fact sensitive enquiry and in particular as the law was not really in dispute between these two counsel, it did not appear to be a case in which one would need to argue or set out the law at great length.

6. Despite the service of the Claim Form on the three interested parties on 22 May 2018, none of them acknowledged service or seek to take any part in this claim for judicial review. It follows that despite the involvement of these two local Councils, as is apparent from the evidence before this court, they have decided not to come before this court to put their arguments. Equally the Secretary of State for Health, of which there is also evidence before this court, has also decided not to come before this court and put an argument. In this regard it is therefore not right for this court to speculate as to what their cases could or should be but answer the case brought by Miss Nettleship alone.

7. On 19 June 2018 the Claimant's Reply was served and settled by the same two counsel.

8. On 1 August 2018 His Honour Judge Saffman, sitting as a Judge of the High Court granted permission on all six grounds and gave case management directions for an expedited trial which was set down for three days.

9. On 27 September 2018 the claimant's amended Statement of Facts and Grounds was served and settled by the same two counsel which later added Ground 7. This ground relies on two subsequent Government initiatives for the NHS, (a) lifting tier-2 limitation on hospital staff, and (b) the injection of finance, both of which they assert are changed circumstances which require this Decision to be re-made.

10. On 18 October 2018 a Detailed Grounds of Defence, together with the Defendant's Summary of Defence on Ground 7 was settled by the same counsel in which (a) and (b) were said to make no difference and therefore the consultation process should not be changed in respect of the Decision.

11. On 23 November 2018 the claimant issued an application notice inviting the court to grant permission on the papers to rely upon Ground 7 on which they attached their updated Submission and it was said to be Wednesbury unreasonable and they noted that these matters had already been raised in their Reply. On 28 November 2018 Lane J gave permission to rely upon the additional ground and made further case management directions. On 5 December 2018 the claimants wrote to the defendant to clarify that in fact the Ground 7 comprised two matters, namely (1) funding and (2) recruitment and they referred to the relevant parts of their amended case. This was disputed by the defendants on 6 December 2018 to which the claimant replied at length on 7 December and made their case clear. In the Skeleton Argument of the defendants it is maintained that Lane J only gave permission in respect of recruitment of a new case and nothing further. Whilst procedurally I am quite satisfied the defendant is quite correct, the argument on funding is plainly before the court and I permitted the claimant to raise this ground as well. To be entirely fair to Eleanor Grey QC in her oral submissions she did not oppose the Claimant.

12. In accordance with the order the claimants served their Skeleton Argument on 12 December, again settled by Vikram Sachdeva QC and Annabel Lee.

13. Likewise on 17 December 2018 the defendants' Skeleton Argument was settled by Eleanor Grey QC.

14. In addition to the core bundle there are now three bundles of files before this court and an agreed authorities bundle. Within those three bundles there are witness

statements from both parties so far as the claimants are concerned, their counsel has provided little or no reliance on them with the exception of a small part of particular paragraphs in the statement of Roger Nettleship to which I shall come. This is not the same so far as the defendants are concerned, who have relied from the outside heavily on their witness evidence to support their case in particular and so far as their submissions are concerned, that of Dr David Hambleton. The most important documents placed before this court on which essentially this judgment can fairly be based, are as follows; the South Tyneside and Sunderland NHS Partnership, the Issue Paper dated November 2016, the NHS South Tyneside and Sunderland Clinical Commissioning Groups Pre-Consultation Business Case, 28 June 2017; the review of the Public Consultation between the 5 and 15 October 2017; the Feedback Analysis Report of December 2017; the Decision-Making Report of 21 February 2018 and the record of the Extraordinary Meeting on 21 February 2018

South Tyneside and Sunderland Hospitals

15. South Tyneside population is 152,000 and Sunderland's population is 275,500. The distance between them is shown on the map as between 7 to 10 miles. South Tyneside is spread over 64sqkm and comprises post-industrial and former mining communities configured around the main towns of Hebburn, Jarrow and South Shields. The level of deprivation in South Tyneside is significantly higher than in England and the life expectancy is lower. Levels of health and underlying risk factors in South Tyneside are among the worst in the country. In 2016 the community health profile provided by Public Health England compared the health of South Tyneside to England as averages and noted the levels of smoking, drinking, obesity and cancer and heart disease among the highest causes of death and that further change to the population would come about due to aging.

16. The hospital-based services across South Tyneside and Sunderland are centred around the South Tyneside District Hospital in South Shields and the Sunderland Royal Hospital in Sunderland. South Tyneside health care services are delivered by 27 general practitioners in South Shields and there are 51 general practitioners in Sunderland. There is also an ambulance service in South Tyneside and Sunderland delivered by the North East Ambulance Service, which is a single point of access for urgent cases.

17. By November 2016 it had become clear that a transformation programme would be required in order to provide a secure, safe and sustainable NHS service in the future. The name given to this process throughout was "The Path to Excellence", which is the title used on all documents provided to the public by the NHS Sunderland and South Tyneside Clinical Commissioning Groups.

Parties (Witness Evidence)

18. In view of the fact that the witness statements, in particular of Miss Nettleship, are short and circumspect and no reliance at all has been placed on them at all by her counsel, and equally having regard for the fact that so far as the defendants are concerned they do place considerable reliance on those witness statements, I propose to first refer to this witness evidence before coming to the documents, which of course are at the centre of this case.

1) The Claimant

19. Miss Nettleship's witness statement is dated 14 May 2018. She is 36-years-old and is unmarried and has no children. She is not currently employed as a result of ill-health and has been involved in the Save South Tyneside Hospital Campaign Group since it started, though she does not give the date. She is passionate that the services should not be moved away from South Tyneside District Hospital and considers that she owes her life to them having been diagnosed with mental health disorders for which they were vital of bringing about or beginning her recovery. She feels that the consultation provided to the public did not explain why no options involving retention of those services at South Tyneside District Hospital were provided, on what she bases this feelings is not clear. She has concerns about travelling to Sunderland Royal Hospital in view of her condition and the anxiety it will cause in the future should this decision not be judicially reviewed. Assertion aside, there are really no details about the basis upon which her views are founded and in particular whether she was or was not aware or indeed had access or any involvement at all with the information or process that took place during this public consultation. No reliance was placed by her counsel on the evidence.

20. Miss Nettleship instructed Helen Smith, a solicitor from public law and human rights department at Irwin Mitchell LLP Solicitors, a very well-known local firm, who has conducted this Judicial Review claim. In her witness statement of 17

May 2018, Helen Smith refers to the reconfiguration of South Tyneside District Hospital in respect of stroke services, maternity, women's health care, children and young people and she sets out the options available for those free services following the public consultation. She was responsible for the pre-action procedural correspondence passing between Miss Nettleship and solicitors instructed for the defendants. She is also aware of the Joint Health and Scrutiny Committee and the referral to the Secretary of State for Health, which is in progress aside from this judicial review claim. She considers that thousands of people in the local area of South Tyneside will have their lives significantly impacted as a result of this reconfiguration and the Decision. This statement is not used as a vehicle to introduce and explain the considerable documentation that is available or give evidence or assist with the background, though she refers briefly to some of the steps. This statement takes matters no further.

21. Roger Nettleship's witness statement is dated 18 May 2018 and he is 69-years-old and the (unofficial) Chair of Save South Tyneside Hospital Campaign Group. It was formed as a result of concerns by local residents in South Tyneside to protect their local hospital and GP services. The campaign group have held demonstrations, rallies, public meetings, fundraising events, handed out leaflets and issued press statements about the proposed changes to the service, including a petition which he says has almost 40,000 signatures. The campaign group has concern with the public consultation because of a lack of clinical involvement in devising of the review options and the risk of patients' safety, which is thought to be low but may become high in the event of complications during childbirth, concerns as to stroke care and timely transport in critical cases and the sustainability as a result of significant ongoing cuts and underfunding of local hospitals. It is the campaign's concerns that the outcome of this matter was settled at an early, pre-determined stage and that there were no options as how good the services are and the option to keep the consultant led team in Tyneside was not available. Overall they suggest the commission should rotate between the two sites to ensure that vital services are retained. He specifically notes that the pre-consultation business case refers to savings of almost £2 million a year and this has to be set against the hospital's budget, which he asserts is £150 million (which is not disputed as such). Having attended a meeting on 4 September 2017 with the Joint Health and Scrutiny Committee which was attended by the North Regional

Secretary and local MPs together as councillor's meeting, he gives evidence of what took place at that time and on that date only. He also refers to the involvement of the Secretary of State for Health. He gives some evidence in respect of "value for money analysis" as he described it, carried out on the basis of what he considers to be reduction in the NHS Service for people in South Tyneside, which he considers unwarranted. What is significant by its absence is that as chair of this campaign group, he fails to deal with the involvement of the public from the outset and the online material, Facebook material and other matters provided by these defendants and their wish to address the public and indeed his organisation which, upon the facts shown, took place at a meeting between the Chief Executive and officers of the clinical group and indeed other meetings, which I shall refer to in due course. Moreover, though he makes assertions in respect of what he calls value for money of this new arrangement, he is unable to give any supporting documentation or material save for that largely general assertion. This was the only evidence relied upon by counsel for Miss Nettleship.

22. Two mothers, Hayley Farquharson and Sonia Morton in their witness statements dated 11 and 18 May give details of their children's attendance at South Tyneside District Hospital. As far as the latter, her youngest son Russell had an unfortunate experience which was dealt with properly and she is concerned about travel to the A & E department of Sunderland Royal Hospital in the future and her two-year-old daughter Nyreen who has been diagnosed with cancer, and has attended South Tyneside District Hospital. Sonia Morton's son Leighton has a chronic lung disease and has received treatment from South Tyneside District Hospital, which carefully manages his condition, and she is also concerned about travel in the future to Sunderland as a regional hospital and the response times, in particular for her son given his condition. Her other son, Oscar, has been treated when he had a skull injury at South Tyneside Hospital. Both these witnesses are concerned with their children and their future travel arrangements. Apart from that, these statements provide no more evidence in respect of the way the case was in fact put by their counsel.

23. Jim Jordan provided a witness statement dated 15 May 2018. He is 71-years-old, a retired police officer and an active member of the campaign group. He gives details of travel time, prices of transport by Metro, bus and car to Sunderland Regional Hospital. The travel arrangements in his view should give rise to Judicial Review.

Again the statement, whilst this is one of the arguments as I will describe in due course, it did not give rise to any oral submissions by counsel for Miss Nettleship.

(2) **The Defendants**

24. Dr David Hambleton is the Chief Executive of NHS South Tyneside Clinical Commissioning Group and had responsibility for the process that gave rise to the Decision. His photograph appears in the Issue Paper and it is clear from this that his role was central from the outset. He provides two witness statements dated 14 June 2018 and 18 October 2018, the latter of which sets out considerable detail of the background of this process. It is understandably relied upon from the outset by these defendants. He explains the background of the whole process including the fragility of the services and gives an overview of the development of options and the assurance of process that went underway for the public and their complete involvement.

25. The background to the process arose as result of substantial pressures facing stroke, obstetrics, gynaecology and paediatric emergency services for which a review of those services was required in order to deliver the National Strategy set out by the NHS in a 5 Year Forward Review and which focussed on collaboration across the health systems and took account of National Guidance intended to improve patient outcomes. It is clear from the outset that those services could not be retained in the current form and this was explained throughout to the public by means of fact sheets, websites including details from clinicians and who provided details of their clinical skills together with patients who were contacted, members of the staff and other organisations including trade unions. This was particularly so in respect of stroke services, which had been consolidated and had shown, as a result, improvements for their patients. As a result of staff sickness and the absence of the special baby care units at South Tyneside District Hospital, it had to close between November 2017 and January 2018, which gave further evidence of the fragility of the service at the time. These services were at breaking point and were not sustainable as there was not enough staff to deliver the services as currently configured.

26. Significant work was carried out on the options by clinically led teams and then put forward for public consultation. Details of those teams make it clear that these were

individuals who were properly qualified to carry out that process. There was, he tells us, a long list of options which considered 'doing nothing' in respect of stroke, paediatric, obstetrics and gynaecology. As far as the published material was concerned, at the outset, doing nothing was described expressly as an option. These options were then assessed against hurdle criteria to establish the viability of each option. In respect of stroke services, those options were not considered deliverable, or affordable, due to the level of infrastructure that would be required. The doing nothing option on this basis could not be achieved but it was considered sustainable and the quality would be improved if these two sites could join in their work forces. As far as gynaecology was concerned, this was also considered by the same hurdle criteria as the current workforce were not sustainable in South Tyneside District Hospital and they did not have sufficient bed theatres or diagnostic capacity to deliver the options. In respect of paediatrics the do nothing option was considered but in due course, and later on was discounted, as it was not sustainable in the long run. The short- term was dealt with differently. What is clear from this is that each service was considered in its own rights and quite separately.

27. Dr David Hambleton considers that the public involvement was a key part in the process from the outset and this was informed by the statutory guidance from NHS England entitled 'Patient and Public Participation and Commissioning Health and Care'. In August 2016 a communications and engagement strategy was produced which established the framework for public involvement and in the programme there were two phases for which phase one was for 'listening exercise', which was used to inform and develop the proposed options and phase two was the public consultation. During phase one this programme developed a dedicated website where it uploaded all relevant documents and produced easy to read summaries of key documents to help ensure the programme was successful and understandable to the public. As the options developed the public involvement took place by means of surveys, face-to-face interviews there were 1,442 surveys and 98 interviews, together with Facebook to reach the unknown local public and public surveys. Patient experiences were recorded as to what was needed to achieve these improvements. During phase two the public consultation was explained by means of a short lift which had then been arrived at. A doing nothing option could not be proceeded with in their judgment. By means of examples reference is made to

strokes, obstetrics and gynaecology and other services which Dr Hambleton considered and reviewed as part of the process. Details were given of the Equalities Impact Assessment in this process, as it was also for the travel and transport and financial affordability arrangements. In respect of feedback to the public involvement in this process, it was a key part from the outset, he tells us, as a result of the statutory guidance from NHS England, with which he was plainly very familiar. Initially it took place with the listening exercise to which I just referred to, and in the public consultation. He was of the view that public engagement in pre-consultation played a significant part in the shaping of final proposals which were subject to consultation. He also provides examples of some of the frequently asked questions during the formal public consultation process and exhibits them to his witness statement. One can look at these questions and compare examples, which I shall not cite at length but any review makes it clear what questions were in fact commonly asked and indeed those that are not.

28. Quite separately, Dr David Hambleton deals with the government announcements to exclude doctors and nurses as a result of the cap on the two-tier visas being lifted which he considers unlikely to resolve the workforce problem. He explains exactly how the system works and refers to the Home Office published monthly figures for April 2016 to September 2018. South Tyneside made attempts in the past to attract international recruitment which proved unsuccessful and he knows the problem with a lack of competent candidates. He considers the fundamental problem is the inability to fill the posts that have been specified which was affecting seriously both South Tyneside and Sunderland and these were reasons which were made clear as part of the public process. The fact that there were few restrictions on doctors and nurses coming into the United Kingdom does not change the fact that he considers it remained an unattractive option in his hospitals and his area. His views are supported by South Tyneside NHS Foundation Trust.

29. Matt Brown is director of operations for NHS South Tyneside Clinical Commissioning Group and gives evidence especially in relation to the additional Ground 7, made as a result of the order of Lane J. As such the defendants did not, in their submissions, rely upon his statement.

The Decision

30. The Decision for Sunderland and South Tyneside Clinical Commissioning Groups is recorded in an extraordinary meeting in common with their governing bodies together with the North East Ambulance Service (NEAS). The meeting was chaired by Dr Walmsley and attended by Dr David Hambleton, Chief Executive of South Tyneside, David Gallagher the Chief Officer for Sunderland, together with Ken Bremner the Chief Executive of the South Tyneside NHS Foundation Trust and City and Hospital Sunderland NHS Foundation Trusts.
31. The first item of assurance was the consultation process, which was presented by David Gallagher who explained that the process and statutory requirements included listening to the local people. Mr Watson, a director of communications in informatics who led the process, then presented the report. NHS Sunderland and South Tyneside Clinical Commissioning Groups had drawn upon the NHS statutory duties, English law, NHS policy, and case law to help them form and shape the process and ensure they achieved appropriate NHS England Assurance for which such improvements and compliance was essential in order that the process would be acceptable and had to comply with and guard against pre-determination of the outcome in the consultation exercise.
32. The process of engagement and consultation had been delivered in two phases. The pre- engagement listening phase and the formal public consultation phase. The pre-engagement listening phase involved the publication of an issues document and the engagement of the partners, stakeholders and staff in relation to the vulnerability of these services. In addition NHS Sunderland and South Tyneside Clinical Commissioning Groups had attended wards and local meetings and undertaken media and publicity and carried out targeted work with people so they could appreciate 'lived experiences' of those services. A detailed outline of the pre-engagement work was set out in the consultation Assurance report (set out in Appendix 4 to the report). It focussed on how the pre-engagement listening phase had influenced the development and that the options in this report was published online and presented to the Joint Health Overview and Scrutiny Committee. It was recognised that pre-engagement listening phase for traffic and transport was a significant issue and it was considered at all stages.
33. To maximise the breadth and depth of the response of the consultation, a range of the focus groups were commissioned which were run on behalf of NHS Sunderland and South Tyneside Clinical Commissioning Groups by local voluntary

organisations and opinions of groups and teams, including key stakeholders, such as Health Watch, Scrutiny Committees, members, trade unions, affected staff groups and other elected representatives and local communities and MPs, local counsellors was received. A response was received from South Tyneside Hospital Campaign Group, along with a petition with approximately 30,000 signatures. The consultation process achieved a response rate of 0.56% of South Tyneside and southern population (the average is 0.7% and therefore a good response would be 1%) but they had been assured that the wide range of views and opinions across society had been achieved. There had been 11 meetings with the Joint Health Overview and Scrutiny Committee which, in response, had considered the process robust and they praised the cooperation and commitment of key staff in the NHS. It may be noted that the final response of the Joint Health Overview Scrutiny Committee in January 2018 gave a contradictory view and asserted that much of the information presented was complex, confusing and lacked clarity.

34. NHS Sunderland and South Tyneside Clinical Commissioning Groups were aware of Save South Tyneside Hospital Campaign Group and Dr David Hambleton and David Gallagher had met leaders of that group during the consultation process. They had therefore had involvement which, on the evidence given by this group, does not seem to have been recorded in their witness evidence.

35. In order to maintain independence and impartiality in the process, NHS Sunderland and South Tyneside Clinical Commissioning Groups commissioned a third party company called Social Marketing Partners to consider the development design of the consultation survey and review the product of the consultation feedback report, which was published in December 2017 on their website. The publication of the report was the start of the period of consultation which lasted until 8 January 2018 and gave the opportunity for comment and findings and the next steps, which would be included in the feedback sessions. The governing body of members of NHS Sunderland and South Tyneside Clinical commissioning Groups had attended workshops in December to hear draft feedback from the public and a number of additional assurances were given and further information was provided to those groups. In addition the Independent Consultation Institute carried out a quality assurance review of the whole process and confirmed in February 2018 verbally that this was best practice but subject to how the final

decision was conducted. A copy of the Institute's mid-term quality assurance feedback was included in this report.

36. On the basis of the above report given by Mr Watson, Dr Walmsley recommended formal approval of the consultation process and therefore put a resolution to both South Tyneside and Sunderland governing bodies that they endorsed the 'Communications and engagement activity undertaken in the consultation process'. The decision was moved and therefore they moved on to subsequent matters which are of less importance to Ground 1.

Factual Background (Documentary)

37. As Ground **1** concern with procedural fairness and consultation process, which resulted in a Decision and Ground 7 concerns subsequent changes of circumstances, it is important to consider the relevant documentation underpinning this Judicial Review Claim as a matter of fact. Both counsel, in their oral submissions, took me through the essential documents which I now refer to. As far as the claimants' counsel is concerned the case was, essentially, simply based on the documentation.

(1) The Issues Paper November 2016

38. An Issues Paper concerning how to create the best possible improvements for health and care in South Tyneside and Sunderland was published November 2016 by Dr David Hambleton, the accountable officer of South Tyneside, Dr Gallagher, the accountable officer for Sunderland and Ken Bremner, the Chief Executive of South Tyneside NHS Foundation Trust and Sunderland NHS Foundation Trust. They were concerned that despite the way the healthcare that had been provided had been dramatically improved over the past 15 years, thanks to the commitment of the NHS staff and advances in medicine and medical technologies and training, things could not stay as they were and some changes had to be considered. They isolated three gaps, namely health and wellbeing of the population, the quality of the care provided and the finance and efficiency of the NHS services which would need to be considered by 2021. In both hospitals there were a number of clinical specialists where each organisation may have one or two consultants and other

specialists providing certain services and that posed an obvious problem of sustainability if consultants took leave or were off sick and departments were not attractive to new consultants and they noted there were some pressures across the workforce on a nationwide basis which included restrictions on overseas recruitment together with funding and training of staff and the need for consultants to work in larger teams to offer them opportunities and the experience. The financial picture was very clear, namely that cost-cutting on an annual basis may not lead to patient safety if both hospitals were trying to provide all those services that they currently offered.

39. The reason that South Tyneside and Sunderland were working more closely and had formed the South Tyneside and Sutherland healthcare group was to develop a plan to deliver the better quality service across their local populations and in order that the key standards could be achieved. They both recognised the importance and the value of having a local hospital providing a range of services but equally recognised that there was an urgent need to rebalance those services as it was not sustainable for each organisation to duplicate some services. It was apparent that both hospitals had been inspected by the Care Quality Commission and had identified a number of key priorities including safe and sustainable clinical staffing and working together to continually improve patient and staff experience. Moreover consideration was given to what was described as critical mass which concerned the Royal College, the General Medical Council, the Academy of Medical Royal Colleges which set out standards of skill and patient safety and ensured that doctors had enough experience to treat patients which required a certain throughput or volume of work with patients to achieve that.

40. The result of this meant that there was a case for change with different options and scenarios and they proposed to publish a consultation document which would allow consultation to take place over 12 weeks and would have different ways of people to feedback their views at public event surveys and focus groups. That feedback would then be used for the final business case to be reviewed by the Clinical Commissioning Groups. The Issues Paper made it clear how the public would get involved immediately at this stage of the process by signing up and joining "my NHS" website. It was made clear that there was a dedicated website containing the most recent information and documents and links with the community

and voluntary sector organisations were going to run events and hold focus groups for service user and carers. A timeline was provided.

41. The Issues Paper indicated that there was going to be a clinical services review in three phases for which phase 1 concerned the stroke, trauma, orthopaedics, including geriatric orthopaedics and gynaecology patients, and increased delivery of effective services over the next two years. The clinical teams would carry out a view of 'likely ways in which services might be reconfigured as they would 'make suggestions as to how the services might be better organised in order to give the highest quality of care to patients and to maximise the best use of staff skills and other resources'.

42. It seems clear that in November 2016 when this process commenced, the following conclusions can be fairly drawn. (1) The public were involved from the outset. (2) No decision had been made on the options or pre-selection. (3) The reasons for review included the quality of care with patients and the maximising use of staff in the full knowledge of (4) that some change was inevitable if the best possible improvements for healthcare in South Tyneside and Sunderland, would be achieved. At this stage it would be incorrect to summarise the drivers of this process as only (1) funding and (2) recruitment though these were factors.

(2) Pre-Consultation 28 June 2017

43. As had been anticipated, the promised pre-consultation paper was published and made available on 28 June 2017 The aims and objects of the Pre-Consultation Business Case were (1) make the case for urgently transforming the models of delivery for acute stroke, obstetrics, gynaecology and paediatrics; (2) describe the potential options for future service configuration and (3) describe the communications and engagement process that had been undertaken with the public clinical teams and stakeholders in developing the potential options for transforming the healthcare that could be delivered. In addition it also made clear that the process of reconfiguration would need to have a strong public and patient engagement as to the availability of choices based on clear clinical evidence. This process had two quite separate stages, (1) consultation, (2) the decision-making process. The order is important. Under the consultation process it was

made clear that it would be open and transparent in respect of the public consultation in order to harness local people's views on the most appropriate way to address the clinical and financial challenges. This was achieved by a 14 week long public consultation process that was to test these change proposals, understand if and how they could be improved and identify if people have better ideas that may have been missed. During this process the Commissioners indicated they would listen carefully to the views of all communities and local stakeholders. The second stage of decision was identified for early 2018 and it would ensure the governance process was transparent and in line with their statutory duties. The respective chair of the commissioners would hold public meetings in their areas.

44. The executive summary set out the importance and value of having local hospitals provide a range of services which it was recognised was duplicated across South Tyneside and Sunderland hospitals and this was presenting a challenge as to the delivery of safe, high quality services. The areas focussed on at this stage of the process were stroke, obstetrics, gynaecology, paediatrics, emergency services, which were facing an unprecedented sustainability challenge driven predominantly by limited medical workforce and resulting in the service continuity, quality and financial pressures. This document set out those problems with the workforce and financial sustainability which was set in the national context of a five-year Forward Review and the National Strategy and Clinical Standards. The Pre-Consultation Paper made clear that any reconfiguration of services required a robust, comprehensive public engagement in the consultation process in order to ensure that the plans were well informed and that the public and stakeholders were aware of the issues and how they could be solved. This required a clear strategy, and action plan, an audit trail which would show how the public and stakeholders would influence the decisions at every stage of this process, and would be compliant with the NHS Act 2006 and the Gunning principles. In order to develop their change proposals it was decided that this would include clinically led design process and that consistent hurdles and criteria would be applied throughout. There were five reconfiguration tests that were mandated by NHS England which were (1) strong public and patient engagement; (2) consistency in current and prospective needs for patient choice; (3) a clear clinical evidence basis and (4) support for proposals from commissioners. The fifth test involving bed closures

which had been announced by NHS England's Chief Executive in March 2017 had to satisfy three conditions. The strategic context of the change referred to both the five-year forward review that at national level, and regional context, which understood those three gaps. Attached to this consultation paper was a document which sets out best practice for communicating and engaging which at that stage made it clear that the drivers for change included financial sustainability, limited workforce availability and those three gaps were identified again. It was during the listening period that the scenario of options would be developed with a view to taking account of the public and stakeholders' response and the ways in which those people in the wider general public think hospital services could be improved at South Tyneside and Sunderland. In carrying out the process they were aware both of a need for public involvement, the requirements of the NHS Act 2006, including specifically Section 14Z2 Public Involvement, together with a requirement that the process had to comply with the Gunning principles and common law principals.

45. Quite separately, there was also attached an overview of the Clinical Design Process (Appendix 5.1). This described the method for developing, evaluating and agreeing the options to be taken forward for public consultation. It was in this attachment that the hurdle criteria was set out which were, (1) support sustainability/ service resilience which had two sub-criteria that asked the question, does this scenario support service sustainability from the clinical worker's perspective and does this scenario support service sustainability from a population activity perspective? (2) Will it deliver high quality safe care, which again had two questions, does this scenario deliver improved quality to that delivered in the current service configuration and does this scenario deliver applicable quality / safety experience standards and regulatory requirements for service? (3) will it be affordable to which the question was is this scenario deliver without any significant additional cost impact on commissioners and the wider health care system? And lastly (4) whether it was deliverable for a period of one to two years? As a set of questions and hurdles which are referable to clinical design process, these questions are understandable in their context. Moreover if you read the document more fully does it provide evidence of who these design team

were, what they are made up of. It also provides details of what the longlist was, in broad terms, although the document was not attached.

46. Once again it is clear from this document at this stage in the process and in the process, (1) the public have been involved once again; (2) there is a clinical design process underway which informed the way forward (3) the options are starting to crystallise at this stage of the process. On 20 April 2017 NHS England wrote to Dr David Hambleton, David Gallagher and Ken Bremner in respect of the assurance required and confirmed the programme was clearly based on medical workforce challenges at the heart of the clinical design process and that such planning was also evidently outwardly transparent and as inclusive as possible as was the evidence of an ongoing dialogue, the Joint Health Overview Scrutiny Committee and the Public Engagement generally. In NHS England's review of the service changes plans when measured against the four criteria, the conclusion was therefore that phase 1 proposal made by South Tyneside and Sunderland Clinical Commissioning Groups met the requirements as determined by the guidance.

(3) **Public Consultation 5 July to 15 October 2017**

47. Again as promised from the outset the Public Consultation Paper was published by South Tyneside and Sunderland Clinical Commissioning Groups. On its face, it appears to be a user friendly document in which it is made clear that those groups who wish to improve the local NHS services by working together to deliver a safe, high quality care which would make best use of resources to meet the needs of the population. It was made clear how the public could get involved by attending public meetings, events, focus groups and completing a survey and a list of dates were placed where public meetings were and the location of the area. It is an impressive list of open and continuous involvement with the public.

48. The public consultation explained the challenges that were faced and the different ways local clinical leaders and doctors and nurses throughout the service could be provided in the future and accordingly set out, (1) three possible options for the way hospitals stroke healthcare services could be organised; (2) possible options for the way hospital based maternity, gynaecology services could be arranged; (3) possible options for the way that paediatrics could be delivered

across South Tyneside and Sunderland. The basis for the development of these options was in order to provide high quality care for patients while getting the best out of the staff and facilities and resources available and it was explained how those proposed options had been arrived at including the independent Royal College feedback and the local patient experiences and engagement. It was made known to the public that this process was keen to find out how this may affect them and how it could be improved in different ways in the future. They wished the public to get involved with the consultation process. It was the basis on which the clinical commissioning groups would make the decision a year later.

49. There were three challenges that had to be faced by South Tyneside and Sunderland Clinical Commissioning Groups which concerned stroke services, which were (1) the inability to make much needed clinical quality improvements as a result of low staff levels and inefficient working arrangements; (2) the need to improve compliance with national / clinical guidelines, and (3) national expectations to deliver a seven-day stroke hospital services to treat a minimum of 600 patients per each year. Equally the challenge in respect of maternity and gynaecology suffered from six particular problems, including shortage of senior doctors, over-reliance on temporary staff, the need to meet national standards of care special baby units staff pressures and the inability to increase senior medical cover and the clinical quality improvement requirements expected by the national maternity strategy. It was also made clear that the 'do nothing' option was discounted as it would not lead to improvements in the service, particularly in relation to staff shortages and there was no wish to discontinue the valuable services, and therefore a local solution was needed which best served South Tyneside and Sunderland. It was also noted that a single identifiable problem was facing the three services but each had to be considered in its own right on its own evidential basis.

50. Both during and after the public consultation, South Tyneside and Sunderland Clinical Commissioning Groups received support from NHS England. On 27 July 2017 Professor Tony Rudd, the National Clinical Director at NHS England wrote to Dr Wahid and copied to Dr David Hambleton, David Gallagher and Ken Bremner in respect of the stroke services change proposals supporting the fact that South Tyneside and Sunderland were working together to achieve care quality and clinical outcomes required and that the Stroke National Audit Programme which had been a driving factor for transformation. It was noted that service consolidation would

deliver considerable clinical benefits and increase standards of care. Having considered the two options it was noted that the four priority clinical standards of NHS England had been considered. On 27 October 2017 Dr Robin Mitchell, the Clinical Director of NHS England wrote to Dr David Hambleton and David Gallagher in respect of child health networks and attached a report dated 24 April 2017 on paediatrics which noted no reasons to question the safety and clinical efficiency of the proposals had been identified and could not suggest other configurations options. On 19 February 2018 NHS England wrote again to Dr David Hambleton and David Gallagher in respect of phase 2 Assurances, which they indicated had their support for changes of all three clinical services given the evident workforce challenges and the inability to deliver sustainable care which could compromise the local community and that they presented a credible solution which was also financially neutral.

51. On 28 November 2017 NHS Northern England's Clinical Senate published a final report which recorded, amongst other things, that they had a session with Save Tyneside Hospital Campaign Group, which had genuine concerns for patients and young people in respect of paediatrics and the campaign group considered that the proposal was less safe and sustainable than the current model in South Tyneside. This was taken into consideration along with other proposals from third parties which were reviewed in terms of the hurdles criteria which they had put in place. Concerns were also expressed in respect of transport and the availability of North East Ambulance Services, which were considered. Indeed on 13 February 2018 NEAS wrote to Dr David Hambleton and David Gallagher endorsing the clinical change case and supporting the proposal for the service, which they recognised could be delivered and would provide greater acute service sustainability from their department.

(4) Feedback Analysis Report-5 December 2017

52. The final draft report and consultation feedback and analysis was published on 5 December 2017 and among the relevant findings highlighted on behalf of Rachael Nettleship's counsel were (1) downgrading of the

services and facilities at South Tyneside and (2) issues over travelling in transport from South Tyneside to Sunderland for residents of the former borough the latter of which is clearly associated with the witness statements on behalf of Rachel Nettleship. As part of the quality of findings there were 11 particular matters raised which included the apparent focus on Sunderland for which the rationale for consolidation of services was recognised that people remained unconvinced that the evidence presented justified downgrading of South Tyneside.

53. The consultation analysis report of 5 December 2017 had been carried out by an independent review body Social Market Partners. It was not a step in the public consultation process required under the statutory regime but an additional step that NHS Sunderland and South Tyneside clinical commissioning groups decided to carry out. As such it shows additional genuine concern by them to have this public consultation process reviewed independently in order to appreciate the public and stakeholder concerns. The summary of findings in section 12 of the report sets out the concerns, the preferred options for stroke services maternity and women's healthcare service and children and young people's health care services in addition to alternative solutions. There was a clear consensus on preferred options in the quantitative feedback where a choice had been made but less so in discussions and a range of overall concerns expressed about the options in the quantitative discussion. The overall concerns were; a specific concern that the options all resulted in a downgrading of services and facilities at South Tyneside District Hospital linked with concerns over the estate's facilities and staff at Sunderland Royal Hospital being able to cope with the increased volume of patients and visitors, issues of travel and transport from South Tyneside to Sunderland and for residents of the former borough and a major concern in terms of additional driving time for those with cars and the significant burden of relying upon public transport, a concern about equalities and special interest groups living in deprived circumstances being disadvantaged in terms of access and financial cost, the additional travel burdens for patients with a detrimental impact on their health and well- being, and the ability of ambulance services to provide a safe and timely transfer for South Tyneside residents to Sunderland. The preferred option for stroke services in the quantitative methodologies preferred option 1 and for the

qualitative discussion a minority agreed option one for cost savings though all groups defended the current situation as the only equitable option which was defined as status quo plus. On the maternity and woman's healthcare services the quantitative preference was for option **1** and the quality of discussions where a preference was shown was also option **1** and a similar situation arose for children and young people's care save in the latter case it was felt to be a compromise downgrading the services at South Tyneside. The alternative solution to address the travel issues included the provision of travel advice to both hospitals a shuttle bus and as an alternative travelling with telemedicine. It is possible to be selective in this report and consider the quantitative findings alone at 1.8 which in a list of eleven matters in 1.8.1 (most of which concerned transport and the complaints contained in the witness evidence of Miss Nettleship) includes concerns about (1) the consultation process itself, the options presented were all very similar favouring Sunderland over South Tyneside and failing to meet the needs of residents in the latter area, equally the format of the consultation was felt to be too complex in language and the number/ complexity of services floor/options being considered and (2) the apparent focus on Sunderland, the rationale for consideration of services was recognised but essentially people remained unconvinced that the evidence presented justify the apparent downgrading of South Tyneside District Hospital. It was felt that the question of moving some services to South Tyneside was not considered fully enough. But even this is to be put in the context of 1.8.2 and 3 which records in respect of stroke services the quality of care and as a centre of excellence the groups generally favoured the idea of a concentration of those services in one area recognising that it provided a concentration of excellent in terms of skill personnel and equipment, and in respect of maternity services' care that despite reservations about the lack of consultation care at South Tyneside the concentration of expertise on one site was felt to be a major benefit of the proposals and lastly in respect of children and young people care it was felt that needs of children to be paramount and the options should focus on delivering safe care always in the most efficient way. As a result of this report NHS Sunderland and South Tyneside Clinical Commissioning Groups undertook in early December further interaction with the public and carried out a review of the children young people options which is recorded the Decision above.

(5) The Decision-Making Document- 21 February 2018

54. Having held the public consultation, the Decision-Making Document reported on that process. There had been full patient and public engagement in the process in accordance with the statutory requirements and the Consultation Institute had been involved and had confirmed the consultation process met best practice. There had been 805 interviews on a street survey and 409 responses online and 324 responses by direct mail in which 32 groups and 324 participants had taken part in the focus group and there had been 19 public meetings, 443 participants together with phone submissions. The decisions included in the appendix set out the initial feedback in October 2016 for which the primary findings and listening exercise was published and details given of the involvement of the Consultation Institute and quality assurance together with Social Market Partners as above.

55. The executive summary report made it clear that the fundamental importance and value of having local hospitals providing a range of services had to be recognised but it was noted that there was duplication across South Tyneside and Sunderland hospitals in the context of availability of workforce and present changes to the delivery of safe high quality services. It made clear that the stroke, gynaecology and paediatrics in South Tyneside and Sunderland hospitals were facing the most severe workforce sustainability challenges proven driven predominately by a limited medical workforce resulting in service continuity quality and financial pressures such that it was categorically clear that retaining the status quo and not making any changes were simply not an option and those services were extremely likely that a failure to act would lead to closure of both hospitals at South Tyneside and Sunderland under crisis circumstances which was putting patient safety at risk. The case for change was based on the regional strategic context of clinical safety, quality of work and sustainability including the financial case for change. The development of the options have been generated from clinically led decisions and the longer list of potential options have been assessed against the hurdle criteria, the consequence of which was that the do nothing option for stroke, gynaecology and paediatrics had by this stage been discounted.

56. In making their recommendations in this decision, evidence had been taken from many sources including clinical services review groups, much public feedback through the consultation process. The feedback favoured retaining the services as they were and it had been serious considerations during the decision-making process in workshops, but the conclusion was that the weight of the evidence received about the need for change was compelling or unavoidable for these particular services. Accordingly, in respect of obstetrics and gynaecology, the recommendation was to approve option **1** which was a freestanding midwifery led unit in South Tyneside and a medical lead obstetrics team at Sunderland, and the recommendation for paediatric services option 2 was that most sustainable long term model but allow option **1** for implementation in the short term which would be the daytime paediatric emergency department at South Tyneside and 24/7 paediatric emergency department at Sunderland initiating followed by the development of a nurse led process to meet paediatric minor injuries and illnesses facilities at Sunderland and in respect of stroke services option **1** was favoured by which all acute stroke would be directed to Sunderland.

57. After publication of the decision, the Independent Reconfiguration Panel wrote to the Secretary of State for Social Care on 18 June 2018 recording the decision and concluding (1) the consolidation of all in-patient stroke services at Sunderland was in the interests of local health; (2) consolidation of obstetrics and gynaecology was also in the interests local health care; (3) in respect of paediatrics it was considered that option **1** would mitigate the current risks of quality continued care and then discuss the further needs. This was to be contrasted with the South Tyneside Council and Sunderland City Council who, on 12 April, wrote to both South Tyneside and Sunderland Clinical Commission Groups and the Secretary of State for Health. In the letter, Councillor Norman Wright, who was the co-chair of the Joint Health Scrutiny Committee (who had been involved throughout and given some support), indicated two grounds of complaint (1) there were several aspects for the proposed changes not in the interests of the health service at South Tyneside and Sunderland; (2) they were not satisfied with the content of the consultation and that it was not compliant with the governing principles. So far as the latter was concerned it was considered that there was a pre-determined plan to move the services from South Tyneside to Sunderland and that no options were considered which involved the services remaining as they were and therefore it was a *fait*

accompli in the people's consultation and despite the overwhelming feedback that people wanted the services to remain in South Tyneside. It also considered the options presented were very similar and favoured Sunderland over South Tyneside and thus failed to meet the needs of local residents in the area. However, the view of the Independent Reconfiguration Panel in respect of those views is also recorded on 18 June. It is their view that the Joint Health Scrutiny Committee had provided no evidence about the adequacy or otherwise of the consultation process and only "believed" that the consultation process did not comply with the Gunning Principles. Their conclusion that: "More could have been done by the NHS from the outset to explain clearly the wider strategic context and to be explicit about the viability of potential options or otherwise. However given the time and effort invested on all sides and the myriad of opportunities to address those gaps before, during and after the consultation period it was disappointing that the process appears to have ended without a shared understanding between the NHS and the Joint Health Scrutiny Committee". It was apparent that the panel considered that there had been a marked change in attitude by that committee at this latter stage, as I have indicated above. As far as the local authorities are concerned, they are not parties to this action and therefore I take the matter no further.

(6) Changed Circumstances

58. On 15 June 2018 the Home Office announced that more highly skilled doctors and nurses would be able to come to the United Kingdom by means of a Tier-2 visa route which had an annual cap to 20,700 since 2011 but in recent months the applications had exceeded the monthly allocation of places available. The NHS accounted for 40% of all places and were driving this process. The Home Secretary, Sajid Javid, considered that this would increase the demand and support for the essential national services. The Health and Social Care Secretary, Jeremy Hunt, announced that this would send a clear message to nurses and doctors around the world that the NHS welcomes and values their skills and dedication.
59. Three days later on 18 June 2018 the Prime Minister, Theresa May, gave a speech about the future of the NHS at the Royal Free Hospital. In regard to long-term funding she recognised that more money was needed to keep pace with the growing pressures of the NHS but it was not just a question of money this year or next, what was needed was a plan for the future. There had been uncertainty over

what the funding position would be in as little as the next two years which had led to a system planning from one year to the next and prevented much needed investment in technology, buildings and workforce. I note the wide range of matters for which this money was intended. It was not proposed there would be a one-off injection of cash under her plan. NHS funding would grow on average by 3.4% in real terms each year from 2020 to 2024 and then would provide an additional £1.25 billion each year to cover specific pension pressures. Again I note what the money is to be used for. By 2024 the NHS England's budget would increase by £20.5 billion in real terms compared to today and that meant there would be £394 million weekly in real terms. That money would be provided specifically for the NHS and funded in a responsible way. How that responsible way was to be achieved was not indicated.

60. On 18 June 2018 Helen Smith, solicitor for the claimant, wrote to the defendants' solicitors about the staff shortages having regard to the announcement made that day, invited the defendants to re-take their decision for reconfiguration by 4pm that evening. Maybe unsurprisingly, this did not take place but on the next day, 19 June 2018 the defendants indicated they did not consider the Government's announcements provide a quick fix to the problem that had been experienced for several years and that on only one occasion, in December 2017, had the tier-2 visa cap been reached. There followed a series of interrogatory letters and responses between Helen Smith, as solicitor for the claimant, and DAC Beachcroft Solicitors for the South Tyneside NHS Foundation Trust on 7 and 11 November, and 17 December 2018 in which in response some sixteen questions the Trust explained that as part of their recruitment programme, that they did not target specific countries to encourage applications from oversees doctors but made use of Skype as an interview technique and had also offered financial assistance and support for doctors to relocate hard to fill posts. They indicated that the problem was not filling the posts as they had large numbers of overseas applicants, but how to recruit appropriately trained, qualified and experienced candidates which met the medical criteria for middle grade consultants and explained that these posts were in highly specialised fields. This of course is highly relevant to the very four areas of service that the public consultation was concerned. They conceded they had not explored opportunities for entering into arrangements with

neighbouring trusts for staff- sharing and had not engaged recruitment agencies for those middle range consultants because of the shortage of appropriate applicants. It was also pointed out the national shortage was outside their control and they did not have means of assessing exactly how many doctors worldwide would meet that criteria, so far as middle range consultants were concerned.

Statutory Framework

61. The statutory framework is the National Health Service Act 2006 ("The Act"). In particular Part 2 Chapter A2, Section 14, which concerns clinical commissioning groups, namely these defendants. Under Section 14P there is a duty to promote the NHS Constitution, a duty to improve the quality of the services under Section 14R, a duty to provide innovation under Section 14X and a duty to promote integration under Section 14Z1, together with the need for equality under Section 14T

62. The relevant subsection is 14Z2 which concerns the public involvement and consultation by clinical commissioning groups. Subsection 2 provides as follows:

> The Clinical Commissioning Group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)
>
> (a) in the planning of the commissioning arrangements by the group,
>
> (b) in the development and consideration of proposals by the group for changes in the commissioning arrangements with the implementation of the proposals would have an impact on the manner in which the services are delivered the individuals or the range of health services available to them, and
>
> (c) in decisions of the group affecting the operation of the commissioning arrangements with the implementation of the decisions would (if made) have such an impact."

63. The Act requires, by subsection 4 that the NHS Commissioning Board must publish guidance for Clinical Commissioning groups on the discharge of their functions under that section. Under subsection 5 that the Clinical Commissioning Groups must have regard to any guidance published by the NHS Commissioning Board. Under Section 14Z8 guidance is given on the commissioning of the NHS

Commissioning Board under which subsection 1 places the Board under a mandatory obligation to publish guidance for Clinical Commissioning Groups on the discharge of their functions under Section 2 and places on those Clinical Commissioning Groups a mandatory obligation to have regard to the guidance.

64. In accordance with those requirements, NHS England published a document titled, 'Patient and Public Participation in Commissioning Health and Care: Statutory Guidance for Clinical Commissioning Groups and NHS England' ("the General Guidance"). There were ten principles of participation based on a review of research of the best practice reports and the views of stakeholders. The General Guidance indicated how the public were to be involved and where public consultation was required on the basis of a 'fair and proportionate' to the circumstances. The concept 'fair' was described by reference to the Gunning Principles, hence principles one, two and four are subject of this case. Of particular importance in this case, in view of the fact that a consultation process was adopted in this case, is the governing principle was defined in this way;

"Meaningful consultation cannot take place on a decision that has already been made. Decision-makers can consult on a single proposal "or preferred option" (of which those being consulted should be informed) so long as they are genuinely open to influence. There is no requirement, and it would be misleading to consult on adopting options which were not genuinely under consideration or are realistic or unviable – but it may be necessary to provide some information about other alternatives".

In broad terms this reflects the common law approach per Lord Wilson in *Moseley (supra),* paragraph 25, which.affirmed *R v Brent London Borough Council, ex parte Gunning* [1985] 84 LGR 168 page 189 and *R v North and East Devon Health Authority, ex parte Coughlan* [2001] QB 213 at paragraph 108.

65. On 1 November 2015 NHS England published a document titled 'Planning Assurance and Delivering Service Change for Patients', which recorded that the Clinical Commissioning Groups were under a statutory duty (see Section 14Z8 above) to have regard to this guidance ("the Service Change Guidance"). The role of NHS England in reconfiguration was to support commissioners to develop a clear, evidence-based proposal for reconfiguration and undertake assurance as required by the Government. The Service Guidance was designed to be used for service reconfiguration and provide a clear path from inception to implementation.

The overview of the service reconfiguration set out a strategic context of implementation which was in six stages (1) discussion; (2) proposals; (3) assurance; (4) formal consultation; (5) decision and (6) implementation. There are four tests for the service reconfiguration required by the Government which were strong public and patient engagement, appropriate availability of choice, a clear clinical evidence base and clinical support which, was mandated to NHS England by the Government and arose under provisions of 14Z, as I have indicated above. The key themes for service reconfiguration were described in paragraph 4.2 as requiring and in particular clear clinical evidence base which was to ensure service reconfiguration and that proposals were 'underpinned by clear clinical evidence'. This was coupled under 4-4 with the need to involve patients and the public by which it was critical that patients and public should be involved in the development planning and decision-making proposals for service reconfiguration and early involvement was required to give early warning of issues likely to be raised and concerning the local community. The Assurance process would be provided by NHS England's external procedures and involved the clinical case for which the change for significance has to ensure it met best practice. In the proposal development the proposals should analyse the full range of potential service changes which could achieve the desired improvements in quality and outcomes and development of options on the analytical. If the Commission was content that those options were viable, and only if they were content, it would then be necessary to carry out an assessment based on those four tests which I have just set out above. It was essential that only those options that were sustainable, in service, economic and financial terms were to be offered to the public. Details were then given of the pre-consultation case and public consultation decision. As a matter of record this document did not isolate separately what constituted the 'formative process' in this public consultation process.

66. It is accepted by both counsel that there is no specific authority on Section 14Z2(2) of the Act but only passing reference, which in general terms, describes the Act by Silver J in [R (Hinsull) v NHS Dorset CCG [2018] EWCA 2231 paragraph 30 to 35 and Mostyn J in *R (Juttla) v Herts Valley CCG* [2018] EWHC 267 at paragraph 28. The application of the common law to this Judicial Review claim is agreed by counsel and requires the three Gunning Principles namely (1) that consultation must be made at a time when the proposal was still at a formative

stage; (2) the proposal must give sufficient reasons for any proposal to admit of intelligent consideration and response and (4) that the product of the consultation must be conscientiously taken into account in finalising the statutory proposals. Both counsel acknowledge generally that there is no real disagreement of the applicable law but it is right to record the claimant showed me more authorities during his submissions than the defendants.

Ground 1

67. The Amended Statement of Facts and Grounds dated 29 September 2018 set out Ground 1 as follows: 'The decision followed an unlawful consultation process and breached the principles of procedural fairness'. Details were given in paragraphs 14 to 57, which was subdivided into (a) failure to consult at a formative stage; (b) failure to provide swift information and (c) failure to conscientiously take in account the product of consultation. Only three of the four Gunning Principles were therefore in issue in this case, namely one, two and four. I deal with three separately.

(a) **Failure to Consult at a Formative Stage - Gunning 1**

68. This sub ground asserts that by the time the proposal went to public consultation, the possibility of retaining all existing services had been ruled out. In particular that all the three options for future stroke services involved a transfer and acute service from South Tyneside to Sunderland. In respect of obstetrics and gynaecology, both options were also Sunderland based. In respect of paediatric services they were downgrading South Tyneside without an opportunity to have their say.

69. The claimants' skeleton argument at paragraphs 11 to 14 set out the law, paragraph 15 a short review of the facts and at 16 submitted that the defendants had 'failed to make even passing reference to the options for retaining or otherwise centralising the hospital service at South Tyneside. The defendants' assertion was not required to consult on the options because it was not arguable and untenable and there was no evidence of such assertion and although there was no duty to consult on non-viable outcomes, the evidence as to the options did not require a wholesale discrimination against South Tyneside and the court should not

consider them to be non-viable options on the evidence placed before it. This, of course, requires looking at the evidence before the court.

70. In his oral submissions Vikram Sachdeva QC made a selective reading of the issues paper of November 2016 relying upon the financial pressures and agency staff problems by reference to duplicating services in hospitals and then moved on to the pre-consultation business case of 28 November 2017 which he said, rightly, that the central drivers were workforce problems and finance and noticed the similarity of the language between the two documents, and the decision dated 21 February 2018 document and the issues document earlier of November 2016. He briefly invited, on my instigation, a review of the decision and some of the formative processes that have taken place prior to that matter. His oral submissions on ground one provided a detailed selection of cases on Gunning One, which updated that authority to modern day authority. I accept generally them.

71. In the defendants' detailed grounds of defence they responded to sub grounds at paragraph 62 and refer back to paragraph 48 and 50 and simply assert that events had meant that this obligation by reference to steps taken at a pre-consultation phase before the formative options was put forward in a formal consultation process and this raised, of course, questions of fact which required review of those matters.

72. In her skeleton argument, December 2018 Eleanor Grey QC at paragraphs 14 and 15 set out the basis for the reasons why change was needed and referred to the issue paper, as explained by Dr Hambleton in his second witness statement at paragraph 26 *et al* and also by reference to the issues paper in 2016, which made further reference to the involvement of Dr Hambleton, which is set out at some length in those statements which I have referred to above. Therefore on that basis it is considered that there had been proper public consultation.

73. In her oral submissions she referred to sub ground one, by again reference to a fuller reading of the issues paper in which she referred to the 'do nothing' option, on the basis of which that was described. She then went to the consultation business case which was clear as to the strategic context, the change of work and subsequently went to the further documents in the process, including appendix five, which was the clinical perspective. Before the public consultation papers were referred to in some detail again by Dr David Hambleton's second witness

statement and the frequent questions asked of the public which she referred to and I have considered carefully so one understands what was asked and in fact what was not asked at that time so far as the public were concerned. This was an iterative process and following the guidance in earlier stage, NHS England had acknowledged compliance with those standards, though she conceded that there was still a common law duty.

74. In his oral reply, Vikram Sachdeva QC submitted that the defendants had to elect either to put their case on the basis that it would be misleading to consult on matters that were not in issue for the public alternatively that the public could be listened to and this process was one of change, which necessarily required that the status quo should be considered. He therefore thought that this was an alternative and did not put his argument in terms of a time basis and a dynamic process or iterative process.

(b)Failure to Provide Sufficient Information- Gunning 2

75. This sub ground asserts that there was a failure to provide sufficient information to enable an intelligent consideration in respect of which it was wholly unclear as to how the defendants arrived at options in the public consultation or how those options had been scored in a final decision and that details of some documented background was provided for the first time in the pre-action correspondence, which he considered to be wholly unclear and not explainable.

76. In the Claimants skeleton argument on this sub ground, paragraphs 17 to 20, he submits the documentation should have been available to the public as part of the consultation and the document would have provided consultees to know the narrow options that had been considered and therefore this would have allowed them to make an intelligent response.

77. In his oral submissions he particularly focussed on the defendants' pre-action correspondence on 10 April 2018 in which he attached the new documents and filed a larger colour copy, which helpfully showed better what in fact had taken place on that table and what was therefore, what has become known as a long list. What it shows is, in respect of each of the three services, there were nine scenarios, including do nothing as the first for each of them, each time the nine scenarios were considered and the four tests by those hurdles which I

have referred to above, namely support sustainability resilience, delivering a high quality safe care, affordability and deliverability. The matter was colour coded such that red meant no in an answer and green meant yes and there were intermediate colours. In respect of stroke there were five reds and therefore the view was that the do nothing option was not available. In respect of paediatric, obstetrics and gynaecology there were three reds, and therefore this was less and therefore the do nothing option arose on some of those, but not all of them. It clearly shows on each matter, independent and separate views were being made, it was not that one case fitted all.

78. The defendants detailed ground of defence in paragraphs 63 to 67 responded to that case. In particular asserted that the documents were easy to read and that they had been reviewed by independent third parties who passed them, and considered that they met the necessary tests. Reliance was placed at the public meetings on the evidence of the second witness statement of Dr Hambleton, in which he had been involved intimately in this process and gave full evidence. In her skeleton argument she notes that with the benefit of hindsight it is always easy to argue after an event as to how the matter had come about but it was better to, and the law required, consideration of the time. She referred to appendix five, which explained the process of hurdles and this, in broad terms was much the same as her pleaded defence. In her oral submissions she noted that the information given to the public was a matter of judgment from the defendants and on request the defendants had disclosed the table to solicitors acting for the claimants. This was not a case in which the documents were being concealed from the public or lacked transparency but when invited it had been provided. The independent reconfiguration panel has supported the decision and though she acknowledged that the Joint Health Scrutiny Committee involvement was not positive, she considered their complaints to have come after the event.

79. In his reply the claimant considered this matter to have been inherently unfair and the rejection of an early stage of this matter meant there was no proper information provided that would allow the public to challenge.

(c) **Failure to conscientiously take into account the product of consultation- Gunning 4**

80. The claimants' amended statement of facts and grounds under this subheading relies on the failure to conscientiously take into account the product of consultation before the decision had been made and therefore it is fundamentally flawed. The date set for this was by reference to the consultation feedback analysis, which I have referred to above on 5 December 2017, which by then should have stopped the process and reliance was placed on the joint health scrutiny committee's complaints which were made subsequently.
81. In his skeleton argument he deals in particular, in paragraphs 20 to 25 with the documents of 5 December that I have just referred to which he said says on analysis was 'clearly and radically wrong in its process' and therefore the consultation should have been brought to an end.
82. This particular ground was not really dealt with in his oral submissions though a brief reference was made to the conclusions only in the feedback document, 5 December 2017.
83. The defendants' detailed grounds of defence deals with this matter more shortly at paragraphs 68 to 70 pointing out that this was an assertion only and it was contradicted the facts in the case, which had collected public material, which was clear from the evidence provided by the defendants. Moreover the matter had been reviewed not only by North of England Commissioning and the Independent Consultation Institute but also Social Marketing Partners and the independent consultants.
84. The defence skeleton argument dealt with the matter shortly at paragraph 72 to 74 pointing out that the reference to evidence of an independent review was compelling and also that the feedback showed that the defendants had not closed their minds but were still concerned with views of the public and these were taken into account in the decision.
85. In her oral submissions reliance was placed on the second witness statement of David Hambleton which sets out detailed feedback including the matters which were dealt with by the public at that stage and he gives examples of those letters to which I have already referred.
86. The matter was not focussed upon in the oral replies of the claimant.

Ground 7 – Changed circumstances

87. This new ground of the claimants' statement of facts and grounds is in paragraph 8 to 85 and asserts it was unlawful for the defendants not to consider what options were now viable and to consult upon the result of the announcement of the 15 and 17 June 2018. These were considered to be extremely significant developments and it was irrational for the defendants not to reconsider the decision to reconfigure their hospital and to take account of these material changes in both recruitment and finance.

88. The workforce and funding arguments are dealt with in paragraph 61 to 76 of the claimants' amended argument with the skeleton argument which was said to be a fundamental difference requiring reconsideration. After those two announcements there was inadequate response from Sunderland and South Tyneside Trusts and he referred to the correspondence in 2017 which he went through carefully.

89. In his oral submissions he said that the failure to use an agency or obtain doctors from abroad was irrational and the defendants, by putting their head in the sand, not making appropriate arrangements to recruit better staff and deal with other Trusts to share staff or otherwise. He correlated this directly back to the problems that had, rightly, been raised at an early stage in the documents to which I have actually referred.

90. The defendants' summary defence to ground seven was that it was highly improbable that the removal of tier-two would have an impact on the particular situation in South Tyneside but the consultation outside had not been a product of the tier-two system and so far as it was concerned, reliance had been placed on the witness statement of Dr Hambleton, who deals with this matter specifically in some more detail. More affordability was not the factor which would change this matter and therefore it is not a factor that actually led to the decision in this matter and therefore the increase of finances is unlikely to have any effect on this decision.

91. In the defendants' skeleton argument, it was not credible to be said that the removal of two-tier systems was likely to make no difference and the shortage in South Tyneside would be resolved by this factor. A reference was again made to Dr Hambleton. The oral submissions for ground seven for the defendants accepted the legal test, which had been relied upon by the claimants. Again there was no dispute as to the law but, as a matter of fact, referred to the evidence of both David Hambleton and the Trust when they answered those questions in which it plainly

made clear that there was an inability to attract the right people, there was no obligation to make aggressive recruitment by these defendants. Indeed, as she said, there was no significant financial difference in the outcome and therefore this factor should be put to one side.

92. In the Claimants reply to Ground 7 two particulars were raised by the defendants. Namely, so far as two-tier doctors were concerned, the welcome of them into this country would have the potential to make a change to recruitment and so far as finance was concerned, again the potential for this money to be available would have been a factor and these had always been driving factors in this process.

The Other Grounds

93. It is common ground between both counsel that ground two should be dealt with in the same way as ground one in association with it. Ground six was an additional ground where some short submissions were made. As far as ground three to five were concerned the parties relied upon their written submissions which they made no oral adumbration and I therefore read subsequent to the closing of their oral case to ensure that I have considered all those matters. I therefore deal shortly with these further grounds on the understanding that neither party focussed on the things said towards their case for Judicial Review.

(a) Ground 2 – Pre-determination of bias

94. For the same reasons as ground one, the claimant contends the decision was pre-determined and biased and reliance was placed on the consultation and feedback analysis, and the letter from the Secretary of State for Health. As far as the defendants were concerned they repeated also that ground one should be dealt with as the same way as this under the same evidence. In their skeleton arguments the matters were dealt with shortly by both counsel as to what was needed in the options paper and the facts so far as the claimants were concerned that the die had been cast and that a fair-minded observer would conclude that this was not the case. The defendants disputed this and indicated that there was no bias and that a fair minded decision-maker could not come to that view. In their oral submissions, which again were dealt with extremely shortly, the matter of bias

was dealt with partly as a matter of law, which again there was no dispute and the usual test therefore was applied.

(b) Ground 6- Irrationality

95. The irrationality in this case arises on financial grounds in respect of the three services of that decision, which includes reference of unnatural sustainability. It is on this occasion that the witness statement of Roger Nettleship is relied upon in which he gives, as I have indicated, short evidence on viability and sustainability. The defendants consider the argument to be wholly unsustainable on grounds of irrationality, in particular NHS England supported the progress throughout as did the Independent Review Panel, which dealt with the matter of finance. Counsels' skeleton argument added little to their completed case and therefore these arguments are somewhat circumspect. It was the claimants' case that to achieve financial suitability there was flawed logic and the defendants and their savings and they, as I have indicated, referred to the evidence which I have set out fairly, I believe, above, given by Roger Nettleship in this regard.

(c) Grounds 3, 4 and 5 Flawed Transport Analysis, Breach of the Tameside Duty Enquiry and Compliance with Section 14T of the Act and Section 149 of the Equality Act 2010 respectively

96. These, as I have indicated, take the form of written submission and so far as arguability permission had been given, it is for me to decide these matters shortly in view of the way they had been dealt with. Put in that way the arguments are, based on the skeleton arguments, (1) that transport analysis was not lawful and it was not open to the defendants to make a key decision about adequate plans for travel to Sunderland; (2) the defendants had not shown any inclination to revisit the original position and therefore had a closed mind on the Tyneside Principles; (3) the obligation to reduce inequalities in the NHS required by the Equality Act 2010 had not been undertaken because the pre-determination at an early stage in the decision-making process. The defendants' response to those were (1) so far as the Equalities Impact Assessment was concerned, it had been considered at all stages of the process and also referred to NEAS, the workings of the ambulance service; (2) so far as Tyneside two-tier enquiry was concerned the defendants

submitted that the decision had been correctly arrived at and indeed had been reviewed by independent bodies and so far as (3) was concerned, the case of equality was evidenced in all the documents and there could be no doubt that this matter had been met.

Discussion

97. By November 2016 it had become clear to the NHS Sunderland and South Tyneside Clinical Commissioning Groups that a transformation program was necessary to provide a secure safe and sustainable NHS service at South Tyneside and Sunderland hospitals. From their perspective and having regard to the statutory duties they had to discharge in particular under section 14R of the Act to improve the quality of the services, something had to be done. In their judgment as Clinical Commissioning Groups providing a service in South Tyneside they were generally aware that the level of depravation was significantly higher than that in England and life expectancy was lower and the levels of health and underlying risk were amongst the worst in the country together with the fact that they had been experiencing problems not only with their own consultants but attracting new consultants to work in this deprived area and they had been subject to cost-cutting on an annual basis giving rise to patient safety concerns so they decided something had to be done; doing nothing was not an option. Specifically, they isolated three gaps that had to be focused on which concerned the health and well-being of their local population (which taken together was about 400,000 people) to improve the quality of the care they were providing and the financial efficiency of the NHS services leading up to 2021.

98. In all the activities the NHS Sunderland and South Tyneside Clinical Commissioning Groups knew full well that they were bound by the General Guidance which was a mandatory statutory duty to ensure that in everything they did they took a fair and proportionate approach and that meant complying with what is known as the Gunning principles. Indeed the General Guidance described this well and imposed on these Clinical Commissioning Groups an obligation that they have meaningful consultation with the public and to achieve this they were not allowed to proceed on the basis of a predetermined decision; however there was nothing wrong in expressing their preferred options provided they were open to influence and they of course could not mislead the public and pretend to consult on options which were generally not under consideration. Equally and importantly they could not proceed on an unrealistic or unviable basis and if they formed this view it still remains a requirement that

they had to provide to the public information of the other alternatives.

99. As this case concerns "reconfiguration" and therefore apart from those general duties which pertain to everything they did the Clinical Commissioning Groups were also aware of a separate and specific obligation to comply with the Service Change Guidance. They were, in their language engaging on the process which was "a path to excellence" and it was premised on the basis that if they wished to improve services, of necessity, there was going to be some change. The approach that they rightly took to achieve this change in services, was to comply, as they were duty-bound to do, with the Service Change Guidance and this normally would take place over several stages. The decision from the outset was that all stages should be complied with and this was appropriate and consistent with such an important decision-making process that they were undertaking; anything short of a full consultation would have been inadequate. In all their dealings and documents, it is clear that the Clinical Commissioning Groups were fully aware of the procedural process they were bound to follow which would require discussions and then proposals followed by an Assurance from NHS England before they could move onto formal consultation and decision. Indeed, not only did they proceed through each of these steps, but they did more to take into account the feedback of the consultation process.

100. For any reconfiguration Clinical Commissioning Groups had to comply with four tests which the Government required them to meet and the order is important. Firstly, there had to be strong public and patient engagement, secondly inappropriate availability of choice, thirdly clear clinical evidence and fourthly, clinical support. From these four tests, it is apparent that the public would be engaged, and anything done had to meet a clinical case and therefore the best practice standards imposed on these medical groups which of course involved the application of a level of expertise which they were best placed to employ. As they developed proposals it was necessary to consider the full range of potential service changes which would lead to the desired improvements of quality and outcomes and thus develop a range of options based on that analysis. It is accepted by the Defendants that in addition to these statutory duties NHS Sunderland and South Tyneside Clinical Commissioning Groups where under a common law duty of procedural fairness in this consultation process in accordance with the dicta of Lord Wilson in *Moseley* (supra).

101. The first step in the process and because they required to have strong public and patient engagement was "discussion" with the public and patients that they had to have as required by the Service Charge Guidance. Accordingly, they published the Issues Paper in November 2016 which was a user-friendly document published on websites and available to the public generally in which they explained the situation. The NHS Sunderland and South Tyneside Clinical Commissioning Groups undertook a listening process. This was entirely transparent and any objective reader of the Issues Paper which at the relevant time included members of

the public and patients could not have thought other than this was a genuine wish to hear what they had to say but on the understanding that doing nothing was not an option. Precisely what was to be done was entirely open and without any premeditated decision or limitation on the options available. What the Issues Paper did do was explain which of the service were to be the subject of early improvement as the first and most compelling step but that this was part of a wider scheme for improvement; those were trauma and orthopaedics including geriatric orthopaedics and gynaecology paediatrics as these were suffering more serious problems. As a matter of fact, Miss Nettleship provides no evidence to indicate that the public or indeed the South Tyneside Hospital Campaign Group where in any way excluded or failed to have any involvement at this formative stage of the process. What, if any, reaction they did have at that time is unrecorded in the evidence provided in this case. At this stage I can see no case whatsoever of a lack of involvement of the public at a formative stage or indeed any insufficiency of information provided to the public. I am satisfied on the evidence that the possibility of retaining the existing services had not been ruled out and no decision had been made to downgrade or close services at the South Tyneside District Hospital. If any decision had been made it was that doing nothing was not an option and therefore something had to be done to improve the services which were unsustainable, but exactly what that was or might become was open for public consultation and an opportunity was given and the public were encouraged to comment. On the evidence, Miss Nettleship and the South Tyneside Hospital Campaign Group do not appear to have taken this opportunity of setting out the case for retaining the existing services at their local hospital. Nor do they appear to give an explanation for any apparent inactivity at this formative and plainly public stage of the process. Conversely the evidence on behalf other Defendant is compelling, and I am satisfied as a question of fact that no decision had been made by NHS Sunderland and South Tyneside Clinical Commissioning Groups. Moreover, the Issues Paper read objectively does in my judgment provide sufficient information to enable members of the public generally to give intelligent consideration and response and express their views should they wish to have done so. Again, the Claimants provide no evidence that at this stage they were provided with insufficient information which is maybe unsurprising given the content of the Issues Paper. In my judgment, thus far, this process of consultation was lawful and did not breach the principles of procedural fairness either by reference to the statutory obligations imposed or indeed the common law duty. Accordingly, NHS Sunderland and South Tyneside Clinical Commissioning Groups were entitled to move on to the second step as part of the consultation process. It is artificial to review this consultation process without regard to this first step of listening to the public before a proposal could properly be made; it is part of an iterative process which of necessity follows a logical and defined process compliant with statute and the common law and the need for procedural fairness at a formative stage.

Ground 1 seeks to airbrush out this whole formative stage of the consultation process; it is simply incorrect to say either; (1) that by the time the proposal went to public consultation the possibility of retaining all existing services at the hospital had been ruled out or (2) that the reality was that the decision to remove or downgrade hospital services had already been taken without any public consultation.

102. The second stage mandated by the Service Change Guide was a "proposal" that these Clinical Commissioning Groups had to make having listened to the public and involved them from the outset. To meet this requirement, the Pre-Consultation 28 June 2017 paper which was some seven months after the Issues Paper was published by the NHS Sunderland and South Tyneside Clinical Commissioning Groups. What this document did as is clear from its face was essentially three things – (1) make the case for urgent transformation of the delivery of acute stroke obstetrics gynaecology and paediatrics, (2) describe the potential options for future service configuration, and (3) describe the communications and engagement processes that have been undertaken with the clinical teams and other stakeholders in developing the potential options for transforming healthcare. The procedural approach was twofold: initially a further consultation process which would be open and transparent where the public and local people's views were received, followed by a decision-making process. The public were told that their two hospitals were facing an unprecedented sustainability challenge caused predominantly by limited medical workforce which resulted in the quality of the service being affected together with financial pressures. Not only did this document fully appreciate the need for public involvement at this stage in accordance with the General Guidance but the public were provided with what of necessity was an overview of the clinical design process that had been undertaken by specified teams properly appointed by NHS Sunderland and South Tyneside Clinical Commissioning Groups. What they had done was to start with a long list (which it is acknowledged was disclosed subsequently) and which in respect of all three of these services asked the question whether they could do nothing from their clinical perspective. To test this matter, they set up a set-up a set of hurdle criteria which is comprehensible and understandable and as such cannot be and is not challenged. It looked at supporting sustainability, service resilience, and whether it was possible to deliver high-quality care which was affordable and could be achieved within the two-year period that had been set from the outset of this process. It was by this means that the options became crystallized to a greater extent, and in accordance with the General Guidance, the NHS Sunderland and South Tyneside Clinical Commissioning Groups had to make it known to the public what those preferred options were so long as they were generally open to influence, and it would have been wrong to mislead the public and continue the consulting process with options which were not generally under consideration or unrealistic or unvialiable. As, in effect, these clinical groups were experts in their field they were well placed to appreciate

what was unrealistic or unviable, but the Clinical Commissioning Groups had to be open to influence otherwise. As set out above, the Pre-Consultation document when read objectively shows that the public were still fully involved, that there was a clinical design process underway which helped inform the way forward but that the options were starting to crystallise by this second stage. Again, there is nothing in the evidence on behalf of Miss Nettleship to indicate their involvement with this document but to the contrary the Defendants explain this process and the continued public involvement in the pre-consultation stage. As part of the formative process both under the statutory requirements and as a matter of common law it is sufficiently clear on the facts made available for this case to me that the public was still properly and fairly involved and that no final view has been formed though understandably and lawfully the consultation process moved onto a second and more focused stage where decisions were starting to be made by means of a proposal only. The mere fact that a proposal has been placed in the public arena does not itself indicate that such a proposal will necessarily be immutable beyond public input where there is a fair chance for further formative consultation. In my judgment this document provides sufficient information to enable intelligent response from the public. Equally as before it would be wrong to ignore this proposal stage as a second step in the iterative process to formal consultation which would take place subsequently after the necessary NHS Assurance.

103. Before this process could proceed further the NHS Sunderland and South Tyneside Clinical Commissioning Groups were under a mandatory obligation to receive an Assurance from the NHS that the process thus far was in accordance with the Service Change Guidance and failure to do so would have halted this process or changed or adapted it in some way. On 20 April 2017 NHS England who was the statutory body charged with providing that Assurance reviewed both the public involvement and the clinical compliance. NHS England were satisfied that the fourfold test referred to above for any reconfiguration had been met and thus this consultation could proceed to the next stage which was publication of the consultation. There was no criticism of how the options had been crystallized by the use of the hurdles to which the long list had been reduced or the public's involvement in this process throughout. The criticism of this document is that it is linguistically incomprehensive, and the failure on the part of the NHS Sunderland and South Tyneside Clinical and Commissioning Groups to make available to the public the long list of options contained in the table subsequently provided. Whilst I appreciate it may have been better to include that table or similar evidence at the time so the public could appreciate that the do nothing option has in fact been considered and rejected for perfectly cogent reasons from the perspective of the clinical teams. I am not satisfied that there was any lack of transparency or indeed that this would have made any difference at all. There is no evidence on the part of Miss Nettleship in which it is said that at the time disclosure of this material was important for the public's perspective

nor that the public somehow lost the opportunity to fairly engage in this process at this time; I am invited to infer this was the case. In fact, the evidence is quite to the contrary. Dr David Hambleton gives cogent evidence in his second witness statement of the involvement with the public from the outset by numerous means of common forms of communication and which had there been concerns in the way in which is now argued, this public process was in place and would have permitted a fair involvement by the public (see also for instance the references in Decision-Making Document 22 February 2018 above). Moreover, whilst I accept that common law duties bound NHS Sunderland and South Tyneside Clinical Commissioning Groups they were also subject to a statutory process by which they in fact received statutory Assurance from NHS England that the procedure at this stage including the clinical design process met the requirements. These are checks and bounds that are in place rightly from a legal point of view to ensure that a compliant process has been met and has been reviewed by an independent body set up by Parliament. It is common ground between leading counsel that the appropriate legal threshold to be applied was whether this was so "clearly and radically wrong" as to render this process unfair and thus unlawful. I am quite unable to conclude in respect of this new document and the lack of provision of a table which was in existence at the time but not in the public domain, that it can be properly considered to have clearly and radically undermined the public consultation process with the result that this was procedurally unfair and thereby unlawful in the process.

104. The argument about the language used in the Pre-Consultation 28 June 2017 paper requires separate consideration. The individual criticisms of each of the detailed comments to the hurdle criteria set out in the attached Appendix 5.1 was said to be impossible to comment on sensibly by members of the public because they make no linguistic sense is, I consider, rather unattractive. It proceeded to construe the document as if it were a contract or similar document on the basis that members of the public would in fact have had to carry out a similar forensic exercise. Maybe unsurprisingly, no witness evidence was tendered by Miss Nettleship on this forensic analysis. The Pre-Consultation document needs to be read in context and the attached Appendix is the overview of the Clinical Design Process which provided clinical analysis of those hurdles (which in themselves are not challenged) and which was required to be undertaken as part of the statutory process that had to receive Assurance from the NHS. I do acknowledge entirely that the Feedback Analysis Report recorded generally that the" language was too complex," without apparent isolation of this Appendix in the many public documents provided in this long process. This goes to illustrate the understandable dilemma that naturally arises when documents produced as part of the statutory process have to achieve both clinical requirements but also public consultation. The engagement with the public went well beyond this Appendix as is apparent from the evidence set out above and, in my judgment, this forensic exercise is misplaced. On Ground 2, I

consider that it is sufficiently clear how the Defendants arrived at the options for public consultation and nothing turns on the late disclosure of the pre-action document which supplements this process but does not undermine it (or suggest a lack of transparency and integrity) and taken generally the public, in the form of Miss Nettleship, had sufficient information to assess the options had there been a wish to do so at that time, nor does the selective reading of the Feedback Analysis Report and a forensic analysis on the complexity of the language used in the Pre-Consultation supporting clinical documentation stand-up.

105. Again, in accordance with the Service Change Guidance, this consultation procedure was therefore entitled to move on to the formal consultation stage. Accordingly, between 5 July and 15 October 2017 a Public Consultation document was published by NHS Sunderland and South Tyneside Clinical Commissioning Groups. This is also a user-friendly document and was widely distributed through the modern means of communication to the public generally. Under the Service Change Guidance this is the last stage before a decision is permitted to be made and as set out above is at a much later stage before a decision is permitted to be made and as set out above is a much later stage, indeed the third stage in the public consultation process and under this statutory regime. The judicial review challenge is that the NHS Sunderland and South Tyneside Clinical Commissioning Group have failed to make even a passing reference to the option of retaining or otherwise centralising the hospital services at South Tyneside in order that the public could be consulted on this option which by then had been ruled out. This of course singularly ignores the fact that these Clinical Commissioning Groups were by law under the Service Change Guidance required to make a proposal for the public's consideration and that proposal had to be clinically based. The Service Change Guidance in regard to public consultation indicated that it is a good practice when undertaking formal consultation to make a specific set of configuration options with effective public communication, and a plan to reach all groups, and staff involvement and maybe of importance in this case, clear compelling and straight forward information on the range of options being tested. It was of course open to consult on these options provided as required by the General Guidance that they are generally open to influence and were not misleading the public in presenting options which in their judgement they had considered unrealistic and unreliable. Both the common law and the General Guidance include an additional requirement that some information of other alternatives should be provided unless they were unarguable. According to Miss Nettleship, the NHS Sunderland and Tyneside Clinical Commissioning Groups are to be criticised for not putting forward the option of retaining South Tyneside hospital, which it would appear from her perspective, meant what had been in place and saved her life. Though there is a suggestion in the evidence of Roger Nettleship that clinicians should rotate between the two sites to ensure that all vital services were retained. I quite appreciate that the local residents (and on her case 40,000 people

signed a petition to keep their local hospital)had a genuine and real concern to save South Tyneside Hospital; hence the name of the organisation "Save South Tyneside Hospital Campaign Group" but for the NHS Sunderland's and South Tyneside Clinical Commissioning Groups to accept this option it has to be realistic and feasible. The whole purpose of this endeavour on behalf of the Clinical Commissioning Groups as all their documents made clear was to proceed on a "path to excellence" and that meant, of necessity, that doing nothing and simply saving the hospital in its present form was not an option. This has been made clear from the very outset in the first step of the Issues Paper and followed through in a second step of Pre-Consultation document before this third step of Public Consultation. That message has been effectively communicated with the public together with other groups who may be interested in the proposed change, the staff had been involved and this plainly was a clear compelling and straightforward basis upon which the range of options would then proceed.

106. Though not required by the Service Change guidance NHS Sunderland and South Tyneside Clinical Commissioning Groups undertook a further step of commissioning and publishing a Feedback Analysis Report on 5 December 2017. The Feedback Analysis Report recorded the petition with 30,692 signatures which opposed the option proposed on the basis that they represented a fundamental downgrading of South Tyneside District Hospital. The majority of submissions focused on a transport difficulty in making a journey from South Tyneside to Sunderland and a small number focused on moving services to Sunderland instead of staying at South Tyneside in addition to other matters unconnected with this case. This of course entirely accords with the witness evidence on behalf of Miss Nettleship but was not the basis of the case argued on her behalf. The executive summary report summarised 11 matters of which only the first two are those which were focused on in the Claimant's argument. Firstly, the consultation itself indicated concerns that the options presented were all very similar and favoured Sunderland over South Tyneside and failed to meet the needs of the latter and the format of the consolation was felt to be too complex in its language. Secondly, there was an apparent focus on Sunderland which in fact provided "the rationale for consolidation of services was recognised but essentially people remained unconvinced that the evidence presented justified the apparent downgrading of South Tyneside District Hospital. It was felt that the question of moving some services to South Tyneside was not considered fully enough." The balance of the matters listed largely concerned concerns in respect of transport to Sunderland including its cost accessibility and health and well-being associated with this concern. In respect of the particular services the subject which are the subject of the path to excellence the report reviewed the quality of care and excellence in terms of skilled personnel and equipment. In respect of maternity services despite reservations about the lack of consultant care at South Tyneside it was considered that the concentration of expertise on one

site was felt to be a major benefit of the proposals and in respect of children the groups felt the needs of children to be paramount and the correct option should focus on delivering safe care in the most efficient way. As the purpose of this whole process was to improve facilities this was important feedback. Reading this document as a whole it is clear that the public consultation had supported the options arrived at during the process and the public's main concern focused on transport (which had been considered throughout the process); it was only the question of moving services from South Tyneside that the public felt was not considered fully enough. The concerns of the public and in particular Miss Nettleship's campaign group concerned quite simply the fundamental downgrading of South Tyneside Hospital but that had to be put in the context of the fact that generally it was accepted that these changes improve the quality of care which was the reason and driving force behind the process. As the report indicates, these concerns of the public resulted in NHS South Tyneside and Sunderland Clinical Commissioning Groups proceeding to undertake a series of workshops in early December 2017 to receive further feedback and provide additional assurances to the public. The Decision records that by February 2018 they were verbally informed by the independent Consultation Institute that they had achieved best practice in the process. The facts of this case indicate that NHS South Tyneside and Sunderland Clinical Commissioning Groups in fact did take account of the product of their feedback consultation by taking further steps to attempt to deal with the real concerns before coming to the decision. What the Feedback Analysis Report essentially illustrates is that the public are unhappy with the substantive conclusion as opposed to the fairness of the process of getting to that conclusion. Their complaint is the" downgrading of South Tyneside" and the "focus on Sunderland" which whilst understandable is not a basis for judicial review. On Ground 3 there was in fact further steps taken to inform the public before a final decision was made and indeed further consultation did take place.

107. The Decision subsequently made properly, fully and fairly sets out the entire background of the public consultation process which makes it clear that it was both transparent and carried out with integrity. As an iterative process, and in accordance with the statutory regime governing such a process, the criteria for the options that were presented in the proposal were of course technical by nature and provided the basis for their selection which in that context is comprehensible and understandable. It has to be recognised throughout this process that there was a constant interaction with the public to deal with concerns and this is apparent from the witness evidence provided by the defendants. The real complaint made on behalf of the campaign group of which Miss Nettleship was a member at the time (allowing for concern that they did not appreciate the technicalities of the language) was that they fundamentally opposed any reorganization that would result in the downgrading of South Tyneside District Hospital in their local community. The Decision deals with the

development of the options (which needs to be put in the context of the pre-consultation options and evaluation by the hurdles set out above) and describes the decision-making process and evaluation by means of the table populated in the usual way with those matters considered (including travel and those particular matters which concerns in the evidence provided by Miss Nettleship). In view of the information that has been conveyed in this table and in the subsequent evaluation of that information, it is both understandable and comprehensible when read in the context of the document as a whole and the consultation process as a whole and in the light of the development of the options that had been undergoing since the early days of this process. Decisions made by the NHS South Tyneside and Sunderland Clinical Commissioning Groups are bound to include technical information illustrative of the clinical process designed to achieve the path to excellence that had to be undertaken and reported upon in order that those involved in this decision were satisfied that the fundamental aims had been met.

108. The case on change of circumstances understandably focuses on two important and material changes in government policy of the NHS both in terms of the recruitment of overseas doctors and in terms of the provision of further finances. These are centrally based Government decisions that on the terms of which they were offered the NHS necessarily require implementation and detailing to see exactly how they will affect the NHS Sunderland and South Tyneside Clinical Commissioning Groups. It is not disputed that the common-law duty only arises if there is a "fundamental difference" as a result of these subsequent events. On the face of these two announcements within three days of each other in June 2018 they are promises made by the Government which are fundamentally different from the state of affairs that previously existed in the NHS. I have considered the interrogatory questions raised in correspondence by solicitors for Miss Nettleship and answered by solicitors for the Trust in December 2018 in respect of recruitment of foreign doctors. Though not provided by these Defendants, I consider that the answers were understandable and the attempts to achieve recruitment acceptable. On all the evidence, the view I take is that both in the past and now that proper, proportionate and reasonable attempts have been made to obtain overseas professional staff, however the real problem as has been clearly isolated from the outset of this consultation process as set out above, is that the quality of the doctors required in these three specialist departments and the ability to find candidates who are appropriate has proved a real problem. I am not satisfied that as a result of the Government general announcements to lift a Tier 2 cap and welcome foreign doctors or the future promise of the percentage of the increase in finances which will only be triggered later and be provided over a longer period of time in the future without any detail is insufficient for me to quash the Decision and impose a mandatory order requiring the NHS Sunderland and South Tyneside Clinical Commissioning Groups to taken a new decision.

109. The challenge in Ground 6 based on the irrationality of the Decision in respect of the financial viability of the proposed changes proceeds on superficial evidence provided by Roger Nettleship. I accept that these figures have not been challenged to any real extent but in my judgment and based on such limited and sparse evidence it would be quite improper to quash the Decision. I accept the argument on behalf of the NHS Sunderland and South Tyneside Clinical Commissioning Groups that this is wholly unsustainable. If such a financial argument is to be seriously considered, it is in my judgment important that some proper evidence based material is available and not what in truth is little more than assertion.

110. So far as the subsidiary grounds are concerned, I am satisfied that the approach taken by counsel on both sides was entirely correct to leave to a review as a paper review which I have now carried out. In my judgment none of them have merit or would give rise to any proper basis to quash the Decision and I accept the Defendant's arguments.

Conclusion

I dismiss the Claimant's judicial review claim dated 18 May 2018.

End of Judgment