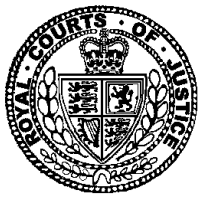

Neutral Citation Number: [2017] EWHC 3349 (Admin)

Case No: CO/1587/2017

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21/12/2017

Before :

MR JUSTICE MOSTYN

- -

Between :

CHERWELL DISTRICT COUNCIL & OTHERS	**Claimant**
- and -	
OXFORDSHIRE CCG	**Defendant**
- and -	
KEEP THE HORTON GENERAL	**Interested Party**

- -
- -

Jonathan Auburn (instructed by **Cherwell DC Solicitors**) for the **Claimant**
Fenella Morris QC and Rory Dunlop (instructed by **Capsticks**) for the **Defendant**
Samantha Broadfoot QC and Leon Glenister (instructed by **Leigh Day**)
for the **Interested Party**

Hearing dates: 6 & 7 December 2017

- -

Approved Judgment

Mr Justice Mostyn:

1. On 16 January 2017, the defendant launched a consultation, pursuant to section 14Z2(2) of the National Health Act 2006, entitled "The Big Consultation: Best Care, Best Outcomes and Best Value for Everyone in Oxfordshire". This was the first of a two-phased exercise. It stated:

> "**Phase 1 consultation**
>
> **We would like your views on proposed changes to the following:**
>
> Acute hospital services (acute hospitals provide a wide range of specialist care and treatment including surgery, medical care, emergency care and tests):
>
> - changing the way we use our hospital beds and increasing care closer to home in Oxfordshire
> - planned care at the Horton General Hospital (planned care includes tests and treatment planned in advance and not urgent or emergency care)
> - acute stroke services in Oxfordshire
> - critical care (critical care helps people with life-threatening or very serious injuries and illnesses) at the Horton General Hospital
> - maternity services at the Horton General Hospital including obstetrics and the Special Care Baby Unit."

2. The consultation document proposed the following changes to the existing arrangements:

   i) More care would be provided <u>out of</u> inpatient hospital beds. The need for hospital beds had reduced and 146 acute beds had been closed already on a temporary basis. This temporary closure should be made permanent.

   ii) More <u>planned</u> diagnostic, outpatient and elective surgery services would be provided at the Horton General Hospital.

   iii) All patients diagnosed with acute stroke would be taken immediately by ambulance to the hyper acute stroke unit (HASU) at the John Radcliffe Hospital in Oxford.

   iv) While the Horton General Hospital would continue to have a Critical Care Unit, the sickest critical care patients from North Oxfordshire would in the future be treated at the Oxford Intensive Care Units at the John Radcliffe Hospital.

v) The existing temporary closure (made in October 2016) of the obstetric unit at the Horton General Hospital would be made permanent. Obstetric services, and emergency gynaecology inpatient services, would be provided in the future at the John Radcliffe Hospital. However, a Midwife Led Unit (MLU) would be established and maintained at the Horton General Hospital.

3. The consultation document had a dedicated section on the Horton General Hospital. It stated, in bold:

> **"Our vision is that the Horton General Hospital will stay open and develop to become a hospital fit for the 21st century. OUHFT is planning to invest significantly in the hospital so it can continue to develop and change as healthcare evolves and meet the needs of local people."**

This section of the document set out in greater detail the proposed changes which I have set out above. Specifically, it confirmed that all patients in North Oxfordshire diagnosed with an acute stroke would be taken immediately by ambulance to the nearest HASU at the John Radcliffe hospital. Similarly, the sickest critical care patients would be treated at the John Radcliffe hospital. Treatment of these patients would no longer be provided at the Horton General Hospital. It explained in some detail, setting out the arguments for and against, its proposal to make permanent the temporary closure of the obstetric unit and the discontinuance of emergency gynaecological services.

4. The consultation sought responses by midnight on 9 April 2017.

5. The consultation document also set out the scope of the second phase. It stated:

> **"Phase 2 consultation**
>
> **During the next phase of consultation we are expecting to invite your views on proposed changes to the following services in Oxfordshire:**
>
> Acute hospital services:
>
> - A&Es in Oxfordshire
> - Children's services
>
> Community hospitals including MLUs
>
> During this second phase we will also be looking in more detail at plans to develop primary care, which will underpin all our other changes (primary care services include GPs, nurses, healthcare assistants, community nurses and other clinicians).
>
> …

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

6. The consultation document did not state when phase 2 would be undertaken.

7. The claimants (which are the district and town councils in which the Horton General Hospital is situated, and two neighbouring councils), and the interested party (a campaign group called "Keep the Horton General"), say in these judicial review proceedings that this consultation was unfair and, therefore, unlawful. They also say that irrespective of the question of fairness the consultation, inasmuch as it concerned bed closures, is defective and thus unlawful as it failed to refer to a newly arrived test on that subject. And they say that in consequence the decision reached following the consultation on 10 August 2017 implementing the proposals is unlawful. They seek that the consultation be re-run and that phases 1 and 2 be merged. They say that will hardly be a problem given that phase 2 has not yet happened. That is their objective, but it is agreed that if I find the primary or threshold case proved, I should not in this judgment deal with the question of remedy, as we ran out of time in the hearing to deal with that. I agree with this approach. A split hearing plainly has merit. If I find that the primary or threshold case is not made out then debates about discretion and remedies just fall away. If I find that it is made out I can see that there will be lively argument about whether there should be any positive relief actually granted, for reasons which I will set out in that event.

8. The grounds relied on by the claimants and the interested party are as follows:

Ground 1: two phase consultation

A The manner in which the consultation is split into two phases is unlawful as decisions are to be made at phase 1 which will have a great influence on matters to then be consulted upon such that the phase 2 consultation will not be conducted when proposals are still at a formative stage.

B During the phase 1 consultation period, consultees did not know what would be proposed regarding A&E, paediatrics, primary care, community hospitals & MLUs, and what those future services would look like. Yet it was important for consultees to understand the nature of services in those areas in order to give an informed view on the phase 1 proposals.

Ground 2: misleading consultation

A The consultation gives the impression that women will be able to give birth locally unless they are "high risk" pregnancy, when in reality almost all (i.e. 94%) will now not be giving birth locally, and will have to contend with the highly congested traffic into Oxford City. The treatment of MLUs, without distinguishing "alongside" from "freestanding" MLUs, obscures this.

B The consultation presented the "need" for beds as a foregone conclusion, rather than one which was very much a live issue which was clear from the JHOSC minutes which stated "…there were concerns around pressures on GPs…together with pressures on community hospitals"

C The CCG's constitution does not fulfil statutory requirements for involvement arrangements.

Ground 3: new bed closure test

The CCG was under a duty to consult on the bed closure test announced on 3 March 2017 by Simon Stevens, Chief Executive of NHS England, given this represented a change of criteria, but it failed to do so.

Ground 4: insufficient consultation information

A The interrelationships between the different services considered, and the impact which phase 1 decisions may have on phase 2 matters, were very important matters for consultees to be informed of. This is related to, but arises independently of, ground 1.

B Consultees were not told about an important and obvious alternative option for the maintenance of an obstetric unit at the Horton General Hospital.

C Consultees were not given information about the effects of the proposal on people living beyond North Oxfordshire.

Ground 5: legitimate expectation

The Secretary of State made a promise in 1998. Mr Smith, on behalf of the defendant stated that the CCG will take this into account in Phase 2 because that is when emergency services are to be decided on. However, if Ground 1A is correct and Phase 1 impacts on Phase 2, then the promise should be taken into account in Phase 1. In addition, emergency gynaecology and emergency critical care is dealt with in Phase 1. Therefore, it should have been put to consultees.

Ground 6: challenge to decision on 10 August 2017

The decision following consultation on 10 August 2017 was unlawful because the decision was contingent on a safe and viable method of transport for patients. As the CCG accepts the temporary ambulance "may not be clinically or financially justifiable", yet the modelling is based on the temporary ambulance data and does not test what will happen in its absence. Therefore, the Board unlawfully failed to consider whether there was a safe and viable transport mechanism in order to implement the permanent changes decided upon on 10 August 2017.

9. Primarily, I have to decide whether this consultation was "fair". In *R (on the application of Moseley) v London Borough of Haringey* [2014] UKSC 56 [2014] 1 WLR 3947, a consultation case, Lord Wilson at para 24 stated that:

> "Fairness is a protean concept, not susceptible of much generalised enlargement. But its requirements in this context must be linked to the purposes of consultation."

10. This reflects observations about the nature and content of the concept of fairness in other spheres. For example, in *R v Secretary of State for the Home Department, ex parte Doody* [1993] UKHL 8, [1994] 1 AC 531 Lord Mustill stated:

> "What does fairness require in the present case? My Lords, I think it unnecessary to refer by name or to quote from, any of the often-cited authorities in which the courts have explained what is essentially an intuitive judgment. They are far too well known. From them, I derive that: … (2) The standards of fairness are not immutable. They may change with the passage of time, both in the general and in their application to decisions of a particular type. (3) The principles of fairness are not to be applied by rote identically in every situation. What fairness demands is dependent on the context of the decision, and this is to be taken into account in all its aspects. …"

11. Similarly, in the field of family law, Lord Nicholls stated in *White v White* [2001] 1 AC 596, [2000] 2 FLR 981 at para 1:

> "Features which are important when assessing fairness differ in each case. And, sometimes, different minds can reach different conclusions on what fairness requires. Then fairness, like beauty, lies in the eye of the beholder."

And in *Miller v Miller; McFarlane v McFarlane* [2006] UKHL 24, [2006] 2 AC 618, [2006] 2 WLR 1283, [2006] 1 FLR 1186 at para 4 he stated:

> "Fairness is an elusive concept. It is an instinctive response to a given set of facts. Ultimately it is grounded in social and moral values. These values, or attitudes, can be stated. But they cannot be justified, or refuted, by any objective process of logical reasoning. Moreover, they change from one generation to the next. It is not surprising therefore that in the present context there can be different views on the requirements of fairness in any particular case."

12. Therefore, at its heart a judgment about what is fair is intensely fact-specific and is instinctive and intuitive. Ultimately, I think it is likely to be determined by the "I know it when I see it" legal technique. That received its most famous expression from Justice Potter Stewart in the US Supreme Court in *Jacobellis v Ohio* (1964) 378 U.S. 184, an obscenity case, where he stated "I shall not today attempt further to define the kinds of material I understand to be embraced within that shorthand description [of hard-core pornography]; and perhaps I could never succeed in intelligibly doing so. But I know it when I see it, and the motion picture involved in this case is not that." However, in order, perhaps, to rein in excessive judicial individualism and subjectivity the courts have given in a number of cases, and over many pages, broad guidance about the nature and content of fairness in cases such as this. Cutting through the foliage I think that the guidelines (all of which are, in my respectful judgment, statements of the obvious) can be summarised thus:

    i) The consultation must be at a time when the proposals are still at a formative stage. Obviously, it is not likely to be fair if the proposals have been worked up to a final conclusion and are presented to the audience as a fait accompli. Consultees should not be presented with a false or empty choice akin to "you can have any colour you like as long as it is black."

ii) To split a consultation into two phases (as here) is not *eo ipso* unfair, but if that route is followed great care will have to be taken to ensure that decisions made following phase 1 do not pre-determine or heavily influence decisions to be made following phase 2. Splitting a consultation obviously runs the risk that the second phase is not at a formative stage.

iii) Sufficient reasons must be given for the proposals to permit intelligent consideration and response. Thus, the audience must be told in full, clear and accurate terms what the proposal is and exactly why it is under positive consideration. The degree of detail may depend on the supposed degree of expertise of the audience. If the audience comprises specialist bodies then perhaps lesser detail needs to be given than if the audience is the general public.

iv) Where a proposal is advanced it should set out both pros and cons. This is not to say that an extensive case arguing the merits of maintenance of the status quo needs to be advanced, or that it is mandatory to set out, and then argue against, all plausible alternatives. Indeed, the proposer may, and, I would have thought, almost invariably would, set out his or her reasons why the proposals should be adopted in preference to the status quo or other alternatives.

v) Where the proposal is to remove an existing benefit then the demands of fairness are likely to be higher than where the proposal is to grant a new one.

vi) Not all findings of flaws in the process will inevitably lead to a finding of unfairness of such a degree that the process was unlawful. Put another way, it is possible for the court as the guardian of fairness to find that while the process was somewhat unfair it was not so unfair as to be unlawful. In one case, it was said it had to be shown that something had "clearly and radically" gone wrong but the courts have rowed away from that acid test. The test is now stated to be that the court must be satisfied that the process was "so unfair" as to be unlawful. The use of the adverb "so" shows that there is a threshold to be surmounted. In my judgment, the court will only be satisfied that the unfairness renders the process unlawful if the unfairness is significant. In this regard, the court will look with especial care at the materiality of the alleged flaws.

13. **Ground 1** (which was in terms of pages of evidence and argument, and time taken in court, by far the biggest ground) complains about the splitting of the consultation into two phases. The ground has two limbs. Limb A is the argument that if the changes proposed in phase 1 are approved then this will heavily influence the outcome of the matters which are subsequently to be consulted upon in phase 2. Limb B is the argument that by splitting the process at no point do consultees have the opportunity to make meaningful representations on the proposal as a whole. In truth, these two limbs are opposite sides of the same coin, as was accepted by parties before me.

14. **Ground 4A** complains that consultees needed to be told about the interrelationships between the different services considered, and the impact which phase 1 decisions may have on phase 2 matters.

15. **Ground 5** complains that a promise made by the Secretary of State as long ago as 1998 about emergency services should be taken into account in phase 1 as well as phase 2.

16. In my judgment, these latter three grounds (1B, 4A and 5) stand or fall on a determination whether as a matter of fact there is a material interdependency.

17. I observed during the hearing that the arguments and evidence for and against these "splitting" grounds seemed to me to be strong on rhetoric and short on hard data or numbers. As a result of questions asked by me a witness statement by David Smith was produced on the second day on behalf of the defendant which gave key numerical evidence. This provoked a heated response from the claimants and the interested party who pointed out, with some justification, that this very material had been sought for a long time from the defendant, not only by them but also by the local MP, to no avail. However, as I had asked for this material I obviously was going to look at it. I did however allow the claimants and the interested party to file evidence or arguments in response which they did on 11 December 2017 in the shape of further witness statements by Ian Davies, on behalf of the claimants, and Peter Fisher on behalf of the interested party. Nobody had sought an adjournment of the proceedings.

18. The statement of facts and grounds asserts that the removal of obstetrics from the general hospital will mean the loss of both the Special Care Baby Unit (SCBU) and the emergency gynaecological service. This is true. This will mean the loss of paediatricians and children's nurses as well as anaesthetists. This is also true. These losses will surely, it is argued, significantly influence the phase 2 consultation on A&E and paediatric services at the hospital. This might be true, but it would all depend on the numbers. How many paediatric cases are neonates? Out of all emergencies how many are gynaecological? How many of those cases where anaesthesia is administered are obstetric?

19. The witness statement of Mr Smith demonstrates that in the year 2014 – 2015 the SCBU had 219 "spells". In contrast for the same year there were 2,699 non-elective paediatric admissions; 242 paediatric day cases; 11,062 paediatric outpatient appointments; and 8,500 paediatric attendances at A&E. Ian Davies argues that this is not to compare like with like. A spell in the SCBU will be for a very sick baby who may need high dependency care for up to 10 days, while an outpatient appointment might last just 15 minutes. Mr Fisher makes the same point (at some length). This is true, but that qualitative difference cannot mask the quantitative one. On any view, the SCBU spells are a vanishingly tiny proportion of the overall paediatric activity, and it is impossible to conclude from this data that a decision to confirm the temporary closure of the obstetric unit has any material relevance to the decisions that have to be made about the maintenance of paediatric services at the hospital. The fears, eloquently expressed by Mr Fisher, are not, in my judgment, borne out by the hard data.

20. Mr Smith's statement does not tell me how many of the overall emergency cases treated in that year were gynaecological cases but there appears to be a consensus that it would have been very small. I do not believe that the loss of emergency gynaecological cases has any material bearing on a future assessment of the A&E department.

21. Similarly, I am not satisfied that the loss of the obstetric unit has any bearing on the question of what anaesthesia services are needed at the hospital in the future. This is because when the obstetric unit was there, a dedicated anaesthetist for that unit was in place, to administer, almost invariably, epidurals, which are given in 60% of births. That dedicated anaesthetist was not on the general rota which covers critical care, advice for the management of general patients, support to A&E, supervision of trainees, elective surgery and some out of hours work. In my judgment, the loss of the dedicated obstetric anaesthetist does not have material relevance to decisions that have to be made about paediatric and A&E anaesthesia. Given that there were just under 1,500 births in the unit in 2014/15 it can be seen that the dedicated anaesthetist would have been very busy administering 900 epidurals (almost 3 each day). Ian Davies does not appear to dispute any of this.

22. It is said that if Level 3 critical care patients are no longer treated at the hospital then there will be even less anaesthetic expertise there. But as Mr Smith's witness statement demonstrates there were only 41 such admissions in the year in question. Even if all of them required anaesthetic services that would only represent 6% of the total critical care workload, and a mere 1% of the overall workload of the anaesthetists. Ian Davies argues that the true percentage is 12%. If that is right it is still a very small proportion. Both Ian Davies and Peter Fisher argue that the removal of these patients may give rise to a risk that accreditation for Year 2 anaesthesia training will be stopped, with a possible knock-on in the future for the training of Years 3 and 4 anaesthetists. Peter Fisher points out that the loss of these patients will mean that junior anaesthetists will have no opportunity to treat ventilated patients. That risk has not been quantified in probability terms to me. In my judgment, and taking that risk fully into account, I nonetheless conclude that the loss of the Level 3 critical care patient cannot be said to have any material bearing on decisions to be made about anaesthetic services overall at the hospital.

23. Quite apart from the question of anaesthesia the figure of 41 admissions is to be compared to 37,816 A&E attendances and 8,948 emergency admissions. Those 41 admissions cannot sensibly have any bearing on decisions that need to be made about the future of the A&E department.

24. It is said that if acute stroke victims are always taken to the John Radcliffe Hospital then the ability of the A&E department of the Horton General Hospital to treat unselected emergencies will be limited. I am not sure that I understand the logic of this argument but in any event Mr Smith's witness statement shows that it is anticipated that around one hundred people each year from North Oxfordshire will be diagnosed with an acute stroke requiring care at the John Radcliffe and that a further hundred patients might present with stroke like symptoms requiring investigation at the John Radcliffe. 200 such cases are to be compared to the figures in the preceding paragraph. For the same reasons, it cannot be said that such a small number of cases has any bearing on decisions that have to be made about the future of the A&E department.

25. The conclusions I have reached thus far should not be taken to signify that I personally approve of the decision to split this consultation. It was said that the reason it was done in this way was because of the urgency of the matters covered by phase 1. But they were not urgent. The obstetric unit had already been closed, albeit temporarily. The number of Level 3 critical care and stroke victims was tiny

compared to overall activity. And in any event, it proposed that phase 2 should follow very shortly after phase 1 – the papers mention the consultation for phase 2 beginning in April 2017. Miss Morris QC argued that to leave the obstetric unit temporarily closed without a definitive decision was bad for morale, but that was mere assertion and did not, in my opinion, justify taking the risks in splitting which I have mentioned above.

26. I can well see why in the absence of hard data the claimants and the interested party would assert that as a matter of principle decisions made following phase 1 would queer the pitch when the phase 2 consultation came around. However, as I have demonstrated, the hard data shows quite clearly that the decisions on the very small number of cases involved will have no material effect on the scope of the phase 2 consultation. It is a mystery to me why that data was not supplied sooner.

27. In my judgment there was no material, significant, unfairness. For these reasons, the challenge under both limbs of Ground 1 is dismissed. That deals with the controversy about splitting. It is not necessary for me to consider whether the consultation with, and the actions by, the JHOSC has any impact on the splitting of the consultation process, although I will have something to say about this in my concluding remarks.

28. Having decided that the splitting was not unfair it follows that Grounds 4A and 5 fall away.

29. I now turn to the remaining grounds. These assert, for various reasons, that the phase 1 consultation was unfair and therefore unlawful (and indeed independently unlawful irrespective of the question of fairness) even if there was never to be a phase 2.

30. **Ground 2** concerns alleged inadequacy of consultation information. It has three limbs. Limb A alleges that the consultation information contained misleading or wrong information about obstetric services. Limb B alleges that there was misleading or wrong information about bed closures. Limb C alleges that the defendant was in breach of statutory requirements for consultation arrangements.

31. The claimants refer to the consultation document which states that "most women have a low risk pregnancy and are cared for by the midwifery teams during the antenatal, labour and postnatal period" and that "higher risk pregnancies" will be going to the John Radcliffe. This implies, they argue that most births will continue under midwife care, which is still available at the Horton General Hospital and so women will not have to travel into central Oxford city to give birth. If people are not of borderline child-bearing age, of normal health, and do not have a relevant medical condition, then they would have no reason to expect themselves to be "high risk", and would presume themselves not to be. Thus, women who have no reason to expect themselves to be "high risk" would, upon reading the consultation document, expect that they would be unlikely to be travelling an appreciable distance to the John Radcliffe.

32. This is said to be thoroughly misleading. It is said that statistics show that only 6% of women elect to give birth in a free-standing MLU, that is to say a MLU with no obstetricians close at hand. 94% elect to give birth in an obstetric unit or in a MLU with an obstetric unit close at hand such as the Spires MLU at the John Radcliffe. Therefore, contrary to the misleading impression conveyed by the consultation document, the overwhelming proportion of pregnant women will have to make the

trek from North Oxfordshire to the John Radcliffe, just as they have had to since the temporary closure of the obstetric unit at the Horton General Hospital.

33. The defendant says that the information provided in relation to the obstetrics proposals was neither misleading, nor wrong. Page 16 of the document explains that the proposal is to provide obstetric services at the John Radcliffe and a MLU at Horton General Hospital. Page 40 of the document makes clear that this means that anyone wanting an obstetric unit, either because of clinical need or because they want obstetricians nearby, will have to travel to the John Radcliffe. Page 36 of the document shows that in 2015/2016 there were 1,466 births at Horton General Hospital. Page 40 of the consultation document shows that it was anticipated that the proposal would lead to a reduction to between 200 and 500 births per year at Horton General Hospital.

34. It was extremely clear that the proposal would involve obstetrics being removed from Horton General Hospital, and that the proposal would thus have an impact not just on those who have a high risk birth and a clinical need to be in an obstetric unit but also on those who wish to have obstetricians in the same location when they gave birth. Therefore, the proposal would likely lead to a significant drop in the number of women wishing to give birth at Horton General Hospital.

35. I do not believe that anyone reading the document could have been in the slightest doubt as to the scope and impact of the proposals. In my judgment, all relevant information was set out. It is clear, as Miss Morris QC says, from the responses to the consultation that the information provided about obstetrics did not mislead the public or prevent them being involved in decision-making. There were 'significant levels of opposition' to the proposal to change Horton General Hospital's maternity services permanently into a MLU because of the impact on mothers who either present as low risk and problems escalate, or who want to have pain relief.

36. I agree with Miss Morris QC. Ground 2A is therefore dismissed.

37. **Ground 2C** alleges that there has been a breach of section 14Z2(3) of the 2006 Act which requires the CCGs must include in their constitution a description of the arrangements made by them to secure the necessary involvement of public under subsection (2) together with a statement of the principles it will follow in implementing those arrangements. Apparently, the defendant's constitution does not contain such a description or such a statement. The claimants accept that by itself this complaint cannot lead to a finding that the consultation was unfair; and, indeed, Miss Morris QC rightly points out that this has nothing to do with the fairness or otherwise of the consultation. This ground was not seriously pursued and I regard it as an arid technical irrelevance.

38. **Grounds 3 and 2B** both complain about the consultation on bed closures. Ground 3 complains that the defendant was under a duty to consult on the bed closure test announced on 3 March 2017 by Simon Stevens, Chief Executive of NHS England, given this represented a change of criteria, but it failed to do so. Ground 2B complains that misleading or wrong information was provided in the consultation document about bed closures.

39. It is certainly true that on 3 March 2017 Mr Stevens announced an additional test or criterion where bed closures were proposed to the existing four general tests. This additional bed-closure-specific test was to take effect on 1 April 2017. It is not disputed that the original four tests were explicitly addressed in the consultation document. The additional test announced on 3 March was that the proposer must (a) demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or (b) show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; and/or (c) where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

40. It can be seen that this new test arose in the middle the phase 1 consultation. The defendant's initial stance was that this new test did not apply retrospectively to a consultation already underway. Plainly, the new test would be operative at the time that any decision following the consultation was made. It seems to me that if it was considered apt to consult on the original test then it was equally apt to amend or supplement the consultation document to consult on the new additional test. It is agreed that the public were not consulted on this new additional test. I do not accept the arguments of Miss Morris at paras 71 – 73 of her skeleton. I cannot see why the later acceptance that the test was met by NHS England or the Clinical Senate has any bearing on the question whether the public should have been asked about it.

41. Therefore, the consultation was flawed but the question is whether the flaw is sufficiently serious to justify a finding either that the consultation was unfair, or quite apart from the question of fairness, was vitiated by this omission.

42. It seems to me that if the consultation document had been amended to set out this new test in terms it would have done so on page 19. I cannot see that any of the text that followed would have needed to have been the subject of any serious redrafting. Indeed, the explanation of the measures taken to reduce the need for beds with the result that 146 had been temporarily closed went directly to addressing, albeit unwittingly, limb (a), and possibly limb (b), of the new test.

43. I therefore consider that the public was de facto substantively consulted about the new test. I cannot see that had it been mentioned the responses, or the decision, would have been any different.

44. In my judgment the omission, while regrettable, and somewhat troubling, was not sufficiently material to lead to a finding that the consultation was unfair, let alone that it is vitiated.

45. Ground 2B says that the consultation presented the "need" for beds as a foregone conclusion, or as an incontrovertible fact. I have to say that this is a very weak argument. The statement is plainly one of opinion or belief, an opinion or belief based on the evidence and reasoning set out in some detail on pages 19 – 22 of the consultation document. The analysis of the responses shows that the consultees treated it in exactly that way: many responded saying that in their view too many acute hospital beds had already been lost. It is not illegitimate for a proposer, such as

the defendant, to express its opinion; indeed, I would have thought it was bound to do so.

46. **Ground 4B** complains that consultees were not told about important and obvious alternative options for the maintenance of an obstetric unit at the Horton General Hospital, namely either a "full integration" of the obstetric services at the John Radcliffe and the Horton General, or the creation of a MLU at the Horton which is alongside the obstetic unit (like the Spires unit at the John Radcliffe). I have explained above that there is no mandatory duty explicitly to consult on all plausible alternatives. This is especially so if the thrust of what is proposed implicitly captures a rejection of such alternatives. The consultation proposal was very clear: the existing temporary closure, since October 2016, of the obstetric unit should be made permanent. It was saying that no reasonable way could be found to keep it open. The alternatives which the claimant say should have been explicitly mentioned both involve keeping the unit, or something like it, open. They were variations on a theme of non-closure. The defendant explicitly consulted on the general option of keeping obstetric services open. Obviously, consultees would have been at liberty to have responded urging adoption of either of these options, and indeed a number did. In my judgment, this ground has no merit.

47. **Ground 4C** complains that consultees were not given information about the effects of the proposal on people living beyond North Oxfordshire. In my judgment, this is a very weak ground, which should be dismissed. It is clear from the evidence that the defendant took steps to ensure that patients and stakeholders outside North Oxfordshire were aware of the proposals and its potential impact. The consultation document was available online and anyone who lived in neighbouring areas who read it would have been perfectly well aware of what was being proposed and how it would affect them.

48. In **Ground 6** the interested party complains that the decision of 10 August 2017 was unlawful because the decision was contingent on a safe and viable method of transport for patients, which on the evidence, it is said, was not proven. This ground does not go to the alleged unfairness of the consultation. Rather, it challenges on Wednesbury principles the actual decision. Thus, the high standard of that test must be met. The interested party must show that the decision was irrational or perverse. I agree with Miss Morris QC that it is unarguable that the defendant misrepresented the letter of the Southern Central Ambulance Service of 31 July 2017, let alone that its conduct in dealing with that evidence reached the levels of irrationality or perversity.

49. I am baffled by the suggestion that the decision not to trial additional ambulance services, was flawed. Following the temporary closure of the obstetric unit and the establishment of a MLU at the Horton General a dedicated static ambulance was provided to take obstetric patients from the MLU to the John Radcliffe where necessary. A contract is in place to provide this static ambulance for a year. During that year, the number of ambulance journeys will be counted and the experiences reviewed. I agree with Miss Morris QC that this is, in effect, a trial. No decision was taken on 10 August 2017 as to what to do when this contract expires. At the end of the year a decision will be taken, in the light of the data, whether to extend the contract for the static ambulance, or whether to revert to using SCAS for obstetrics patients, or whether to conduct a further trial. Thus, the complaint is meritless as well as being premature. I note from the recent witness statement of Ian Davies that in its first year

of operation the Horton MLU transferred 98 cases to the John Radcliffe, a rate of nearly two each week.

50. I am not satisfied that the other aspects of Ground 6 which were advanced have any merit, let alone come close to meeting the Wednesbury test.

51. For all these reasons, the claim will be dismissed. I will not, therefore, have to consider the question of discretion or remedy. I can therefore keep my concluding remarks brief.

52. Under Regulation 23(1) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (SI 2013 No. 218), the defendant was obliged to consult the relevant local authority (county council) where it has under consideration any proposal for a substantial development of the health service in the area of the local authority. This it does by consulting a committee known as the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC). If the committee is not satisfied that consultation on any such proposal has been adequate, or that the reasons given by the CCG are adequate, or that the proposal would not be in the interests of the health service in its area, it may make a report to the Secretary of State. In that event, then pursuant to regulation 25, the Secretary of State has wide-ranging powers which include, relevantly for the purposes of this case, a direction that the public consultation be re-run, or that the decision to make permanent the closure of the obstetric unit be reversed. The time taken for the Secretary of State to make a decision, including taking advice from an advisory panel, should be, according to the material put before me, no more than six months.

53. On a 7 August 2017, the JHOSC held a meeting at which it was resolved to support the proposals for critical care, for acute stroke services, and for the closure of the beds that had already taken place. However, it strongly opposed the proposals in respect of maternity services and decided to refer the matter to the Secretary of State on the grounds that the committee had not been adequately consulted and that the proposal was not in the best interests of the residents of Oxfordshire. Nothing has since been heard from the Secretary of State. However, as I have explained, given the terms of the reference, it is within the power of the Secretary of State to reverse the decision to shut permanently the obstetric unit.

54. Given that judicial review is meant to be a remedy of last resort it can be seen that had I decided that the consultation was unfair, or that the decision of 10 August 2017 was unlawful, then I would almost inevitably have deferred any question of exercise of discretion or remedy until after the Secretary of State had rendered a decision.

55. Moreover, it seems to me that in exercising his powers the Secretary of State is far more able to make a broad merits-based decision that am I exercising the very stringent powers of judicial review.

56. Finally, I record two concessions made by the defendant during the course of the hearing. First, it was made crystal clear that it was not the intention of the defendant to close the Horton General Hospital. Second, it was stated that decisions made following Phase 1 of the consultation would not affect decisions to be taken on Phase 2.

57. That concludes this judgment.
