Appendix 1

Neutral Citation Number: [2019] EWCA Civ 1412

Case No: C1/2018/2334

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE,
ADMINISTRATIVE COURT
SIR STEPHEN SILBER SITTING AS A DEPUTY HIGH COURT JUDGE
CO/5867/2017

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 07/08/2019

Before :

THE SENIOR PRESIDENT OF TRIBUNALS
LORD JUSTICE BEAN
and
LADY JUSTICE SIMLER

- -

Between :

ANNA HINSULL	**Appellant**
- and -	
NHS DORSET CLINICAL COMMISSIONING GROUP	**Respondent**

- -
- -

Jason Coppel QC and **Hannah Slarks** (instructed by **Leigh Day**) for the **Appellant**
Fenella Morris QC and **Annabel Lee** (instructed by **Capsticks LLP**) for the **Respondent**

Hearing date: 24 July 2019

- -

Approved Judgment

Lady Justice Simler:

Introduction

1. Having heard this application for permission to appeal (on 24 July 2019) from the order of Sir Stephen Silber dismissing a judicial review challenge to a series of decisions (that followed a Clinical Services Review, "the CSR", and a lengthy formal consultation process) made by the Dorset Clinical Commissioning Group ("the CCG") on 20 September 2017 ("the Decisions"), the Court announced that permission to appeal is refused, indicating that reasons would follow later. These are my reasons for having agreed to that decision.

2. The appellant, Ms Anna Hinsull, has the misfortune to suffer from a large number of different health conditions and is heavily dependent on safe access to emergency health care, hitherto provided at Poole General Hospital ("Poole Hospital") which is close to her home.

3. She challenged the Decisions which made significant changes to the configuration of health services in the Dorset area as a result (among other things) of a significant shortfall in funding and increasing demand on health care and social care services. Her particular concern is that the Decisions reduce acute hospital provision at a time when demand for acute hospital beds is increasing, by closing the Accident and Emergency ("A&E") unit at Poole Hospital, leaving only two acute units in Dorset: one at the Royal Bournemouth Hospital ("RBH") (which is 8.5 miles from Poole) and the other at Dorset County Hospital ("Dorset Hospital") in Dorchester. She also challenges the proposed closure of Poole Hospital's Specialist Maternity Unit, with its consultant-led maternity and paediatric services proposed to be delivered only from RBH and Dorset Hospital.

4. The grounds of challenge were many and varied and overlapped to a substantial extent. All were rejected by the Judge in a detailed judgment that deals comprehensively with the background and process leading to the Decisions (see paragraphs 7 to 29) and the legal and factual issues arising from each ground of challenge.

5. Three of the grounds advanced below are raised on this appeal. They and the Judge's answer to them in summary, are as follows:

i) **The sufficiency of social care workforce issue.** The appellant contends (and contended below) that the Decisions should be quashed because the CCG failed to have regard to the relevant consideration of whether there would be a sufficient social care workforce to deliver its new integrated model of community provision.

The Judge dealt with this issue at paragraphs 42 to 91 of the judgment. He concluded, in summary, that the CCG appreciated the significance of the need for a sufficient social care workforce (paragraph 78) and its Governing Body was aware that this question was subject to continuing work after the Decisions were taken. That was an approach the CCG was entitled to take. It considered all material factors and developed a clear strategy that it would "continue to work on workforce development alongside partner organisations" as Dorset County Council recommended it should do

(paragraph 91). This approach was neither *Wednesbury* unreasonable nor in breach of the CCG's public law obligations.

ii) **The alternative community provision issue.** The appellant contends (and contended below) that the Decisions should be quashed because the CCG failed adequately to investigate and reach a conclusion on whether alternative community provision could be put in place, before deciding to close hospital beds, contrary to the *Tameside* duty of careful enquiry, with its duty to make further enquiries as to what alternative community provision would need to be put in place to achieve the reduction in demand for acute hospital care; how the workforce for this community provision would be recruited; and how it would be paid for.

The Judge dealt with this issue at paragraphs 92 to 102 of his judgment. He accepted the evidence and arguments that the CCG was entitled to act as it did. In other words, in the context of a decision to reconfigure health service arrangements in Dorset, comprising a large number of interrelated decisions concerning community services, acute hospital services, and maternity and paediatric services across the area, the judge was satisfied that the CCG took reasonable steps to acquaint itself with the relevant information and was entitled to act as it did. He therefore rejected the contention that the CCG acted unlawfully by failing adequately to investigate and reach a conclusion on whether alternative community provision could be put in place before deciding to close hospital beds.

I note in this context that there was a separate ground of appeal relating to the CCG's alleged failure to take account of the requirements of the new "bed closure test". This ground failed below and is no longer pursued on this appeal.

iii) **The travel time issue**. The appellant contends (and contended below) that the Decisions should be quashed because the CCG failed to consider adequately the impact of increased travel times in emergency cases to RBH, which was the major emergency hospital rather than Poole Hospital which was the more centrally located hospital.

The judge dealt with this issue at paragraphs 126 to 157 of his judgment. In summary, the judge concluded that contrary to the appellant's case, the CCG in fact equipped itself with the appropriate information required to apply the accessibility criterion. The CCG reached conclusions open to it on the information available and considered appropriately the issue of access to services for those in the more remote and isolated areas of Dorset. Moreover, it was open to the CCG to conclude that the advantages of improved health services under the proposed reconfiguration outweighed any problems caused by increased journey times (see, in particular, paragraph 157).

The CCG obtained a number of specific reports on this issue, including a report by South Western Ambulance Service NHS Trust ("SWAST") "to establish the potential impact of the proposed CSR reconfiguration on the emergency ambulance services". The judge held that the CCG was entitled to conclude that the statistics and analysis in that detailed report analysed a total of 21,994 patient records covering all incidents where an ambulance attended and conveyed a patient to hospital during the period 1 January 2017 to 30 April 2017. The judge found that the CCG was entitled to rely on that report to conclude that the additional clinical risk caused by the increased travel times as a result of implementing the proposed reconfiguration was minimal.

6. In summary, Mr Jason Coppel QC, who appears with Ms Hannah Slarks on behalf of the appellant, contends that Sir Stephen Silber's judgment on these grounds is "replete with significant errors on key issues and glosses over and fails to grapple with the most problematic aspects of the CCG's defence to the claim". He maintains this is not a merits challenge, but a process challenge to the decision-making in the context of very significant changes to the delivery of healthcare services, against a background of a crisis in both health and social care, and giving rise to what he described as questions of life and death for residents of Dorset.

7. Mr Coppel accepts nonetheless that the approach to be adopted by this court on appeal is the standard approach to appeals of this kind: if, after reviewing the judge's judgment and any relevant evidence, the appellate court considers that the judge approached the questions raised on judicial review correctly as a matter of law and reached decisions which he or she was entitled to reach on the evidence and findings made, then the appellate court will not interfere. If, on the other hand, after such a review, the appellate court considers that the judge made a significant error of principle in reaching a conclusion or reached a conclusion that should not have been reached, then, and only then, will the appellate court reconsider the issue for itself if it can properly do so.

The statutory framework and applicable legal principles

8. The judge set out the relevant statutory framework created by the Health and Social Care Act 2012 which amended the National Health Service Act 2006, establishing CCGs as bodies corporate, responsible for commissioning, that is arranging for the provision of various services to the extent they consider necessary to meet the reasonable requirements of people for whom they have responsibility (see s.3 (1) of the 2006 Act). No criticism is made of this part of the judgment, and it is not repeated here.

9. Further, the approach of the courts to a judicial review challenge of this kind is well established and not in dispute. The judge dealt with the applicable legal principles at paragraphs 40 and 41. Again, I do not repeat them here.

The factual background leading to the Decisions

10. The factual background is comprehensively described by the judge. I summarise it below based on the judge's findings, which are gratefully adopted.

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

12. By 2012, Dorset, like the rest of England, had been facing, and was continuing to face, a crisis. The judge set out the six main causes of the crisis. They included a

population older than the national average which placed particular demands on the health and social care system; and the fact that the CCG was spending more money than it received and was facing a shortfall of £158 million each year by 2020/2021.

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

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

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

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

    i) Services organised around people;

    ii) Supporting people to stay well and take better care of themselves;

    iii) Delivering more care closer to home;

    iv) Integrated teams of professionals working together;

    v) Centralised hospital services.

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

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

the CCG has placed significant focus on community health and care services as well as continuing to work on the options for acute hospital services.

19. Following considerable engagement with stakeholders and others, the CCG identified six criteria drawn up by doctors and other health professionals in conjunction with the Patient (Carer) and Public Engagement Group by which to evaluate the different options:

    i) The quality of care and patient safety;

    ii) Access to services (travel);

    iii) Cost and affordability;

    iv) The impact on staff (workforce);

    v) Whether the changes would be delivered within the required timescale (deliverability); and

    vi) Other factors such as research and education.

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

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

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

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

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

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

    i) Transport / travel times (emergency and non-emergency);

    ii) Clinical risk;

    iii) Equality Impact Assessment;

    iv) Health and wellbeing.

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

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

28. The CSR set out the information required by the Governing Body to make their decisions on the configuration of healthcare services for Dorset in its document entitled, Decision-Making Business Case (September 2017) (referred to as "the DMBC") and made its recommendations. As a result of the feedback from public consultation, some of the recommendations for integrated community services changed from the proposals set out in the Consultation Document. In respect of acute hospital services, the recommendation for Option B remained the same.

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

30. The judicial review challenge to the Decisions was heard on 17 and 18 July 2018. On 5 September 2018 Sir Stephen Silber handed down his judgment dismissing all grounds of judicial review.

The application for permission to appeal

31. As indicated above, there were five contested areas of challenge below, but only three are pursued on this appeal. Although Mr Coppel reversed the order in which he took these issues, I take them in the order set out in the Notice of Appeal (which follows the scheme of the judgment below).

Issue 1: Sufficiency of Social Care Workforce Issue

32. In advancing this ground, Mr Coppel emphasised that the need for a social care workforce was accepted as a relevant consideration by the CCG and should therefore have been front and centre of their considerations, but in the result it was deliberately excluded. He relies on the letter of 17 March 2017 from Dorset County Council responding to the CCG's public consultation on the CSR, which agreed in principle with the case for change but raised concerns about a number of areas and in particular, shortages in the social care workforce and concerns about the care market capacity in Dorset, suggesting that further consideration of these (and other) issues was necessary. Thus the CCG was expressly warned about this important deficiency, but, he submits, deliberately and consciously excluded the sufficiency or capacity of the social care workforce from its considerations.

33. To demonstrate that there was no evidence that the CCG undertook any kind of workforce modelling to understand the future demand for the social care workforce, Mr Coppel relies on the fact that out of many hundreds, or thousands, of documents produced in the course of the process leading to the Decisions, there was only a single document (headed "Assumptions for ideal activity levels and staffing mix" that formed part of a document called "Supporting people in Dorset to lead healthier lives") that referred in terms to a social care workforce. However, even this document included no assessment of current activity or future activity in this area and/or of the numbers of social care staff consequently required. This was all left "to be determined" (as the entry "tbd" in each column shows).

34. Likewise, the DMBC recognised that delivery of the integrated community and primary care services would require staff employed in social care services in Dorset. It also recognised the existence of shortages of staff in key social care roles (including domiciliary care workers). Yet it described the future clinical workforce required to deliver services in the community (identifying the potential gaps in current versus future workforce numbers and the assumptions made for addressing the gap) but social care was expressly "excluded as workforce assumptions for relevant activity".

35. Mr Coppel submits that this was powerful evidence of the failure of the CCG to inform themselves, by modelling or otherwise, as to what increased numbers of social care staff would be needed and how they would be recruited in order to achieve the integrated care model proposed. Even after the Decisions were taken, in December 2017, in a document produced by the CCG called 'Integrated Community Services Review and Design, Outline Business Case', social care was expressly excluded "due to the difficulty in establishing current input" (paragraph 3.30). This demonstrates, he

submits, the CCG was even then, failing to make inroads into this important consideration.

36. Mr Coppel criticises the judge's reasons for rejecting his case on this issue, summarised at paragraph 89, as irrelevant or surprising or both.

37. I do not regard this ground of appeal as arguable. It seems to me that, contrary to Mr Coppel's protestations, this is a merits challenge dressed up as a process challenge. In any event, the judge made no error and reached conclusions that were supported by the evidence. This ground is simply an attempt to reargue the merits of the challenge advanced below.

38. There was in fact an ample evidence base entitling the judge to conclude the CCG appreciated the significance of the need for a sufficient social care work force and had developed a clear strategy to "continue to work on workforce development alongside partner organisations" as Dorset County Council recommended that it should do.

39. First, the DMBC made clear on the face of the document the challenges that existed in relation to workforce capacity and in particular social care. It explained that the aims of the "Workforce and Capability Plan" were to (i) ensure there were the "right staff in the right places to deliver services across Dorset"; (ii) identify and address the workforce challenges, both existing gaps and shortages as well as areas where there is likely to be a future challenge in workforce supply; and (iii) "work in partnership to address these challenges together, through recruitment, networking and development of skills".

40. The DMBC explained (at appendix E, and elsewhere) that the recommendations in relation to workforce capacity and capability planning were iterative and developing; they would be developed in relation to each service area over the following 12 to 24 months; the pace of those developments would be dependent on the readiness of the services and the timescales for changes set out in the CSR implementation plan. That demonstrated, as the judge found, that consideration of the sufficiency of the social care workforce would have to be considered after the decisions were taken in the light of what the DMBC described as "a risk that they may not be available staff and resources in the system to deliver the future service models". These statements in the "implementation of recommendations" sections of the DMBC show clearly that the sufficiency of the workforce was to be the subject of continuing work after the decisions were taken. In the meantime, the DMBC made clear that work would continue to develop the recommendations set out in the plan and in Dorset's "Leading and working differently" strategy.

41. That was consistent with the recommendation of Dorset County Council "that the CCG continues workforce development, alongside partner organisations." As the judge found, the use of the word 'continuous' demonstrated that this was ongoing work and that Dorset County Council was content with the CCG's work on workforce development as it wanted the CCG to continue with its work "alongside partner developments". The judge found that this is what happened.

42. Furthermore, it was an inevitable inference, based on this material that consideration of the sufficiency of the social care workforce would continue to be considered after the Decisions were taken. As the DMBC described it, there was "a risk that there may

not be available staff and resources in the system to deliver the future service models". The Governing Body was on notice of this and could have pursued these issues in whatever manner they thought appropriate, but accepted the CCG's approach that the sufficiency of the workforce would be subject to continuing work after the Decisions were taken; and made the Decisions with full knowledge of this approach, as the judge found.

43. Secondly, the second witness statement of Mr Goodson, the CCG's Chief Officer, explained that a critical feature of the CSR was more collaborative working between health and social care (also a feature of the Sustainability and Transformation Plan "STP") and in order to develop proposals, local social care professionals were therefore involved throughout the lengthy process. He described one of the five enabling portfolios within the STP, the "Leading and Working Differently" portfolio and that the work streams within that portfolio included

> "recruitment and retention of staff: the vision is to develop a system-wide approach to attract new staff and retain existing staff within the health and social care sector in Dorset".

It also included workforce planning, with a vision to

> "ensure that a workforce with the required skills and competencies to deliver new models of care is available".

To achieve these aims, the CCG developed a partnership known as the "Better Together" programme with the three local authorities in Dorset (as well as Poole Hospital, RBH and Dorset Hospital and Dorset Healthcare). It was supported by the Dorset and Bournemouth and Poole Health and Well-being boards. This partnership was used to "sense check" the CCG's vision for community-based services and to implement some initial changes to introduce jointly delivered services. Mr Goodson explained that the importance of the involvement of the three local authorities was that as they were responsible for the social care, they would have had a strong incentive to ensure that there would be a sufficient social care workforce able to deliver the services required by the CCG's proposals, especially as these were replacing certain hospital services.

44. There was also substantial involvement of the three local authorities in the programme for developing "Integrated Community Services" and the development of "Better Care Fund" plans. The latter was informed by and aligned with the STP and the CSR. Both the STP and the Better Care Fund plan were formally signed off by the local authority Health and Well-being Board, while the STP was also signed off by all of the NHS providers in Dorset. Moreover, during the CSR process, the local authorities were identified as key stakeholders in the programme and an extensive programme of engagement with the local authorities was undertaken during the CSR. There was also evidence that the CSR programme included a "Leading and Working Differently" portfolio which included social care professionals, and reviewed what would be the workforce requirements of the proposed new regime as well as the skill mix that would be required within the workforce, including the social care workforce. There was detailed analysis of workforce considerations which formed one of the six criteria for decision-making. The analysis included specific consideration of "workforce capacity" for "care services".

45. The judge set out in detail the collaboration between the CCG and the local authorities at paragraph 61 to 70 of his judgment, some of which is highlighted above. He noted the letter from Dorset County Council, which was before the CCG Governing Body when they made their decision, and drew attention to concerns over the capacity of the social care workforce, relied on by Mr Coppel. At paragraph 83 of his judgment the judge held:

> "These statements in the "Implementation of Recommendations" sections of the DMBC show clearly that the sufficiency of the workforce was to be the subject of continuing work after the Decisions were taken. The Governing Body was put on notice and it could have decided to pursue it in any way they wished, but they accepted the approach which I have explained and then made the Decisions with full knowledge of this approach. I cannot accept the criticism of Ms Monkhouse that this policy amounts to "closing the door after the horse has bolted" as there is nothing to suggest that the decisions relating to the workforce required would not be taken in advance of and in the light of proposed changes."

46. Accordingly, these and other materials were relied on by the judge as supporting his conclusion that the CCG was entitled to take the approach it adopted to delivering the proposed new integrated model of community service. The judge stated that his conclusion that the CCG were entitled to take the approach it did was supported by the confidence the main healthcare providers, the NHS Trusts, had in the proposals. There was also no suggestion from any of the local authorities that the CCG had failed to give adequate consideration to the sufficiency of the social care workforce. I see nothing wrong in that approach.

47. Equally, the judge drew support for his conclusion from the fact the relevant local authorities had not exercised their power under rule 23(9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 to make a reference to the Secretary of State. The judge said it was highly likely they would have at least complained to the CCG or made a reference to the Secretary of State if they thought a sufficient social care service could not be provided. That was true at the time of his judgment, but is no longer the case. I do not accept Mr Coppel's criticism of the judge for relying on this factor, but in any event, the fact that it no longer applies does not begin to invalidate his decision, given the other evidence and findings he made.

48. Similarly, Mr Coppel criticises the judge's rejection of his submission that the CCG had not had regard to the relevant consideration of whether there would be a sufficient social care workforce because social care costs were excluded from all the workforce calculations and/or because no document was produced showing that the CCG had considered the capacity of the workforce. Again, I can see no error of principle in the judge's approach. The social care sector is a market that responds to need. Unlike NHS performance data which is available and exists to a high degree of specificity and quality, the social care sector has no subset of data available in the same way. As the DMBC stated, the workforce demands would depend on uncertain factors including the "readiness of the services and the timescales for changes in the CSR

implementation plan" all of which were uncertain. That made it difficult to produce calculations. In any event, I share the judge's doubts that information obtained from the local authorities would have enabled the CCG to work out how, when and in what order the implementation of the new regime would occur, which were critical matters for any calculations.

49. In the circumstances, and bearing in mind the absence of any statutory or other obligation on the CCG to produce documents or calculations in respect of this issue, together with the wide discretion as to the method for commissioning services, I do not consider there is any basis for interfering with the judge's conclusion that the CCG was entitled not to have prepared calculations or produced documents showing such calculations. The Governing Body was put on notice of the approach adopted, which entailed considering the sufficiency of the social care workforce in the light of what the DMBC described as "a risk that they may not be available staff and resources in the system to deliver the future service models". They adopted this approach of the CCG nonetheless.

50. Finally, as the judge observed, with the benefit of hindsight, it will always be possible to suggest ways in which the consultation process might have been improved: see the observations of Sullivan J in *R* (*Greenpeace) v Secretary of State for Trade and Industry* [2007] Environmental Law Reports 29 at paragraph 62. But that of itself does not justify granting judicial review.

Issue 2: Alternative Investigations Issue

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

52. The appellant argued before the judge that there were two problems with the CCG's approach, which pointed to the volume of documentation it had produced and the bodies with whom it had liaised during the decision-making process. The first was the DMBC was clear that the workforce crisis was to be considered as a detail of implementation after the decisions were made, whereas, the careful inquiry required of the CCG had to be taken before and not after the critical Decisions were made. In the present case the inquiry that should have been made was by reference to the bed closure test. The second problem was that the CCG's enquiry was operated at too high a level of generality. It described a "vision" but did not provide any concrete evidence.

53. Sir Stephen Silber rejected the contention that the CCG failed to adequately investigate and reach a conclusion on whether alternative community provision could be put in place before deciding to close hospital beds. He relied on eight factors: the broad discretion of the CCG; the fact that the CCG had considered numerous models

and 65 potential options before choosing the proposed options; that it had not been shown there was a particular alternative option which should have clearly been explored; the important confirmation of Stage 2 assurance received from NHS England; the confidence of the NHS entities in the proposal; the decision of Dorset County Council not to refer the Decisions to the Secretary of State; and the fact that neither the JHSC nor the five constituent local authorities had made such a referral or sought to suggest that the CCG should have carried out further investigations. As the judge observed, if the appellant's case was correct it would mean that in almost every case it will be possible to think of some further inquiry that the decision-maker could have taken.

54. The appellant challenges this conclusion and contends the judge erred in rejecting this ground of challenge. In summary, Mr Coppel contends that the broad discretion of the CCG did not mean it could decide not to investigate and reach conclusions on whether alternative community provision would be in place before beds were closed. This is particularly true given that the health of vulnerable people was at stake: *R (Refugee Action) v Secretary of State for the Home Department* [2014] EWHC 1033 (Admin) [121]. The fact that the CCG had considered 65 potential options said nothing as to whether it had conducted a sufficient investigation. The judge's approach was "never mind the quality, feel the width." Moreover, it was not for the appellant to show there was a particular alternative that was not explored. So far as the views of other bodies were concerned, the Stage 2 assurance received from NHS England almost a year before the Decisions were taken says nothing as to whether the CCG had conducted a sufficient investigation into the practical availability of its alternative community provision. The same is true of the expressions of support by other NHS entities. Finally, the judge should not have given weight to the absence of a referral to the Secretary of State as Dorset County Council was still considering its position on referral.

55. The question is whether the CCG took reasonable steps to acquaint itself with the relevant information. There was no obligation to leave no stone unturned; such an approach would stifle all administrative decision-making. The CCG took its Decisions after a painstakingly detailed assessment of all the relevant factors, as evidenced in the documentation before the judge. After considering the evidence, the judge was unequivocal in his conclusion that the CCG was entitled to act as it did. In the light of the totality of the evidence, the context in which the decisions were being made, and the broad discretion afforded to CCGs in decision making, it is simply not arguable that the CCG failed to take reasonable steps to investigate alternative community provision.

56. Moreover, the Respondent submits that this ground is a blended reiteration of the first ground and the bed closure ground which is no longer pursued. I agree. The first ground addresses the steps taken by the CCG in considering the sufficiency of the social care workforce to support alternative community provision and whether this could be put in place. The appellant submitted that the careful inquiry required in this case was by reference to NHS England's bed closure test. The judge plainly took the view that the CCG considered the requirements of the bed closure test to the satisfaction of NHS England and this was determinative of the issue as NHS England were the arbiters of whether the test had been complied with. His approach was

endorsed in *Keep the Horton General v Oxfordshire Clinical Commissioning Group* [2019] EWCA 645 (CA).

Issue 3: The Travel Times Issue

57. The appellant's case before the judge on this issue was that the CCG failed to consider adequately the impact of increased travel times to RBH in emergency cases, if it were to become the major emergency hospital rather than Poole Hospital, which was said to be the more centrally located hospital. In summary, it was argued that the CCG failed to equip itself with essential information which it required in order to apply the accessibility criterion. Further, the CCG misdirected itself as to the conclusions to be drawn from the information which it did acquire and failed to consider the mandatory consideration of accessibility to services for those in the more isolated, rural areas. In this regard, the CCG failed to exercise its functions in accordance with its duty to secure continuous improvement in the quality of services provided in breach of s.14R of the National Health Service Act 2006.

58. The judge considered the evidence and arguments and held, contrary to the appellant's case, that the CCG equipped itself with the appropriate information required to apply the accessibility criterion and that it was open to the CCG to conclude that the advantages of improved health services under the proposed regime outweighed any problems caused by increased journey times to differently situated hospitals. In reaching this conclusion the judge rejected nine specific contentions advanced by the appellant.

59. One of those, (the first) was a submission that the CCG misrepresented the SWAST report's conclusion that *"the change of Poole General Hospital's emergency department to an urgent care clinic will have a minimal impact on emergency journey times for direct emergency adult admissions, adding an average of one minute to each journey. 16,113 patients had no difference in journey time, 650 had a shorter journey and 3,067 had to travel further. The longest additional time on top of the current journey length being 23 minutes*." The misrepresentation relied on was said to be the statement in the DMBC at paragraph 3.5.1, where the CCG said,

> " "the modelling resulted in a report which concluded that the CSR proposals have only a limited impact on emergency transport times, will reduce the number of inter-hospital transfers and that **there is minimum clinical risk**…" (Emphasis added).

60. The judge rejected that argument. He found the SWAST report showed that in a four-month period there were only 696 adult emergency/acute cases with longer journey times out of a sample of 21,944 cases in that period. Random sampling of 125 of these led to a finding of 27 cases which carried potential additional clinical risk as a result of increased travel time. The judge scaled back up to produce a figure out of 696 (ie. 696 x 27/150): 125 adult cases. There were also 4 paediatric cases and 3 maternity cases. The total was therefore 132 cases out of a total of 21,944 (that is to say 0.6%) where there was potential increased clinical risk as a result of implementing the proposed reconfiguration of medical services.

61. The judge held that the "*CCG with its broad discretion was quite entitled to conclude that the potential additional clinical risk quantification of 0.6% would indicate only a minimal clinical risk which may be caused by increased travel times…*".

62. Mr Coppel challenges that reasoning as plainly erroneous and based on a misreading of the critical passage of the DMBC by the judge. The assertion of "minimal critical risk" in that passage was not a description of the number of cases in which there could be increased clinical risk, but rather of the extent of clinical risk in any particular case. However, the extent of the clinical risk in any particular case was not ascertained. The only assessment of clinical risk made by the SWAST report was that more work needed to be done to ascertain the extent of the increased risk. The CCG accepted that further work was necessary and commissioned an expert review. However the only further work done was on 31 August 2017, the day before the publication of the DMBC, leaving little or no time to factor in any conclusions reached. In the event, the review was inconclusive so that the risk remained unquantified and should not have been described as minimal (which it certainly was not). The result is that this was such a serious misrepresentation by the CCG that it vitiates the Decisions.

63. Moreover, Mr Coppel contends that the CCG never considered how many patients could come to harm as a consequence of the additional travelling time caused by the reconfiguration. Had it done so, even on these figures, there were approximately 400 cases per year (132 x 3) where patients would be at potential increased clinical risk of harm. Even if that could be regarded as minimal in the abstract, it was not minimal given the weight placed by the CCG on the number of lives estimated to be saved by the reconfiguration proposals. Mr Coppel relies on the fact that a central plank of the CCG's argument in favour of its proposal to create separate specialist roles for Dorset's acute hospitals was that if implemented, it was estimated that "an extra 60 lives could be saved each year" (paragraph 2.1 of the DMBC). Plainly, if a significant number of patients could come to harm as a result of having to travel further to hospital, that would provide an important counterbalance to the 60 lives per year saved claim. Not only was that never assessed; but in any event, he submits that the 60 lives saved per year claim was unsupported by any evidence and, in the appellant's view, false. Moreover, the judge wrongly refused to entertain the appellant's criticism of the 60 lives per year saved claim notwithstanding that it had been raised in correspondence well before the hearing and the CCG had ample opportunity to respond to it.

64. Mr Coppel accordingly submits that the CCG failed to carry out a sufficient investigation of the issue of emergency travel times and misled its governing body as to the outcome of the investigations which had been carried out, preventing the governing body from taking into account the highly relevant consideration that a significant number of patients were potentially at increased clinical risk due to having longer emergency travel times should pool hospitals accident and emergency unit be closed. These matters were critical to the CCG fulfilling its statutory duty under s. 14R of the 2006 Act, to act only so as to improve patient outcomes.

65. This ground is also not arguable and is a merits, and not a process, challenge.

66. The vast majority of Mr Coppel's criticisms of the judge's reasoning is misplaced. There are two criticisms that have some force. I agree that the judge should not have prevented the appellant from relying on the "60 lives saved" point in the

circumstances of this case. Secondly, although he was entitled to rely on the absence of any reference to the Secretary of State at the date of his decision, in light of developments since, and the reference that has been made, this is no longer a factor that can be relied on by the CCG. Nonetheless, I am quite satisfied that neither of these points is significant in the context of the evidence and the findings made by the judge.

67. The judge dealt carefully and comprehensively with the evidence of the CCG's consideration of the impact of increased travel times. In summary, he found as follows. In January 2015 the CCG published its case for change in which it set out a number of proposals including that RBH and Poole Hospital would have different and distinctive roles: one would be a hospital for major planned care allowing for continuous delivery of treatment away from the disruption that urgent and emergency care can create; the other would be a major emergency hospital with more consultants available more of the time to deal with urgent and emergency care. By specialising in this way, the judge found, the evidence showed that outcomes for patients could be improved and more lives could be saved. In both options, Dorset Hospital would remain a district general hospital serving the west of the county and providing planned and emergency care. Safe access to emergency care was accepted as a relevant consideration by which to judge the proposals for change. Access was not by itself determinative of the outcome. It was however, one of six criteria for determining which option to select.

68. The CCG commissioned an organisation called Steer Davies Gleave ("SDG") (who are experts in the provision of transport consultancy) to conduct an analysis of travel times in order to analyse the impact of the options for reconfiguration and in particular the decision whether to locate a major emergency hospital service at RBH or at Poole Hospital. Although SDG concluded in one particular scenario that locating emergency services at Poole Hospital would result in a higher proportion of the whole of Dorset's population being able to reach these services within 30 minutes, further analysis resulted in RBH scoring better than Poole Hospital on the access criterion.

69. Following the consultation and in the face of concerns expressed during it about travel times for emergency cases and specialist maternity needs, a review was commissioned by the CCG from the SWAST. The SWAST was asked by the CCG "to establish the potential impact of the proposed CSR reconfiguration on the emergency ambulance services." The SWAST report was published in August 2017. It made clear that "no model can predict the future; it can only consider the potential impact of the Dorset CSR on historical data". It analysed 21,944 patient records covering all incidents when an ambulance attended and conveyed a patient to hospital in the period 1 January to 30 April 2017. The report considered maternity related calls, adult and child emergencies.

70. The inter-hospital or inter-facility transfers were discounted, leaving 19,830 cases involving direct admissions to hospital. At paragraph 5.2.4 the report said,

> "the model suggests that the change of Poole General Hospital's ED to an UCC will have a minimal impact on emergency journey times for direct emergency adult admissions, adding an average of one minute to each journey. 16,113 patients had no difference in journey time, 650 had a

> shorter journey and 3067 had to travel further. The longest additional time on top of the current journey length being 23 minutes."

A table set out the extra journey time in minutes for these patients. There are also tables predicting emergency journey travel times for inter-hospital transfers and giving the predicted distribution by hospital of the adult emergency department patients together with a map of the predicted geographical distribution of adult emergency department incidents by hospital. The report set out the same data for paediatric emergency cases and maternity cases.

71. At paragraph 5.4, the report dealt with clinical risk. It concluded that the change of Poole Hospital from an ED to an UCC would result in an overall one-minute increase in the average weighted journey time to hospital. However the report said, conversely, the same change would result in a 16 minute decrease in the 95th percentile travel time and a 56 minute reduction to the maximum travel time.

72. Overall, 16,000 odd patients had no difference in journey time and 3000 odd had to travel further. The report then identified the 696 incidents referred to above and explained that a randomised sample of 150 were selected for review. Of the 150 cases, a total of 27 cases were highlighted. These are detailed in table 12 at paragraph 5.4.5 where the age of the patient and the provisional diagnosis is identified, together with the extra journey time and whether or not there was potential harm. In some cases this is answered positively as "yes"; while in others it is answered as "possible". The report recommended a review of these cases.

73. In his judgment at paragraph 130, the judge described the exercise conducted by SWAST as leading to 132 cases (3 maternity cases, 125 adult emergency cases and 4 paediatric emergency cases) out of 21,944 cases where "extended journey times *may* increase the clinical risk". In relation to the 132 cases, SWAST recommended that the CCG should "support the expert review of cases identified where extended journey times may increase the clinical risk". The judge found in terms that those 132 cases, amounting to 0 .6% of the total, were cases where "the possible additional clinical risk remained unquantified".

74. The judge dealt with the expert review meeting which took place on 31 August 2017, involving various medical experts to consider the potential additional risk cases identified by SWAST as requiring further clinical review. He found that the meeting participants concluded that they were unable to comment further on the risk posed to patients from the proposed CSR changes for a number of reasons. These included the fact that to determine reliably whether a patient would come to harm with the extended journey time would require hospital notes of the medical condition, injury sustained and necessary treatment of the patient concerned. Accordingly, he found the meeting did not produce a conclusion on the risk posed to patients and no further meetings took place to review these cases.

75. The DMBC, published on 1 September 2017, referred to the additional work in the SWAST report and acknowledged that further work needed to be done during the implementation phase (and a Transport Reference Group to develop an integrated transport plan was set up). At paragraph 3.5.1 the DMBC referred to the analysis and impact modelling conducted by SWAST and continued : "the modelling resulted in a

report which concluded that the CSR proposals have only a limited impact on emergency transport times, will reduce the number of inter- hospital transfers and that there is minimal clinical risk."

76. The judge concluded that the figures in the SWAST report could be relied on as giving an accurate picture of the historical data to make reliable predictions about the future position. The judge rejected (as having no merit) the appellant's contention that there were unexplained and questionable steps used to reduce the total adult cases from 1,636 cases to 696 cases. The judge held that SWAST was entitled to reduce the number of patients to exclude those with a low risk diagnosis code. He rejected the argument based on the absence of a proper expert review of the 132. That review could only confirm the number or further reduce it. The expert review could not have increased the number of cases in which increased journey time could have resulted in potential harm to the patient and the CCG worked on the assumption that all of the 132 cases remained the only cases in which increased journey time could have resulted in harm to the patient. In any event, in light of the urgency of tackling the crisis in health and social care provision, the CCG was entitled not to await a further review. As for the argument that the CCG did not consider "outliers" (patients who would be most seriously affected by increased journey times) the judge rejected that criticism since the report referred to the maximum travel times for adult patients and children and that included outliers. The judge also dealt with the issues of total as opposed to just increased journey time, the effect of the SDG report, and the asserted failure of the CCG to consider the effect of increased travel times for self-presenting patients. He rejected the criticisms made and identified the reasons for doing so and the material he relied on. He concluded that the CCG equipped itself with appropriate information in order to apply the accessibility criterion.

77. In terms of the conclusion of minimal clinical risk, it seems to me that the figures in the SWAST report do show that for the vast majority of patients, the impact on travel times was minimal. For approximately 400 patients per annum (0.6% of patients) however, the increased travel time would have a potential impact and for that group the extent of the increased clinical risk was never quantified but as a matter of common sense must have included potential serious harm or death. The judge was well aware of the fact that the extent of that increased clinical risk remained unquantified and said so expressly at paragraph 130. Having done so, I do not consider that he intended to convey that the clinical risk itself was quantified at 0.6%. Though perhaps not as well expressed as it might have been, the judge was simply finding that the number of cases in which a potential clinical risk was identified was minimal.

78. Similarly I do not accept that the reference to 'minimal clinical risk' in the DMBC (cross-referenced to and supported by the SWAST report which was also available to the Governing Body) is misleading; nor is there evidence that anyone was misled. The maximum increased travel time identified was 23 minutes and it stands to reason that an emergency patient having to travel for an additional 23 minutes might come to some clinical harm. That was plain on the face of the report. In any event, the CCG was entitled to regard a potential clinical risk in a very small percentage of cases as approximating to an overall minimal clinical risk.

79. Furthermore, as the judge found, the evidence showed that on the footing that Yeovil and Shaftesbury would continue to provide general emergency services, if Poole

Hospital was the major emergency hospital, 71% of the population of Dorset would reach services in 20 minutes and 94% within 30 minutes with a maximum travel time of 40 minutes – well within the period of 45 minutes referred to as the maximum travel time for acute and emergency conditions on the appellant's side. On the other hand, if RBH was the major emergency hospital, 78% of the population of Dorset would reach services in 20 minutes and 95% in 30 minutes, with a maximum travel time of 40 minutes. So RBH was more accessible to a larger proportion of the population than Poole Hospital. RBH was also easier to reach by a larger proportion of the population by blue light, while Poole Hospital was regarded as better placed for public transport which suited a planned site there.

80. I do not read a central plank of the CCG's argument in favour of its proposal to create specialist hospitals, as being to save an estimated 60 lives. Although that figure was given, the real point was that national evidence showed that creating specialist hospitals as proposed was likely to improve outcomes for patients and more lives could be saved.

81. The judge also referred to a variety of additional reasons set out in the DMBC as to why RBH and not Poole Hospital was the proposed major emergency site. First there is better access to RBH as more of the population live in the east of the county and it is better for patients living in West Hampshire, a considerable number of whom use RBH. Secondly, RBH would be cheaper and easier to develop and expand than Poole Hospital. Thirdly, it had lower running costs than Poole Hospital. Fourth, unlike Poole Hospital it had emergency access for helicopters on site. None of those factors had been effectively challenged by the appellant.

82. The judge concluded that the CCG reached conclusions open to it on the information it acquired and considered appropriately the issue of access to services, including for those in the more remote areas. Here too there was a painstakingly detailed assessment of all the relevant factors, as evidenced in the documentation before the judge. In my judgment, in light of the evidence, the judge was amply entitled to conclude that "it was open to the CCG to conclude that the advantages of improved health services under the proposed regime outweighed any problems caused by increased journey times". I can see no arguable error of law or fact in his conclusion.

Conclusion

83. For all these reasons, the application for permission to appeal is not arguable and there is no other compelling reason for permission to be given. Sir Stephen Silber conducted a full and careful analysis of the evidence and reached conclusions that were open to him on the evidence and not arguably wrong. As Gross LJ acknowledged when directing a hearing in this case to include the issue of permission, "there is a real danger of over-judicialising administration, so impeding decision taking. Moreover, the court will not likely intervene on questions going to the allocation of scarce public sector resources. Still further and unpalatable though it may be for some, the delivery of public services does need to change from time to time". Those observations apply with considerable force in this case, where difficult judgments had to be made as to how scarce resources are best allocated to the maximum advantage of the maximum number of patients.

Lord Justice Bean:

84. I agree.

The Senior President of Tribunals:

85. I also agree.