R v North and East Devon Health Authority and North Devon Healthcare NHS Trust ex p Pow (Lorna Beatrice) and Others; R v Same ex p Metcalfe

Queen's Bench Division
Moses J
4 August 1997

A health authority must consult with community health councils in respect of proposals, to substantially develop or vary health services, which have become of such particularity as to be identified as such while remaining at a formative stage so that effective consultation can take place. The time for deciding whether consultation can be dispensed with on the ground of urgency is the time when an identifiable proposal first emerges; not any later time when a formal decision not to consult is made. Even in cases where development or variation is urgently required, there are powerful reasons for quashing decisions undertaken without proper consultation.

Facts

By the end of 1996 the North and East Devon Health Authority (NEDHA) became aware that it needed to reduce its expenditure for the financial year 1997/98 by £1 million. On 20 February 1997 NEDHA met with the North Devon Healthcare NHS Trust (the NHS Trust). Consideration was given, *inter alia*, to the temporary closure of certain community hospitals, namely Lynton and Winsford Hospitals. On 27 February 1997 NEDHA met with the National Health Executive and agreed, *inter alia*, to review the services provided at Lynton and Winsford. On 3 April 1997 an internal memorandum at the NHS Trust stated that there was no current intention to close any community hospitals, contrary to claims made in a television documentary. On 9 April 1997 the board of NEDHA met. According to the evidence filed by the chief executive of NEDHA, by that stage it was clear that NEDHA had identified closure of community hospitals as its best option for reducing its operating costs and that this was common knowledge. A director of the NHS Trust filed evidence to the effect that, by the meeting of 9 April 1997, temporary closure of Lynton was regarded as one of the few practical solutions available. A further meeting between NEDHA and the NHS Trust on 25 April 1997 included discussion of the proposals to close Lynton and Winsford. The NEDHA chief executive discussed the matter with two general practitioners from Lynton on 29 April 1997. On 1 May 1997 there was another meeting concerning the closure of Lynton between a director of the NHS Trust and the chief officer of the North Devon Community Health Council. On 2 May 1997 a petition was sent to NEDHA showing those in support of keeping Lynton open. A meeting of NEDHA on 9 May 1997 confirmed that no savings were contemplated other than through closures of community hospitals. In about mid-May officers at NEDHA and the NHS Trust reached final agreement on the closure, *inter alia*, of Lynton and Winsford. The chief executive of NEDHA disseminated a paper by 20 May 1997 proposing that Lynton and Winsford should be closed temporarily, as soon as possible, and without prior consultation with the local community health council. On 28 May 1997 NEDHA notified the community health council that it was minded to determine to close Lynton and Winsford without prior consultation, on the ground of urgency. On 4 June 1997 NEDHA so determined. The community health council

sought to quash that decision on the ground that NEDHA had failed to comply with Community Health Councils Regulations 1996 SI No 640 reg 18 (made pursuant to the Secretary of State's powers to issue directions under the National Health Service Act 1977). Regulation 18(1) provides:

> *Subject to paragraphs (2) and (3) it shall be the duty of each relevant Health Authority to consult a Council on any proposals which the Health Authority may have under consideration for any substantial development of the health service in the Council's district and on any proposals to make any substantial variation in the provision of such service . . .*

Regulation 18(3) provides:

> *Paragraph (1) shall not apply to any proposal on which the Health Authority is satisfied that, in the interest of the health service, a decision has to be taken without allowing time for consultation . . .*

Held:

1 A health authority has under consideration a proposal for the purposes of Community Health Councils Regulations 1996 reg 18, when the proposal is of such particularity that it can be identified as a proposal of a substantial variation in the provision of health services and has crystallised to the extent that it is capable of consideration by the health authority. Since such a proposal is the trigger for consultation it need not and must not be the subject of any final resolution. It must still be at a formative stage in order for effective consultation to take place, whereby representations can be made and conscientiously taken into account before the proposal is finalised: see *R v Barnet LBC ex p B* [1994] ELR 357, QBD, at p370H-371A. A proposal to close Lynton and Winsford Hospitals temporarily was of sufficient cogency by the meeting of 9 April 1997 to trigger the duty to consult with the community health council. NEDHA had erred in law in concluding that no duty to consult arose until its board had made a decision, if possible with the agreement of the NHS Trust.

2 There was little doubt that by June 1997 the need to make savings had become urgent but it was fallacious to argue that, on account of such urgency, NEDHA's decision to dispense with consultation could not be stigmatised as irrational. It would seriously undermine the purpose of Community Health Councils Regulations 1996 reg 18 if a health authority could allow time to pass to the point where matters were so urgent that there was no time left for consultation. It would permit a health authority which took the view that there was only one practicable solution to pre-empt the result of proper consultation*: R v Tunbridge Wells Health Authority ex p Goodridge* (1988) *Times,* 21 May; *R v Richmond, Twickenham and Roehampton Health Authority ex p Richmond LBC* (unreported, 20 February 1994); *R v North West Thames Regional Health Authority, Riverside Health Authority and Secretary of State for Health ex p Daniels (Rhys Williams)* [1993] 4 Med LR 364; [1994] COD 44 considered.

3 Relief would not be refused as a matter of discretion. To grant relief would make the task of finding the necessary savings far more difficult, but not impossible. The importance of the duty to consult was such that the greater burden facing NEDHA, caused by its own error of law, did not justify refusal of relief. After all, a conscientious process of consultation with an informed community health council might produce alternative means of making savings. Although objectors had had the opportunity to make their grounds of opposition known, that was not the same thing as being included in positive consultation.

Cases referred to in judgment:

R v Barnet LBC ex p B [1994] ELR 357; [1994] 1 FLR 592; [1994] 2 FCR 781; [1994] Fam Law 185; (1993) *Independent*, 17 November, QBD.

R v North West Thames Regional Health Authority, Riverside Health Authority and Secretary of State for Health ex p Daniels (Rhys William) [1993] 4 Med LR 364; [1994] COD 44; (1993) *Independent*, 18 June; (1993) *Guardian*, 21 June; (1993) *Times*, 2 January, DC.

R v Richmond, Twickenham and Roehampton Health Authority ex p Richmond LBC (unreported, 20 February 1994).

R v Tunbridge Wells Health Authority ex p Goodridge (1988) *Times*, 21 May.

Legislation/guidance referred to in judgment:

National Health Service Act 1977 s97A – National Health Service and Community Care Act 1990 – Community Health Councils Regulations 1996 SI No 640 regs 17 and 18 – National Health Service (Functions of Health Authorities and Administration Arrangements) Regulations 1996 SI No 708 – Executive Letter EL(90)185.

This case also reported at:

Not elsewhere reported.

Representation

R Gordon QC and M Fordham (instructed by Leigh Day & Co) appeared on behalf of the applicants.

P Engelman and C Quinn (instructed by Bevan & Ashford) appeared on behalf of the first and second respondents.

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Judgment

MR JUSTICE MOSES: By this application, the Applicants seek to challenge a decision of the North East & Devon Health Authority (NEDHA), made on 4th June 1997, to instruct the North Devon Health Trust ('the Trust') to close in-patient services at Lynton Hospital temporarily as from 15th August 1997. The relevant date reveals the urgency of this application. Accordingly, on 10th July 1997, I gave leave to move, ordering expedition and a substantial abridgement of time for service of the affidavits.

The Hospital at Lynton

The hospital was founded in 1874. It has fifteen beds, nine GP medical beds available for admission by the local GPs, Dr Ferrar (from whom there is an affidavit) and Dr Frankish, and six consultant beds for rehabilitation. There are a minor operations theatre and hospice facilities. There are also out-patient facilities, such as chiropody, physiotherapy and occupational therapy, the decision to close which is also the subject of challenge. There are respite facilities, that is facilities to relieve carers. The hospital also provides 24-hour casualty services. Currently, according to Caroline Sandford, the Locality Coordinator of the Respondents, there are eight in-patients, although two are expected to be discharged before closure. It is planned that they should be cared for in other Trust Hospitals such as Barnstaple, and there are also seven other patients receiving respite care.

I need not detail further the facilities provided or deal with the merits of providing those services elsewhere. This case is not concerned with the merits of the decision to order temporary closure. The case is concerned with the procedure by which the decision to close was reached.

The Applicants are three elderly patients at present in the hospital. No point has been taken before me as to their *locus* to bring this application. Lynton Hospital commands widespread local support. It is understandable that the decision to close the hospital, although temporarily, has caused a dismay and a determination to resist the action of the Health Authority. I am not concerned as to whether this response is well founded or not.

The Application in ex parte Metcalfe

I should also mention an application brought by a patient in relation to another community hospital, Winsford Hospital. This is a small hospital providing in-patient facilities and is also a branch surgery for the community around Winsford. The decision temporarily to close that hospital was made on the same date. Leave to move in relation to that decision has not been granted yet, but it is agreed that that decision will follow my decision concerning Lynton Hospital.

The Statutory Framework

The Secretary of State is under a duty imposed by the National Health Service Act 1977 to promote in England and Wales a comprehensive health service. He has power to provide such services as he thinks appropriate to discharge that duty. His duties in relation to provision of services have been delegated to health authorities, such as the Respondent, by virtue of the National Health Service (Functions of Health Authorities and Administration Arrangements) Regulations 1996.

An internal market for the provision and purchase of health services was created by the National Health Service and Community Care Act 1990. Health Authorities purchase services from National Health Trusts, who are, in the main, the service providers.

Funds for such purchases are provided by Central Government annually, based on formulae designed to take into account local characteristics. Health Authorities' financial years run from 1st April, the amount available being determined by the National Budget (in this case the budget of 26th November 1996) and by the allocation formula announced in December 1996. Health Authorities are required, by section 97A of the 1977 Act, to balance their books, that is to secure that expenditure does not exceed income. Deficits from previous years must be carried forward and they impose an additional demand upon annual income.

Under the statutory scheme created by the 1990 Act, health authorities are not in law responsible for the provision of services such as those provided at Lynton. They are the responsibility of the Trust. If a Health Authority decides not to purchase services hitherto provided by a Trust, then the service will have to cease. In this case, as Julia Neville, Director of Development of the Respondents, deposes, in the course of negotiations as to the contract between the Health Authority and the Trust for 1997 to 1998 the Respondent decided not to purchase the Lynton Hospital in-patient services and the Trust cannot therefore, at least temporarily, provide them. But it has been agreed that that process should be regarded as an instruction to close temporarily those services. The Trust has been served as a person directly affected. Mr Engelman appears for both the Health Authority and the Trust and both have agreed that the Health Authority should take responsibility for the decision.

Community Health Councils

By 1996 the Government had resolved to make the National Health Service more responsive to the needs of its consumers (see Circular EL(90)185). To this end Community Health Councils were established by the Community Health Councils

Regulations 1996 pursuant to the Secretary of State's powers to issue directions under the National Health Service Act 1977. Part IV of those Regulations identifies the functions of a Community Health Council. I should read Regulation 17 and Regulation 18. Regulation 17 provides:

> *It shall be the duty of each Council to keep under review the operation of the health service in its district, to make recommendations for the improvement of that service and to advise any relevant Health Authority upon such matters relating to the operation of the health service within its district as the Council thinks fit.*

Regulation 18 is headed by the rubric, 'Consultation of Councils by relevant Health Authorities':

> *(1) Subject to paragraphs (2) and (3), it shall be the duty of each relevant Health Authority to consult a Council on any proposals which the Health Authority may have under consideration for any substantial development of the health service in the Council's district and on any proposals to make any substantial variation in the provision of such service . . .*
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> *(2) . . .*
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> *(3) Paragraph (1) shall not apply to any proposal on which the Health Authority is satisfied that, in the interest of the health service, a decision has to be taken without allowing time for consultation; but, in any such case, the Health Authority shall notify the Council immediately of the decision taken and the reason why no consultation has taken place.*

Thus, a Health Authority is obliged to consult a Community Health Council if, in relation to this case, two conditions are satisfied: (a) there is a proposal to make any substantial variation in the health service; and (b) that proposal is under consideration by the Health Authority.

The Essential Issue

The real decision which is impugned is not the decision temporarily to close but the decision, made on 4th June 1997, to do so without consultation with the Community Health Council. The essential issue is whether the Health Authority acted lawfully in issuing instructions to close Lynton Hospital without consulting the North Devon Community Health Council. The decision not to consult was made pursuant to Regulation 18(3), and it was notified on 28th May to the Community Health Council. The letter of notification gives the reasons for the decision not to consult. It states:

> *Consultation is not possible because of the urgent need to release resources to 1997/98 and 1998/99 to allow the Authority to meet its statutory requirements. Closure of the inpatient services by 15th August is necessary to allow the cost of the contract with North Devon Healthcare Trust to be reduced to affordable levels. Neither the Trust nor the Authority can agree an unaffordable contract.*

The Problem of Shortage of Funds and Proposals between September 1996 and January 1997

Analysis of the course of discussions between the Trust and the Health Authority between January and mid-May of this year (1997) is of the greatest importance. I shall, however, deal with the events leading to those discussions. They have been the subject matter of some comment, although they are not vital to the decision I have to make.

In September 1996 the Health Action Plan was published to signal to providers

proposed changes in contracts for the year beginning April 1997. That plan referred to a deficit of £1 million expected by the end of the year and a gap in resources of £2 million for the financial year 1997 to 1998.

The Health Action Plan referred at page 22 to community hospitals. It said:

> *The current occupancy of many community hospitals is relatively low and needs to be increased, to their maximum capacity. This should not, however, be done by admitting patients from the community who would not otherwise have been in hospital, or by prolonging the current length of stay and slowing down the rehabilitation of patients. A key priority is for the community hospitals to take patients from the general hospitals to increase the capacity of the general hospitals to deal with acute illness. Community hospitals are important local resources.*

In fact the expected deficit of £1 million had, by January 1997, become £4 million.

In September 1996 the Trust was considering the temporary closure of Lynton Hospital, but, as the Health Authority was informed on 18th September 1996, it decided not to do so for the reason that a long awaited review of health care needs in the Lynton and Lynmouth areas was considered to be vital before properly informed decisions in the short- or the long-term could be made. A meeting of the Review Group to initiate the Lynton Review, which was the local review of those healthcare needs, was held on 5th November 1996. It was designed to examine existing resources. It was said at that meeting that the hospital would stay open in the year 1996 to 1997. It was expected that the Lynton Review would be finalised in time for the financial year 1997 to 1998. That hope was not realised.

The suggestion has been made that those concerned with closure of the hospital in September 1996 were entitled to assume that it would be safe until the review was complete. In my judgment, no contention of irrationality can properly be founded on the basis that the Health Authority should have waited until the review was complete. That suggestion has, rightly, in my view, not been pursued.

On 26th November 1996 the funds available overall to health authorities were announced in the budget. The allocation formula revealing how much the Health Authority had at its disposal was published in December 1996. North and East Devon was allocated the smallest pro rata increase. A Health Investment Strategic Review was initiated. It was separate from the Lynton Review.

On 10th January 1997 it was recorded that an additional £1 million had to be found. It was said at a meeting of the Steering Group that:

> *The Authority is planning to find these resources from proposed disinvestment and service change, and from the efficiency benchmarking exercise.*

In early 1997 the Health Authority was reminded by the NHS Executive, which acts for Central Government, of the need to produce a scheme which broke even for 1998 and 1999 and to come within £1 million of the break-even point for the financial year 1997 to 1998.

Discussion and Negotiation with the Trust, February-May 1997

A meeting to consider the contract to be agreed between the Health Authority and Trust for 1997 to 1998 was held on 20th February 1997. It was recorded that:

> *Further discussions were had about the possible service changes and it was agreed that Winsford and Lynton may be considered both in terms of temporary closures, and more permanent closures. It was agreed that in order to have any true impact on 1997/98, a clear decision on these would have to be made quickly.*

A summary of key objectives was agreed between the Health Authority and the National Health Executive. It stated at Clause 4.2 under the heading 'PROGRAMME AREA 4' that the action to achieve the objectives would include the undertaking of review of services at Lynton, Winsford and Great Torrington, and a timetable referred to June 1997.

At that meeting on 27th February there was a discussion concerning the need to find £500,000. It was indicated that community hospitals were among the areas being looked at to achieve that saving. That meeting was recorded in a letter from the Chief Executive of the Trust to Dr Morgan, the Chief Executive of the Authority, on 10th March 1997. It is clear from that letter that the proposals to make savings by closure of Lynton or Winsford had not yet been crystallised. Indeed, by 27th March 1997 the National Health Service Executive was under the belief that no significant progress had been made.

On 3rd April an internal memorandum of the Trust referred to a recent television documentary claiming that certain community hospitals, including those in North Devon, faced closure. The Director of Operations, Mr Waldic, wished to emphasise that any such claims were inaccurate. The memorandum stated:

> *. . . there is currently no intention to close any community hospitals in the North Devon Healthcare Trust.*

On 9th April 1997 the Board of the Health Authority held a meeting. It is a date of some significance, since it was by that date that the Applicants suggest a proposal temporarily to close Lynton and Winsford was sufficiently cogent to trigger the duty to consult under Regulation 18.

The minutes of the Board meeting record that:

> *The Chief Executive reiterated that the Authority was living beyond its means and would be faced with some hard decisions in the next couple of months. An action plan to reduce the deficit would be brought to the Authority in May or June.*

Dr Gillian Morgan, Chief Executive of the Authority and Julia Neville, the Director of Development of the Trust, provide important evidence of the position that had been reached by 9th April. At paragraph 11 of her first affidavit Dr Morgan said:

> *By April it had become clear that the Trust had identified the community hospitals as their best option. I have also referred to my letter dated 9th April to the local MP, Mr Harvey, when I explained the position to him. That was reported in the North Devon Journal on 17 April 1997. By the time of the May meeting I would have regarded it as public knowledge that the Respondent was looking at community hospitals as a way of meeting its budgeting target.*

Dr Julia Neville states at paragraph 40 of her first affidavit:

> *By the 9th April it had become plain that: –*
>
> *40.1 savings of £1.5 million had to be made . . .;*
> *40.2 £500,000 was being sought from Trust; and*
> *40.3 the only practical solution was, amongst other things, the temporary closure of Lynton Hospital.*

On the same day, as Dr Morgan said in her affidavit, she wrote to the local member of Parliament who was concerned about rumours as to closure:

> *As the time-frame is short we are looking at a whole range of options, some of which would be permanent, others temporary. Clearly all community hospitals feature in this debate, but it is too early to give a definitive view. We meet the*

Trust to discuss options next week, with the aim of developing firm proposals for change by June at the latest.

When we are further on, I will let you know.

A letter was also written by the Chief Executive to the Trust to the Mayor of Lynton on 14th April 1997, in which she said:

Further to our discussion today, I can confirm there is no discussion within the Trust regarding the closure of Lynton or any other community hospital. I did indicate to you that the current rumour and speculation is most likely arising from the Health Authority's deficit position, and its proposal as set out in the paper to the March Authority meeting to consider ways of reducing expenditure over the next few years.

News of the suggestion, to use a neutral word, temporarily to close the hospital was leaking out by 17th April 1997. There was a meeting with the Trust which referred to the concern as to the closure on 25th April 1997. Under the rubric 'Community Hospitals', it was said:

– the justification for including Lynton, Winsford and Torrington in a corporate contract are that they are old, small and more importantly, serve smaller populations . . .

I take 'including' to mean that that proposal was included in the areas of possible savings. The note goes on:

Gill [that is Dr Morgan] advised that she was meeting Dr Ian Jack and the two Lynton GPs next week. We might wish to look out for ripples arising from that. Gill also suggested a joint PR [that is, I suspect, some public relations exercise] as and when any decisions are made.

On 29th April Dr Morgan records that she had a meeting with two of the GPs from Lynton Hospital. She says:

I specifically discussed with them the proposal that the savings might have to be made from the closure of Lynton and we discussed the implications from such a closure. They made it very clear to me that they believed the Trust could make savings elsewhere, and that in their view the Trust should do so, although the GPs did not make any specific suggestions or offer any alternative solutions.

On 1st May Julia Neville records that she had a meeting with Linda Stapleton, the Chief Officer of the North Devon Community Health Council, to discuss what she describes as:

. . . the intended proposal concerning the closure of Lynton which would be presented to the June Respondent Board meeting.

On 2nd May a petition was sent to the Health Authority showing those in support of keeping the hospital open.

On 7th May it was recorded at a meeting of the Health Authority that:

[The] Chairman of the . . . Community Health Council expressed members' concern regarding the Authority's financial situation and the hard choices which would need to be made. He was anxious that this did not lead to short term changes, which are not always best in the long term. The Chief Executive reported that a prudent assessment of risk had now been built into the 1997/98 expenditure plans and that all service changes were indicated in the Health Action Plan published in September and there were no new additional areas being reviewed.

A The reference to 'no new or additional areas' is, I was told by the Respondents, a reference to areas other than those referred to in the Health Authority and therefore areas other than community health hospitals. But I hope I might be forgiven for commenting that that record of the meeting might have been better expressed.

B By 9th May 1997 Torrington Hospital was still a possible candidate for closure. The Trust's position by that date is recorded in a minute of 9th May in which it is said:

> *Joint work has been going on since the Health Investment Review was established, and a number of potential savings areas have been put forward by the Trust. Some of these may form part of the overall action to balance 1997/98, others may be picked up as part of longer term reviews.*
>
> *There is an outstanding matter in respect of the Trust's 1997/98 contract with the Authority. It revolves around a very specific list of service pressures which the Authority believes should have been funded by other means.*

C D It shows that a decision as to the matters which had been put forward was still awaited, but that minute was, I was told, relating in the main to possible sources of savings other than the hospital.

The position in mid-May is related by Julia Neville in her affidavit at paragraphs E 49 and 50. At a meeting on 13th May it was recorded:

> *The Health Authority and the Trust will agree which hospitals will close under emergency procedures . . .*

Julia Neville said that:

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> *. . . in about mid-May 1997 the agreement as to which hospitals were to be included was finally reached and the Board paper was prepared. It was at this time that a formal proposal came into existence for inter alia the temporary closure of Lynton Hospital.*

G The Chief Executive produced a paper discussing the temporary closure which was disseminated by 20th May 1997. In that paper he states, under the heading 'Urgent action without prior Consultation . . .':

> *The above proposals [which did not include the closure of the hospitals] are not sufficient to bridge the gap between the Authority's expenditure plans and the resources available to meet them. Further* ***urgent action without prior consultation*** *under the terms described in NHS Executive Letter (90)185, is required. The paper recommends three proposals for urgent action to the Health Authority:*
>
> ***3.1 Community Hospital closure in North Devon***
>
> *The Authority to instruct North Devon Healthcare Trust to proceed to close, as soon as possible, and by 15th August, 1997 at the latest, inpatient services at Lynton and Winsford Hospitals.*

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The paper then goes on to deal with the pressures which the Authority faced and refers at 2.2.1 to 'a commitment of £2.2m over the resources available'. In other words, the commitment was higher than had at first been appreciated. It referred to the statutory requirement to balance the books and also long-term reviews. At 6.2, under the heading, 'Urgent Action: North Devon', it is stated:

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> *6.3.1 It has been agreed with the Trust that the value of the contract must be reduced by £500,000 in 1997/98. Urgent action is needed to release this resource.*
>
> *6.3.2 This is a different task in view of the increased pressure and demands on*

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the service in North Devon and requires the closure of facilities whilst detailed service reviews are completed.

At 6.3.3 there is the recommendation to close as soon as possible the hospitals on financial grounds and in the interest of the health service. The paper recorded an occupancy at 77 per cent to Winsford, at 63 per cent to Lynton, and scheduled the planned savings for North Devon as £500,000.

That paper has led to an assertion by the Applicants that members of the Health Authority making the decision were misled as to the occupancy of the hospitals and as to the expected savings. That assertion is partly based upon a comment on the paper it was proposed to lay before the members, made by the Trust on 21st May, which pointed out that 77 per cent occupancy at Winsford was not low occupancy and stated concern that the Authority ran a risk of significant challenge over this. It said:

To eliminate these real risks it may be better to simplify the reason as financial need and then go on to look at the implications for beds.

It also commented upon the expected financial savings. It said:

The paper is still quoting £0.5m saving for the year, although we have consistently indicated that it is more likely to be around £250K to £300K for a 7 to 8 month closure period in 1997/9.

The paper was not corrected.

The expected saving is now disclosed, at paragraph 63, as (in the affidavit of Julia Neville) approaching £215,000 by the end of the financial year. It is therefore said that the paper was inaccurate in its reference to £500,000. It is possible for cognoscenti to understand that paragraph 6.3.4 of the paper as meaning areas other than the hospitals would be available for savings to make up that £500,000. I do not think that members were misled although the amendment should have been made to the paper as suggested by the Trust, and it would certainly have made matters more readily understandable.

As I have said, on 28th May notification of closure without consultation was given to the Community Health Council. The decision is recorded in the Board minutes and the meeting of the Board was attended by members of the public, including protesters such as the Reverend Ringer.

I need not set out the formal decision save to note that it was approved with only one vote against and an amendment was moved to defer for a short period the decision to allow some kind of consultation but it did not receive a seconder. I should also record that at that time other decisions were made as to sources of savings, some of which have become the subject of consultation with Community Health Councils.

Was there a Proposal within Regulation 18(1) by 9th April?

The Applicants contend that the evidence discloses that by 9th April a proposal to close Lynton and Winsford hospitals had been formulated such as to trigger the provisions of Regulation 18(1). The Respondent contends that no proposal temporarily to close those hospitals of such a nature to require consultation had been formulated until mid-May. The significance of the disagreement as to those dates is that, if the Applicants are right, they say that there would then have been time to consult the Community Health Council. The Respondent's failure, it is said, to appreciate that the time for consultation had been reached in April was an error in law and vitiates the decision on 4th June 1997 to dispense with consultation on the grounds of urgency.

A As Professor Joad might have said, it all depends what one means by proposal. The answer, in my judgment, is to be found in the Regulation itself. The proposal of a substantial variation, which the Regulation contemplates, is a proposal of such particularity that it can be identified as a substantial variation. It must also be crystallised to the extent that it is capable of consideration by the Health B Authority. But since it is the trigger for consultation, it need not, indeed must not, be the subject of any final resolution. If it was, it would undermine the purpose of Regulation 18(1) which is to provide for consultation.

Consultation involves the opportunity for representations to be made and for them to be conscientiously taken into account before the proposals are finalised. C Thus, it must take place while the proposals are still in a formative stage (see Auld J (as he then was) in *R v London Borough of Barnet ex p B* [1994] ELR 357 at 370H-371A).

Circular EL(90)185 refers to consultations as an integral part of the management process. It says that consultation responds to the desire of the public to D have influence in the delivery of health services. Thus the process envisaged by the Regulation is a process whereby the Community Health Council and the Health Authority jointly seek to reach a solution to the problem with which the Health Authority is presented. The Health Authorities are under a duty, once they are considering a proposal, to consult the Community Health Council before that E proposal has evolved into a definite solution.

In my judgment, a proposal to close Lynton and Winsford's health services temporarily was of sufficient cogency by 9th April 1997 as to trigger the duty to consult with the Community Health Council. It is true that at that stage the proposal included other possibilities for savings, such as the closure of Torrington, F but in my view that does not mean that it was not capable of forming the subject of the consultation with the Community Health Council. After all, they might well have wished to debate the merits of those other possibilities as alternatives to closure of Lynton and Winsford. That the proposals might have encompassed permanent closure rather than temporary closure does not, to my mind, alter G their essential nature or mean that they were not ripe for consultation.

The Respondent relies upon the letter of 9th April to the local MP as showing that no proposal was in existence, and the letter from the Chief Executive of the Trust to the Mayor dated 14th April. Far from being misleading, the Respondent asserts they demonstrate that no proposal has yet been formulated. In my judg- H ment, the evidence of Dr Morgan and Julia Neville is far more revealing. At paragraph 11 Dr Morgan says that the Trust had identified the community hospitals as the best option for saving. This was no accident in drafting as the affidavit of Julia Neville reveals. She refers to that proposal as the only practical solution, amongst other things. She also speaks of a discussion as to the proposal on 14th and 29th I April.

It is true that the proposal had not been considered by the Board, but that does not mean that it was not under consideration by the Health Authority. The trigger to Regulation 18(1) is not confined to decisions as to solutions by the Board of the Health Authority. The proposal was, after all, sufficiently under consideration to J permit a discussion with the Mayor and concerned GPs on 14th and 29th April.

In those circumstances, I conclude that a proposal for substantial variation was under consideration and the duty to consult arose by mid-April 1997. I do not think that on 9th April the Chief Executive, in her letter to the MP, or on 14th April, Julia Neville, in her letter to the Mayor, had any intention to mislead, although the K letter of 14th April which said that no discussion was taking place may have been born out of an attempt to dispel or disquiet or calm the ripples which were

referred to at the meeting of 25th April. Rather, those letters reveal a confusion between a proposal at a formative stage, such as will trigger the duty to consult, with a final solution. Hence, Dr Morgan refers to a definitive view and the development of firm proposals. The Health Authority was clearly under the impression that no duty to consult arose until a decision had been made by the Health Authority, in agreement, if possible, with the Trust. Thus, the meeting on 13th May recorded that the Health Authority and Trust will agree which hospitals will close under emergency procedures. That wording suggests a decision and not a proposal at a formative stage. There is no reference before then to the need to consult or to dispense with consultation.

I turn then to the nature of the Health Authority's error and its consequence.

Consequences of the Existence of a Duty to Consult arising in April 1997

A Community Health Council in a paper dated 16th July 1997 suggested that six weeks would be sufficient time for appropriate consultation. The Applicants contend that since there was time for consultation with the Community Health Council once the duty arose in mid-April 1997, the decision to proceed without consultation by reason of the urgent need to make savings is unlawful and cannot stand.

There can be little doubt that by June 1997 the need to make savings required to attempt to comply with the obligations to balance the books, under section 97A of the 1977 Act, was urgent. Earlier estimates of deficit had been too optimistic. By 7th May the deficit was expected to be £2.2 million. Whatever the reason for the passage of time between February and June, the Respondent says matters had become so urgent by June that it cannot be said that the decision to dispense with consultation under Regulation 18(3) was irrational. For it is that ground alone, which, it is said, could justify a review of a decision under Regulation 18(3), absent any suggestion of bad faith. The Respondent relies upon *R v Tunbridge Wells Health Authority, ex parte Goodridge, The Times*, 21st May 1988. In that case there was no evidence to suggest that there had been a decision to close without consultation or that the closure was urgent.

Mr Engelman, on behalf of the Respondent, suggests that once it is clear that the need to make savings by temporary closure was urgent, it follows that the decision to dispense with consultation cannot be impugned as irrational and cannot, therefore, be reviewed. He relied upon *R v Richmond, Twickenham & Roehampton Health Authority, ex parte London Borough of Richmond* (unreported) 20th February 1994, a decision by Mann J. In that case no formal decision had been made under Regulation 18(3), but the need for closure was described as urgent. No argument appears to have been advanced suggesting that it was the Health Authority's own fault for allowing matters to become urgent. Nevertheless, Mr Engelman suggests that it could have been advanced, and contends that absent bad faith, if the need is urgent, the decision cannot be challenged even if the Health Authority might have acted earlier at a time when consultation would have been possible.

Mr Richard Gordon QC, on the other hand, relies on *R v North West Thames Regional Health Authority and Others, ex parte Daniels* [1994] COD 44, of which I also have an unreported transcript. In that case, Kennedy LJ said of the failure to consult:

> *The District Health Authority cannot be in a better position because instead of making a proposal they allowed the situation to drift in the way I have described. In my judgment that submission is unanswerable, and neither Miss Davies nor Mr Shaw really sought to answer it.*

In that case, however, no relief was given because the hospital had already closed. In this case, the Respondent did not merely allow the matter to drift in the sense of doing nothing. The negotiations, in order to reach a final solution, as I have found, continued.

I do not think that the authorities assist. Greater help is to be found in the scheme of the Regulation. Regulation 18, read as a whole, is designed to ensure that consultation does take place with a Community Health Council once a proposal of the nature it describes is under consideration. It then derogates from that provision, where a decision has to be taken without allowing time for consultation. Regulation 18, in certain cases, permits the Secretary of State to require further time for consultation; it is clearly aimed at achieving sufficient time for proper consultation. It would seriously undermine the purpose of the Regulation if a Health Authority could allow time to pass to the point where matters were so urgent that there was no time left for consultation. It would permit a Health Authority, taking the view that there was only one practicable solution, to pre-empt the result of proper consultation.

I note what Dr Morgan says in her affidavit at paragraph 15:

> *There was also a reluctance to consult widely with staff of the Hospitals or the public before plans and proposals for cost savings had been finalised, in order to avoid any unnecessary anxiety.*

Julia Neville says at paragraph 69.2 of her affidavit:

> *In my experience public consultation and consultation with CHC's will generally produce comments on the proposal itself and not realistic alternatives. I would not have expected a formal consultation exercise to produce new information or comment over and above what was contained in the representations received by the Respondent before the meeting and which had already been taken into account.*

It may not be fair to characterise those statements as explanations for the failure to consult, but if the Respondent was correct, a belief that consultation was pointless or would merely provoke anxiety might lead a Health Authority to delay announcing a decision until it was too late to consult. Regulation 18 would thus be rendered ineffective.

In my judgment, the Health Authority erred in law in failing to appreciate that the proposal temporarily to close Lynton and Winsford Hospitals was a proposal within the meaning of Regulation 18(1) such as to trigger the duty to consult in April 1997. That error taints its decision of 4th June 1997 to dispense with consultation and, subject to the issue of discretion, cannot stand.

In the light of that conclusion, it is unnecessary to consider the question raised in relation to the decision to alter out-patient services which followed the decision in relation to in-patient services.

Discretion

It is clear that the earlier the savings can be made the greater those savings. Nearly half the financial year has passed. Unless the hospitals are closed, it was said, the necessary savings cannot be achieved. I was told, although I could find no evidence of this, that if I grant relief it will not be possible to use the temporary closure of the hospitals as a means of making savings at all. I accept that to grant relief now will make the task of the finding the necessary savings far more difficult. But I do not accept that the evidence shows that it would be impossible. I appreciate that such savings may have to be made out of other valuable services.

It has been suggested that waiting lists will be increased. Even though the task is harder, in my view the importance of the duty to consult is such that I do not think the greater burden of the task facing the Health Authority, caused by its own error in law, justifies the refusal of relief. After all, a conscientious process of consultation with an informed Community Health Council, and, not with the public at large, and which should not be confined to mere protestations of opposition, may produce alternative means of saving the £215,000 which it was hoped to achieve by the end of the financial year.

Secondly, it is contended that since it was known in September 1996 that the hospital might be closed, there has been ample opportunity for those who oppose the decision to make their views known. This they have done. Those views have been taken into account. It is said that nothing further has been said or could be said which could cause a fresh decision to be taken.

There are cases, of which Mr Engelman has helpfully provided me with examples, where proposals have been well known in advance and where it can be said that, despite the absence of a formal consultation process, all possible suggestions have already been advanced or that the decision is so obvious that there is no reason to think further opportunity of a consultation would make any difference.

In this case the opposition has been vociferous and forthright. Its substance has, in a number of respects, been set out in the evidence of the Reverend Ringer and Dr Ferrar. But the mere fact that the grounds of opposition are already known or that it is well understood that the opposition is widespread and deeply felt does not mean that there is no room for a process of consultation whereby not just opposition but also the offer of alternative solutions is advanced. Julia Neville thinks that consultation provides no fruitful solution. That is undoubtedly correct, if that consultation merely consists of rejection of an existing proposal. But proper consultation should be far more positive and, as contemplated by the Regulation, may provide alternative solutions.

I reject the suggestion that opportunity has already properly been given to advance alternative solutions to a Health Authority prepared to listen, as I am sure this Health Authority will. I decline to follow the path down which the Respondent beckons me. I prefer the warning of Megarry J. I shall not, in the exercise of my discretion, refuse relief. I shall discuss the form of that relief with counsel.

I well understand the frustration that the Respondent must feel, faced, as it is, with its duty to make savings which are bound to disappoint and cause grave dissatisfaction amongst some section or other of its patients. A period of consultation of six weeks may only confirm the Authority in its original view, although it may reveal the opportunity for savings from other sources. Although the Authority's only satisfaction may be that it has reached a decision after consultation in accordance with the Regulation, at least such a process will have inspired the confidence in its decision which that Regulation is designed to produce.