CO

IN THE HIGH COURT OF JUSTICE

QUEEN'S BENCH DIVISION

ADMINISTRATIVE COURT

IN THE MATTER OF AN APPLICATION FOR JUDICIAL REVIEW
BETWEEN

R
(on the application of
SAVE LEWISHAM HOSPITAL CAMPAIGN)

Claimants

- and -

SECRETARY OF STATE FOR HEALTH (1)
TRUST SPECIAL ADMINISTRATOR APPOINTED TO SLH NHS TRUST (2)

Defendants

- and -

LEWISHAM HEALTHCARE NHS TRUST (1)
LEWISHAM PRIMARY CARE TRUST (2)
LEWISHAM COUNCIL (3)
LEWISHAM CLINICAL COMMISSIONING GROUP (4)

Interested Parties

## SECTION 5-8: DETAILED GROUNDS OF CLAIM, STATEMENT OF FACTS AND DETAILS OF REMEDY SOUGHT

**Note**: Page references to are to the Claimant's bundle of documents lodged with this claim.

**Essential reading:**

(i) Pre-action protocol letter dated 15th February 2013 **[B260-B275]**

(ii) Pre-action protocol response from Secretary of State to Lewisham Council dated 22nd February 2013 **[B276-B280]**

(iii) These grounds of claim and the documents marked in bold herein

## Introduction

1. The Claimant is a company limited by guarantee formed for the purposes of fighting a campaign against the proposals to downgrade and close services at Lewisham Hospital.

2. The Claimant's assets are limited to the fighting fund it has been able to raise for the litigation. Although its own lawyers are acting on a CFA, a PCO is sought in respect in respect of the Claimant's adverse costs liability on the grounds that:

   i) The issues raised are of general public importance[1];

   ii) The public interest requires that those issues should be resolved[2];

   iii) The applicant has no private interest in the outcome of the case[3];

   iv) Having regard to the financial resources of the Claimant and the Defendant and to the amount of costs that are likely to be involved it is fair and just to make the order;

   v) If the order is not made the Claimant will probably discontinue the proceedings and will be acting reasonably in so doing because otherwise it would be at risk of an insolvent liquidation if the litigation were unsuccessful.

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[1] See generally in relation to the healthcare sector: *R(Compton) v. Wiltshire Primary Care Trust* [2008] EWCA Civ 749.

[2] A test that is inextricably linked to the first question – see *Compton*, supra.

[3] A test that has been deprecated in a number of cases, see in particular *Wilkinson v. Kitzinger* [2006] EWHC 835 (Fam) at paragraph 54: '*a somewhat elusive concept to apply*' and *Compton* supra.



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See *R(Corner House Research) Secretary of State for Trade and Industry* [2005] EWCA Civ 192

3. A witness statement dealing with the PCO application is served herewith. The PCO sought is that the Claimant's adverse liability in costs be capped at £15,000.

**Decision challenged**

4. The Claimant brings this challenge to a decision of the Secretary of State announced in Parliament on 31st January 2013 **[B251-B255]** which, if implemented, would result in substantial cuts to the services at Lewisham Hospital. The Claimant's case is that the decision and the manner in which it was made was unlawful and seeks an order from this Court quashing such decision on the grounds set out below.

5. At the time of drafting the Claimant has not had a response to its pre-action protocol letter, but has been passed a copy of the Secretary of State's response to a pre-action letter from Lewisham Council which challenges the same decision by the Secretary of State decision on the grounds that the decision was *ultra vires*. The Claimant reserves the right to amend this pleading in the event that the Secretary of State provides a response to the Claimant's pre-action protocol letter.

6. Further, shortly prior to lodging this claim the Claimant was informed that Lewisham Council had lodged their own judicial review proceedings against the decision of the Trust Special Administrator ('TSA') and the Secretary of State in proceedings under case number CO/2744/2013. The Claimant requests that this claim is consolidated with those proceedings and appropriate directions are sought as set out at the end of this document.

7. While there is a degree of overlap in the arguments which are advanced by the Claimant and Lewisham Council, particularly with regard to the decision



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challenged being *ultra vires* the TSA and the Secretary of State, (and which the Claimant at the hearing of the matters raised herein, will not duplicate in oral argument but will adopt) the Claimant has its own freestanding arguments based on legitimate expectation, misdirection, and requirements of lawful consultation which ought to be determined by the Court.

**Summary of grounds of challenge**

8. The Claimant's case is that:

- The decision was *ultra vires*. The decision was purportedly made under s.65K(1) of the National Health Service Act 2006 ("the 2006 Act"). The powers of the Secretary of State under s.65K **[C56]** do not extend to making decisions about the configuration of services at Trusts which are not subject to the special administration process. In as much as the Secretary of State may hereafter assert that the Secretary of State had power to make the decision under his general powers under the 2006 Act, the Claimant will show that this is misconceived[4].

- The Secretary of State misdirected himself and/or acted in breach of the Claimant's legitimate expectation in that he failed to follow each of his 4 tests which had committed himself to being satisfied before he promised he would approve any NHS reconfiguration.

[4] The Claimant notes that Lewisham Council names the TSA as a Defendant to the proceedings in order to quash the *ultra vires* recommendations which have led to the decision of the Secretary of State. Rather than reproduce those arguments the Claimant simply adopts them.



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- The Claimant had a legitimate expectation that the special administration process would not be used by the Secretary of State to impose a "back-door reconfiguration" on the NHS in South East London. The Secretary of State acted in breach of that legitimate expectation by taking the decision.

- The decision could not have been made without further consultation, because the original proposals were so markedly changed in the final decision that the configuration was one upon which no proper consultation had been undertaken and which therefore required lawful consultation – *R (Smith) v. East Kent Hospital NHS Trust* [2002] EWHC 2640.

**The background to the Claim**

9. The decision subject to challenge is the Secretary of State's decision announced to parliament on 31st January 2013 which followed recommendations contained in a report by the Trust Special Administrator ('TSA') to South London Healthcare NHS Trust dated 8th January 2013. The Secretary of State announced his decision in Parliament. The recommendations to which approval was given are summarised at paragraph 141 of the Report of the TSA **[B218].** They will result in a major reconfiguration of services in Lewisham and will have wider effects throughout South East London.

10. The Trust for which the Special Administrator ('TSA') was appointed pursuant to s.65A of the 2006 Act was South London Healthcare NHS Trust ('SLHT'). That Trust came into existence on 1st April 2009. It was the product of a merger of three formerly separate hospital Trusts: Queen



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Mary's Sidcup NHS Trust, Queen Elizabeth Hospital NHS Trust, and Bromley Hospitals NHS Trust. It operates out of three main sites: Princes Royal University Hospital Farnborough, Queen Elizabeth Hospital Woolwich and Queen Mary's Hospital in Sidcup.

11. Lewisham Hospital NHS Trust which operates Lewisham University Hospital is not and has never been part of SLHT.

12. In July 2012 the Secretary of State made the decision to appoint the TSA in respect of SLHT. In the original "*Case for Applying the Regime for Unsustainable NHS Providers*" prepared by the Department of Health in July 2012 **[B15-B36]** there was discussion of the possible use of the powers introduced under the Health Act 2009 to deliver change "*beyond the organisational boundaries of SHLT*" (see paragraph 75 of the Case **[B34]**) since that appeared to be an option that was being proposed by the London Strategic Health Authority.

13. That proposed wider remit was not adopted by the Secretary of State. The Secretary of State's statement to Parliament said:

> "In addition to maintaining the provision of services during the period of the regime, the duty of a trust special administrator appointed to an NHS trust is to develop and consult locally on a draft report, making recommendations to me in a final report about what should happen to **the organisation and the services it provides**. The objective is that high quality, sustainable services are delivered to the local health economy" (*Emphasis added)*

14. The Secretary of State also gave the following clear and unequivocal assurance to Parliament that the TSA process would not be used as the basis for a wider reconfiguration of services within the South London NHS. The Secretary of State said:



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"The trust special administrator's regime is not a day-to-day performance management tool for the NHS **or a backdoor approach to reconfiguration**" (*emphasis added)*

15. The TSA produced a report in January 2013 which made a number of recommendations which went substantially beyond the proper remit of his office. The TSA effectively proposed a widespread "backdoor" reconfiguration of acute hospital services in South East London and thus went very substantially beyond recommendations concerning the SLHT organisation and the services it provided.

16. The Secretary of State substantially accepted the TSA's recommendations relating to organisation of SLHT and changes to the services that SLHT provides. The Claimant accepts that those decisions were intra vires the Secretary of State and does not challenge them in this action. However the Secretary of State went substantially beyond his powers by purporting to make decisions affecting a series of commissioners and providers other than SLHT across South East and Central London.

17. The Claimant is concerned with the changes which the Secretary of State proposes to the services at University Hospital Lewisham which are as follows:

    a. The community based Care Strategy developed by the CCGs in south east London should be fully implemented, at pace.

    b. Kings College hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas's Hospital should provide emergency care for the most critically unwell and that these services be developed to



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meet the required clinical quality standards. University Hospital Lewisham, Guy's Hospital and Queen Mary's Hospital should provide urgent care services for patients that do not need to be admitted to hospital.

c. Paediatric emergency services and inpatient units should be co-located with all acute admitting units and paediatric urgent care services should be provided at University Hospital Lewisham, Guy's Hospital and Queen Mary's Hospital.

d. Four obstetric-led units should be provided at King's College Hospital, Princess Royal University Hospital, Queen Elizabeth Hospital and St Thomas's Hospital, each with a co-located midwifery-led birthing unit; and a freestanding midwifery-led birthing unit should be provided at University Hospital Lewisham.

e. An elective centre of excellence for non-complex inpatient procedures should be developed at University Hospital Lewisham for patients across south east London, managed by a partnership board of representatives of all provider organisations.

f. That Lewisham hospital should retain a smaller A and E service with 24/7 senior emergency medical cover.[5]

18. The practical effect of these changes for University Hospital Lewisham, if implemented, is that the Secretary of State purported to decide that the Lewisham hospital would cease to provide:

[5] The first of Sir Bruce Keogh's recommendations which the Secretary of State adopted – a model not discussed, and not recognised by the College of Emergency Medicine as a common form of emergency service



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(i) A full Accident and Emergency Service

(ii) In patient paediatric services

(iii) A full obstetric service

(iv) Adult intensive care unit

(v) In patient adult acute surgery and medicine services; - (Sir Bruce Keogh recommended a 'direct admission step up facility for unscheduled attendances' at the amended A&E – we assume a sort of short stay ward for people who are unwell but not unwell enough to go elsewhere, eg with pneumonia or meningitis – a strange concept without clarity.

19. There will be substantial further changes to services at University Hospital Lewisham if these changes are implemented, details of which will be provided in evidence in due course.

20. In contrast to the decision making powers adopted by the Secretary of State, in law decisions to which services should be provided at University Hospital Lewisham are decisions which can only be made by Lewisham Healthcare NHS Trust which is the corporate body that runs University Hospital Lewisham. These are not decisions where the Secretary of State is the decision maker.

21. Decisions about what services should be commissioned for NHS patients to be provided at University Hospital Lewisham are decisions for the local NHS commissioners, and in particular Lewisham Primary Care Trust. Local NHS commissioners place contracts with the Lewisham Healthcare NHS Trust. These contracts detail the services that the commissioner requires



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the Trust to provide at University Hospital Lewisham for the NHS patients for whom the PCT is the responsible commissioner.

22. The contracts define the services that local NHS commissioners are prepared to pay for at University Hospital Lewisham as part of NHS funded healthcare. However there is nothing in law to prevent Lewisham Healthcare NHS Trust offering or providing a service at University Hospital Lewisham to any patient whether it has been commissioned as part of NHS funded healthcare or not. The Trust is entitled to provide services for private patients (see paragraph 19 of Schedule 4 to the 2006 Act). The terms of Schedule 4 of the 2006 Act make it clear that the Board of the Trust (and not the Secretary of State) acts as the decision maker concerning the affairs of the Trust.

23. This Judicial Review is not about the clinical merits of the decisions that the Secretary of State has taken about the reconfiguration of services in South East London. Whilst the Claimant believes on substantial grounds that the decision of the Secretary of State has no clinical merit and will result in substantial harm to patients, the Claimant does not seek to make a *Wednesbury* merits based challenge to the decisions. The Claimant is confident that the decisions taken by the Secretary of State would not have been taken by those NHS bodies with whom decision making power lies to make decisions about the configuration of NHS services in Lewisham.

24. This Judicial Review is about whether the Secretary of State was entitled to take such decisions in the way that he took the decisions and/or whether he followed a fair process in doing so.



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## Law and legislation

25. The Secretary of State has duties under sections 1 to 3 of the 2006 Act which include a duty to continue the promotion of a comprehensive health services and has the duties to provide services to meet all reasonable requirements in section 3 of the 2006 Act.

26. Section 3 of the National Health Service Act 2006 (prior to the amendments of this section brought in by the Health and Social Care Act 2012) provides:

> "(1)The Secretary of State must provide throughout England, to such extent as he considers necessary to meet all reasonable requirements—
>
> (i) hospital accommodation,
> (ii) other accommodation for the purpose of any service provided under this Act,
> (iii) medical, dental, ophthalmic, nursing and ambulance services ..."

27. The Secretary of State has delegated the discharge of these functions to local NHS commissioners, namely local primary care trusts, under the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 ("the 2002 Regulations"). These Regulations will be amended by the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 but the relevant part of these Regulations do not come into force until 1st April 2013.

28. Regulation 3(2) of the 2002 Regulations provides **[C76]**:

> "(2) Subject to regulations 6 and 8, the Secretary of State's functions relating to the health service under the enactments specified in column (1) of Part 2 of Schedule 1 (the subject



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matter of the relevant functions being indicated in column (2) of that Schedule) are to be exercisable by—

(a) Primary Care Trusts; and

(b) Strategic Health Authorities but, subject to paragraph (2A), only to the extent necessary to support and manage the performance of Primary Care Trusts in the exercise of those functions"

29. The functions in column 2 of the Schedule to the 2002 Regulations include the function of commissioning the provision of hospital services under section 3(1). Accordingly decisions about which hospital services should be commissioned as part of NHS funded treatment for people who are either registered with NHS GPs in Lewisham or were ordinarily resident in Lewisham but were not registered with a GP in order to discharge the duty owed by the Secretary of State under section 3(1) are and continue to be a matter for Lewisham Primary Care Trust.

30. Further the duty to commission accident and emergency services for people in Lewisham was delegated by the Secretary of State to Lewisham Primary Care Trust (see Regulation 3(7)(b)(i) **[C77]**). Lewisham PCT is now part of the South East London Cluster of PCTs, but the commissioning responsibility for services in Lewisham has been passed to the shadow CCG, which is presently operating as a committee of Lewisham PCT.

31. As the 2002 Regulations make clear, the Secretary of State has arranged the provision of NHS services by creating and maintaining a clear division between "commissioners" and "providers" of NHS services. The duties on the Secretary of State under section 3 of the 2006 Act have been delegated to local commissioners. Those commissioners in turn discharge their duties to provide services for NHS patients by putting in place contracts under



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which a range of providers agree to provide healthcare services to NHS patients. Providers include:

(i) NHS Trusts

(ii) NHS Foundation Trusts

(iii) Companies, partnerships or other persons who are not NHS bodies such as GP practices or commercial healthcare providers and

(iv) Non-profit sector providers.

32. Section 8 of the 2006 Act **[C37]** entitles the Secretary of State to give Directions to a range of NHS bodies, excluding NHS Foundation Trusts. The Secretary of State has no power to make Directions to require any other provider of services to the NHS to cease to provide a service to NHS Patients. However to the best of the Claimant's knowledge and belief the Secretary of State has not at any time exercised his power under section 8 of the 2006 Act to make any directions to require Lewisham Healthcare NHS Trust to cease to deliver any services to any NHS patient.

33. The powers of the Secretary of State to appoint a Trust Special Administrator ("TSA") arise from section 16 of the Health Act 2009 which introduced a new section 65A into the NHS Act 2006. Section 65B(1) provides **[C39]**:

> "The Secretary of State may make an order authorising the appointment of a trust special administrator to exercise the functions of the chairman and directors of an NHS trust to which this Chapter applies"



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34. Accordingly the primary function of the TSA is to take the place of the Trust Board and, once appointed, the TSA is entitled to exercise the powers of the Trust Board to run the Trust.

35. Section 65F(1) provides for additional functions to be undertaken by the TSA as well as acting in place of the Trust Board. It provides **[C47]**:

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

## Submissions

### Ground 1: The purported decision of Secretary of State was *ultra vires* s.65K(1) of the 2006 Act

36. Section 65I(1) provides:

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

37. Section 65K(1) then provides:

> "Within the period of 20 working days beginning with the day on which the Secretary of State receives a final report under section 65I, the Secretary of State must decide what action to take **in relation to the trust**"

38. The TSA provided his report to the Secretary of State on Friday 4th January 2013. Within the 20 working day period, the Secretary of State made his announcement as follows:



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"Yesterday, 30 January, as no viable alternative plan had been put forward, and in light of Sir Bruce's opinion, I decided to accept the recommendations of the trust special administrator, subject to the amendments suggested by Sir Bruce"

39. Where a TSA is appointed under the 2006 Act, the Secretary of State does not retain a power to make a decision which has been delegated to and falls to be taken by:

    (i) a local commissioner of NHS services or

    (ii) the Board of another NHS Trust.

40. It follows that each recommendation made by the TSA and each decision by the Secretary of State in reliance on it, is required to be specific to (and not wider than) the Trust for which the TSA has been appointed.

41. The TSA had no power to make proposals in his report that there should be changes to the services that Lewisham Healthcare NHS Trust were able or required to provide at University Hospital Lewisham. Equally the TSA had no power to make proposals concerning the services that Lewisham Primary Care Trust was required to commission for NHS patients from Lewisham Healthcare NHS Trust. Neither Lewisham Primary Care Trust nor Lewisham Healthcare NHS Trust were bodies which formed part of SLHT, the Trust for which the TSA was appointed as special administrator.

42. The Board of Lewisham Healthcare NHS Trust was and remains (subject to the right of the Secretary of State to make Directions under section 8 of the 2006 Act) the sole decision-maker concerning which services are provided for patients at University Hospital Lewisham.



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43. Decisions about which services should be commissioned by NHS commissioners at University Hospital Lewisham are decisions for the local NHS commissioners, who are exercising the delegated powers which are vested in the Secretary of State under section 3 of the 2006 Act. These duties have been delegated to the Lewisham PCT by the Secretary of State. Lewisham PCT is the lead commissioner acting on behalf of other PCTs, for commissioning NHS funded services to be provided at University Hospital Lewisham.

44. The power given by Parliament to the Secretary of State to make decisions "*in relation to the Trust*" was a power that was given to the Secretary of State to make changes to the structure and functions of the specific NHS provider trust to whom the TSA had been appointed. SLHT is a body corporate created and maintained under Chapter 3 of Part 2 of the 2006 Act and the TSA had powers to make recommendations in relation to that corporate body alone.

45. The policy of successive Secretaries of States has been to put in place and to respect a clear division between NHS commissioners (NHS bodies under Chapter 2 of Part 2 of the 2006 Act) and NHS providers, which includes NHS Trusts (NHS bodies under Chapter 3 of Part 2 of the 2006 Act) as well as a range of other providers. The Secretary of State has the power under section 17 of the Health Act 2009, which introduced a new Chapter 5B of the NHS Act 2006, to appoint a TSA over an NHS commissioner, namely over a local primary care trust. The Secretary of State has a wide power to appoint a TSA in respect of a primary care trust if the Secretary of State considers that it is:

> "appropriate in the interests of the health service"



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46. The existence of this additional power to appoint a TSA over a commissioner alongside the power s.65(B)(1) over an NHS Trust is support for the contention that Parliament did not intend decisions made by a TSA for a Provider Trust to override the decisions of local commissioners or for decisions to go beyond the specific NHS Trust for which the Special Administrator is appointed.

47. However the Secretary of State did not at any stage exercise any power he may have had to appoint a TSA in respect of either Lewisham Healthcare NHS Trust or Lewisham Primary Care Trust. In the absence of any TSA appointed in respect of Lewisham Primary Care Trust that PCT continued to have the powers and duties delegated to it by the Secretary of State. Equally, in the absence of any TSA appointed in respect of Lewisham Healthcare NHS Trust, that Trust continued to have the sole power to decide what services should be provided at University Hospital Lewisham.

48. It follows that, upon receipt of the report from the TSA, the decision making powers of the Secretary of State were limited to making decisions "*in relation to the Trust*". The decision making power vested in the Secretary of State did not extend to:

    (i) Making decisions concerning matters that remained part of the decision making powers that the Secretary of State had delegated to Lewisham Primary Care Trust; and

    (ii) Making decisions concerning matters that fell within the exclusive power of the Board of Lewisham Healthcare NHS Trust.

49. The Claimant's point is therefore a simple and compelling one. Ordinarily, it would, for obvious reasons be outwith the power of one NHS Trust (A) to solve its financial and/or clinical problems by making a decision to scale



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back the range of services provided by its neighbouring trust (B). The (only) proper means by which reconfiguration of such area-wide services could legitimately be done is by involvement of the local commissioners of services (the relevant primary care trusts, or a joint committee of primary care trusts) to agree a reconfiguration of services. This has not been done.

50. It is noted in its pre-action response to the local authority that the Secretary of State **[B276-280]** prays in aid the fact the requirements of consultation contained in ss.242 and 244 of the 2006 Act are expressly excluded in relation to the procedure contained in Chapter 5A of the 2006 Act (s.242(6) of the 2006 Act and Regulation 4(3A) of the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002). But this only emphasises the importance of the statutory wording '*in relation to the Trust*' which limits the TSA's powers deliberately in order to avoid reconfiguration without proper and full public consultation.

51. The Claimant does not say that the TSA was not entitled to consult upon the issue of the internal problems at SLHT. It did so, and the Claimant has no complaint as to the substantial changes proposed to SLHT. The Claimant's complaint is in respect of those matters where the TSA recommendations have gone beyond the TSA's proper remit (and further than the Secretary of State's instructions to him) and has sought to determine changes to other Trusts within the wider NHS economy of South London.

52. Accordingly the Secretary of State acted unlawfully when purporting to make decisions as a result of the power granted to him under section 65K(1) of the 2006 Act which purported to determine which NHS healthcare services should be commissioned and/or provided at a range of NHS Trusts and NHS Foundation Trusts outside SLHT.



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**Ground 2: Breach of legitimate expectation concerning a backdoor reconfiguration**

53. Even if, which is denied, the powers granted to the Secretary of State by section 65K of the 2006 Act included the power to make decisions affecting the services that other NHS Trusts were permitted to deliver as part of NHS funded healthcare and/or the NHS services that NHS commissioners are entitled to commission as part of NHS funded healthcare, the Secretary of State made a clear promise to Parliament that the TSA process that he commenced in July 2012 would not amount to a "*backdoor reconfiguration*".

54. Although the word "national" is part of the title of the NHS, decisions about the configuration of local NHS acute services are local decisions to be made by the local NHS bodies. They are almost always made by local commissioners and providers working together but can, on occasions, be made by local NHS providers exercising their powers under Schedule 4 of the 2006 Act. No approval needs to be sought from the Secretary of State for local NHS commissioners and providers to make changes to the shape of NHS services in their area. These are local decisions and not decisions taken in Whitehall.

55. The scheme of the 2002 Regulations provides that decisions about which services should be commissioned to meet the healthcare needs of local patients and from whom those services should be commissioned lie in the first instance with the local NHS Commissioner. In this case Lewisham PCT has the power to make decisions how NHS services for local people should be commissioned.



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56. The Department of Health has published Guidance Principles and Rules for Co-operation and Competition. This is Guidance to which all commissioners are required to have regard when discharging their responsibilities. The first principle in the Guidance is that **[C4]**:

> 'Commissioners must commission services from providers who are best placed to deliver the needs of their patients and populations having regard to their overall present and future needs and the sustainability of services'

57. The Guidance therefore gives PCTs a wide margin of discretion to determine the services that local NHS providers should be commissioned to provide as part of NHS funded treatment. Discretionary decision making to decide what services should be commissioned thus lies with local NHS commissioners who are best placed to determine the shape of local acute services needed to meet the needs of patients and populations.

58. The Secretary of State has an appellate or review role to make decisions about local configuration of NHS services only where a referral is made to the Secretary of State by the local authority Health Overview and Scrutiny Committee which is objecting to a proposed reconfiguration of local NHS services. See the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. If such a referral is made the practice of the Secretary of State is to seek advice on the proposals from the Reconfiguration Panel.

59. The Claimant accepts that the Secretary of State has a reserve power to impose decisions on local NHS bodies by way of Directions under section 8 of the NHS Act 2006. This power has not been exercised in the present case, nor could it have been to implement the decision in question. In any event the terms of the recommendations are too wide-ranging, imprecise, and unspecific to have formed the basis of a lawful direction.



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60. The scheme of devolved decision making within the NHS means that, unless the Secretary of State is given a decision making power by statute or by Regulations:

(i) decisions about the services to be commissioned as part of the local NHS are matters exclusively for local NHS commissioners; and

(ii) decisions about what services should be provided by an NHS Trust are for the Board of that NHS Trust.

61. It follows that the Secretary of State does not retain a residual decision making power to decide which services should be commissioned as part of NHS funded treatment. This decision making power has been delegated to PCTs to exercise and it would be inconsistent with that delegation for the Secretary of State to retain a primary decision making power. See *Blackpool Corporation v. Locker* [1948] 1KB 249 and *Department for Environment Food and Rural Affairs v. Robertson and others* [2004] ICR 1289. Further decisions about which services should be provided by a local NHS Trust are matters exclusively for the Board of an NHS Trust (unless the Secretary of State makes Directions to direct the Board to act in a certain way).

62. It also follows that the promise made by the Secretary of State that the appointment of the TSA would not lead to a "*back-door reconfiguration*" was a promise that local decision making about the configuration of local NHS services in South East London to be provided by NHS bodies other than the Trust which was the subject of the TSA process (and possibly including the services provided by that Trust) would remain matters to be decided locally.

63. The decisions that the Secretary of State took amounted to a reconfiguration of local NHS services in South East London, as the Secretary of State accepted when presenting his statement to Parliament.



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64. It follows that the Secretary of State acted in clear breach of his promise that the decisions taken following the TSA process would not be a "back-door reconfiguration".

65. Having made the promise that the TSA process would not be a "back-door reconfiguration", the Secretary of State is required as a matter of public law to abide by his promise unless there are overwhelming reasons of public policy to permit him to depart from his promise. There are no such overwhelming reasons of public policy because the vast majority of the financial savings proposed by the TSA relate to matters concerning the internal arrangement of services at SLHT and do not arise in relation to the wider configuration of services that was proposed by the TSA.

**Ground 3: The Secretary of State breached his own rules and/or breached a legitimate expectation regarding reconfiguration of NHS Services.**

66. The Coalition Government published "rules on reconfiguration" in July 2010 which were set out in the Amended NHS Operating Framework published by the Chief Executive of the NHS, Sir David Nicholson, shortly after the 2010 General Election. The 2010 NHS Operating Framework[7] provided that "current and future reconfiguration proposals must meet four new tests before they can proceed" – see paragraph 15 of the Operating Framework **[B8]**.

67. The four tests were described as follows:

- *support from GP commissioners;*

[7] See http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_116860.pdf



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- *strengthened public and patient engagement;*

- *clarity on the clinical evidence base; and*

- *consistency with current and prospective patient choice.*

68. Speaking in parliament on 27 November 2012 the Secretary of State gave further assurance that a reconfiguration of local services would not be approved by him arising out of the TSA process unless the above 4 tests were all satisfied. He said:

> "The Coalition Government have introduced four tests, which were not used by the previous Government. Those tests state that we will not impose closures of A and E and maternity units unless there is local clinical support, and evidence that it will benefit local people and improve patient choice. The tests exist to provide precisely the safeguards about which the hon. Gentleman is concerned"

69. This clear statement of policy gives rise to a legitimate expectation to persons affected that NHS acute services will not be reconfigured unless each of the above tests is met, and in particular that local services would not be changed without the support of local NHS commissioners.

70. In the present case the Secretary of State has confirmed in Parliament that the decision under challenge is a 'reconfiguration' and has asserted that the above tests were met for this decision. Specifically, in his statement on 31st January 2013 the Secretary of State said:

> "I believe the amended proposals meet the four tests required for local reconfigurations"

**Ground 3A: The support of local commissioners.**



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71. Notwithstanding the statement of the Secretary of State, it is clear that the local commissioners for NHS services in Lewisham, which for these purposes is Lewisham PCT (acting through its committee the CCG), have not consented to the proposals for service reconfiguration for the population of NHS patients served by the CCG in Lewisham.

72. The Secretary of State has also wrongly claimed that 5 out of the 6 CCGs supported the proposals. It is clear that the other CCGs did not give their support to these changes because:-

i. the responses to consultation contained a number of serious reservations about the proposed changes at Lewisham Hospital. By way of example, Bexley CCG sent a letter to the TSA on Friday 25th January 2013 from the CCG which noted "*widespread concern at the proposed reduction in A & E capacity in south-east London, specifically the closure of Lewisham A & E*". Neither this nor the approach of Southwark CCG who stated:

> 'Notwithstanding support for the reduction in the number of emergency sites NHS Southwark CCG does have concerns about the impact of the closure of Lewisham A & E on other Emergency Departments across South East London, most particularly at KCH, where there is already high demand for emergency care and some straights on capacity. The CCG would wish to see more detailed modelling of the impact of the closure of Lewisham A & E on KCH A & E attendance and admission rates, and had detail on what emergency capacity at KCH will be following the three-year implementation period".

can be characterised as 'supportive'.



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ii. The proposals on Accident and Emergency care were substantially changed following the intervention of the Medical Director of the NHS, Sir Bruce Keogh, in the days before the Secretary of State's decision. Views on the changes to the TSA plan proposed by Sir Bruce Keogh were not obtained from either Lewisham CCG or the other CCGs about the new proposed arrangements for A & E services at Lewisham before the Secretary of State made his decision.

iii. There was no proper consultation about the intended changes to paediatric services at Lewisham because the effect on paediatric services of the changes that the TSA was proposing was omitted from the TSA's draft report. Accordingly the CCGs were not invited to respond concerning the effect of the proposed changes on paediatric services at University Hospital Lewisham and did not do so.

iv. There was no consultation about a proposed midwife led maternity unit at Lewisham because this was specifically excluded from the proposals upon which responses were invited as part of the TSA's consultation. The final decision made by the Secretary of State is to the effect that Lewisham should have a midwife led maternity unit even though this was not included in any consultation. It follows that the other CCGs cannot be said to have expressed support for this proposal.

73. Moreover, regardless of the position taken by other CCGs, the CCG with primary responsibility for commissioning services at Lewisham Hospital is the Lewisham CCG. The Claimant understands that 70% of the activity at



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Lewisham is provided to patients served by Lewisham PCT (now the CCG). Having delegated the discretion to the CCG, the Secretary of State's decision unlawfully usurps the discretion conferred about where to commission acute care for its residents.

**Ground 3B: The requirement of strengthened public and patient engagement.**

74. The second test adopted by the Secretary of State was that there should be strengthened public and patient engagement before any reconfiguration decision was made. The Claimant accepts that the TSA undertook a measure of consultation in Lewisham. However the consultation in this case occurred prior to the preparation by the TSA of the final report which went to the Secretary of State. This consultation was defective and incomplete. The following are given by way of example. The Claimant will provide further examples in the evidence to be given in this matter:

(i) There was a complete failure to identify paediatric care as an area which would be affected by the changes at Lewisham Hospital in the TSA original draft report (and thus the failure to consult widely on the implications for care for children, 20% of the population).

(ii) The TSA refused to permit consultation on a midwife led maternity unit (ruling it out on the grounds of being financially unsustainable) even though this was proposed in the final report. This proposal has therefore never been put out to consultation.

75. In these areas the proposals eventually adopted went far beyond what could be called "modifications" of the original proposals consulted on. As a



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result, as a matter of fairness, there was a need to re-consult on the new proposals before the decisions could be taken. The consultation was legally flawed and could not therefore constitute strengthened public and patient involvement.

76. It follows that:

(i) Even if this had been a proposed reconfiguration proposed by the local NHS, there would have been a need for further consultation in accordance with the principles set out in *R (on the application of Smith) v East Kent Hospital NHS Trust & Anor* [2002] EWHC 2640 (Admin); and

(ii) This state of affairs cannot satisfy the enhanced promise of consultation with local people set out in the promises made in the NHS Operating Framework.

**Ground 3C: The requirement of clarity on the clinical evidence base.**

77. The third test adopted by the Secretary of State was that there should be clarity on the clinical evidence base before any reconfiguration decision was made. The process adopted by the TSA and the further process adopted by the Secretary of State resulted in a distinct lack of clarity concerning the evidence base to support the final shape of acute NHS services for South East London.

78. Changes to one set of acute services as part of a reconfiguration inevitably affect the other services that a Trust is able to provide in a clinically appropriate manner. This "knock-on" effect is well recognised within the NHS and thus any reconfiguration needs to have a clear evidence base to support all of the changes before any decisions are made. If there is no



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clear evidence base one set of changes will have unintended consequences by adversely affecting a hospital's ability to continue to deliver other services. This was shown in the present case because the original proposals from the TSA for the removal of A & E services at Lewisham had consequences for paediatric services which did not appear to have been properly thought through by the TSA.

79. This assurance was also important because removing services at one hospital inevitably diverts patients who are in need of services to a different hospital. The need for clarity about the evidence base to support changes to acute services focuses the mind of those proposing changes to ensure that the hospitals who will receive the additional patient flows have the clinical capacity to undertake the additional work in a way that is safe and sustainable.

80. Finally the need for clarity on the evidence base is important for proper planning of services. In this case, for example, the Secretary of State's decision about the extent of changes to the Accident and Emergency Department at Lewisham Hospital was varied after the intervention of Sir Bruce Keogh. The Secretary of State announced in parliament that this would result in 75% of A & E patients continuing to be able to access services at Lewisham Hospital. He said:

> "To better serve those patients, who will often be frail and elderly, and would arrive by non-blue light ambulances, Sir Bruce recommends that Lewisham hospital should retain a smaller A and E service with 24/7 senior emergency medical cover. With these additional clinical safeguards and the impact that this is likely to have on patient and clinician behaviour, Sir Bruce estimates that the new service could continue to see up to three quarters of those currently attending Lewisham A and E"

81. The effect of the changes would be very different if that "estimate" of 75% proved to be incorrect (and there was no clinical data to support it as far as



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the Claimant is aware). The promise made by the Secretary of State was designed to ensure that substantial changes to local services were not made on the basis of "estimates" but only where there was a clear basis grounded in clinical evidence to support the proposals.

82. There is also no clarity about the evidence base to support the midwife led maternity service at Lewisham because this has not been the subject of consultation and only appears to have been introduced at a very late stage.

83. Further no or no proper regard appears to have been given to the risks of breaking up the networks built between GPs, Social Care, Community health services and Lewisham Hospital. The TSA and the Secretary of State failed to recognise that reconstructing these links in Greenwich would be a lengthy task with no guarantee of success. This factor was part of the clinical evidence base for the proposals that ought to have been taken into account.

84. The promise by the Secretary of State that there would be clarity on the clinical evidence base to support changes before decisions were made ought to have :

    (a) Provided assurance that <u>all</u> of the clinical consequences of the proposed changes had been properly thought through before any decisions were made;

    (b) Ensured that there was sufficient capacity in the NHS to absorb the patient flows generated by the changes and thereby answering concerned questions from several CCGs and other responders to the TSA ; and

    (c) Ensured that there would be no unintended consequences arising from the proposed changes.



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85. In this case the Secretary of State acted in breach of his promise that there would be clarity concerning the clinical evidence base before decisions were taken because:

i. Changes to the plans for maternity and the configuration of A & E services which have been proposed at a very late stage by Professor Keogh. No evidence has been disclosed to explain how the model proposed by Professor Keogh would operate and there was no clarity of the evidence base to support this model of care;

ii. The statement made by the Secretary of State to the House confirmed that, at this stage, there was no clarity about how paediatric services would change. These were all supposed to be matters for future decisions. However the range of options open to a future decision maker would be severely constrained because of other matters where the Secretary of State had purported to make binding decisions; and

iii. There was no clarity around the evidence base to support the changes to maternity services.

86. Accordingly the Secretary of State acted unlawfully in breaching his promise that there would be clarity about the evidence base before final decisions would be taken about a reconfiguration.

**Ground 3D: The requirement that the decision is consistent with current and prospective patient choice.**

*87.* The fourth test adopted by the Secretary of State was that there should be *"consistency with current and prospective patient choice"* in any



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reconfiguration. This also was not met in respect of the decisions under challenge.

88. Patients in Lewisham have made it clear in response to consultation to the TSA that they want to access maternity and paediatric services at Lewisham Hospital. Public opinion in Lewisham is also very strongly supportive of the provision of A & E services at Lewisham Hospital. Lewisham Hospital's high quality Care of the Elderly Service is also under threat. It very substantially frustrates that patient choice to remove or downgrade these services. The Secretary of State cannot have considered, on proper analysis, that removing these services was consistent with current and prospective patient choice.

**Ground 4: Consultation was inadequate and/or there is a need for further consultation**

89. In any event, and having regard to the published criteria for reconfiguration proposals (summarised above) there was a failure to ensure proper public and patient engagement with the proposal through adequate consultation.

90. The consultation which has been undertaken by the TSA is inadequate because there is a fundamental difference between the proposals consulted on and those which the Secretary of State now wishes to adopt. Specifically:

    (i) There was a complete failure to identify paediatric are as an area which would be affected by the changes at Lewisham in the TSA draft report, with the consequence that there was a total failure to consult widely on the implications for the care of children.



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(ii) The TSA refused to permit consultation on a midwife led maternity unit even though this was proposed in the final report. This proposal has therefore never been put out to consultation.

(iii) The recommendations adopted go well beyond the proposals consulted on. As a matter of fairness there was a need to re-consult on the new proposals before the decisions could be taken – see *R(Devon County Council) v. Secretary of State for Communities and Local Government* [2010] EWHC 1456 (Admin).

91. It follows that:

i. even if this had been a proposed reconfiguration put forward by the local NHS, there would have been a need for further consultation in accordance with the principles set out in *R(Smith) v. East Kent Hospital NHS Trust and Anor.* [2002] EWHC 2640; and

ii. the current state of affairs cannot satisfy the enhanced promise of consultation with local people set out in the promises made in the NHS Operating Framework.

**Summary**

92. In summary, the decision of the Secretary of State to impose changes to Lewisham hospital is:

(i) *ultra vires* s.61K of the Act

(ii) not authorised or justified by any residual general powers under the NHS Act 2006 or otherwise



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(iii) if *intra vires*; then made in breach of a legitimate expectation based on clear and unequivocal statements:

(iv) that there would be no 'backdoor' reconfiguration, and

(v) no reconfiguration without the four tests in the Operating Framework being satisfied.

**Details of Relief Sought and any interim remedy/applications for other orders**

93. The Claimant seeks the following directions:

1. A protective costs order capping its adverse liability in costs to £15,000.
2. Consolidation of this claim with that brought by Lewisham Council under case no CO/2744/2013
3. That the Secretary of State and TSA lodge detailed grounds of resistance and any evidence in support within 28 days of service of this claim form.
4. That the Claimant do serve any evidence in reply and its skeleton argument no later than 7 days after the date after the date on which the detailed grounds and evidence of the Secretary of State and the TSA are served on it
5. The Secretary of State and TSA must serve their skeleton argument no later than 7 days after the date of service on them of the Claimant's evidence and skeleton argument.
6. The claim to be listed in accordance with Counsel's availability on the first open date after 7th May



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2013 for an expedited hearing at which the application for permission to apply for judicial review, and if permission is granted the substantive application will be heard with a time estimate of 1 day.

7. Liberty to apply.

94. By way of final orders the Claimant seeks:

i. a quashing of the decision of the Defendant dated 31st January 2013 (and of the recommendations of the TSA in its report of 8th January 2013)

ii. such further or other order (including declaratory relief) as the Court thinks just

iii. costs

**DAVID LOCK Q.C.**

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