Neutral Citation Number: [2021] EWHC 928 (Admin)

Case No: CO/3239/2020

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/04/2021

Before:

MR JUSTICE LINDEN

- -

Between:

The Queen (on the application of JAYNE DAWSON)	**Claimant**
- and -	
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	**Defendant**

- -
- -

Mr Vikram Sachdeva QC, Ms Catherine Dobson and Ms Clara Benn (instructed by **Irwin Mitchell LLP**) for the Claimant
Ms Fenella Morris QC and Mr Peter Mant (instructed by **Capsticks**) for the Defendant

Hearing date: 4 March 2021

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Approved Judgment

Covid-19 Protocol: This judgment was handed down remotely by circulation to the parties' representatives by email, release to BAILII and publication on the Courts and Tribunals Judiciary website. The date and time for hand-down is deemed to be 2.00pm on 16th April 2021

Mr Justice Linden:

Introduction

1. As is well known, in the first, "Manage", phase of the government's response to the Covid-19 pandemic, in early 2020, NHS care providers were obliged to give priority to the treatment of Covid-19 patients. There was also a fall in patients attending hospitals for non Covid-19 related treatment because they were shielding or, it was thought, they were fearful of infection with Covid-19 whilst at hospital.

2. On 29 April 2020, at the beginning of the government's second, "Restore", phase of its response to the pandemic, NHS England and NHS Improvement ("NHSEI") therefore issued a letter to all NHS care providers. This required that NHS Trusts "step up" non Covid-19 urgent services as soon as possible over the following six weeks, and work across local systems and regional teams over the next 10 days to make judgements about whether there was further capacity for at least some routine non-urgent elective care.

3. In response to this letter, on 11 June 2020, the Defendant Trust decided to designate Grantham and District Hospital ("the Hospital") a Covid-19 free "Green" site from 22 June 2020 until at least 31 March 2021. In broad terms, this meant that there would be no Covid-19 related treatment on the site. There would be an increase in elective treatment and chemotherapy at the Hospital, and cancer and other elective surgery would be transferred to the Hospital from other hospitals in Lincolnshire. There would also be increased capacity for urgent diagnostics.

4. In order to minimise the risk of Covid-19 infection of patients using these services, it was decided that all patients would be required to have a known Covid-19 status on admission. Unplanned admissions and certain other outpatient services would be transferred to other hospitals and locations in the area. It was therefore necessary to replace the existing Accident & Emergency ("A&E") department with a walk-in Urgent Treatment Centre ("UTC") located in a separate part of the site in order to minimise the risk of Covid-19 infection as a result of frequent and unpredictable footfall. The UTC would deal with minor ailments and injuries, but those with more serious injuries or conditions would need to travel to one of the other hospitals in Lincolnshire.

5. The Decision was to be subject to quarterly reviews. These reviews have taken place and the Hospital remained a Green site at the time of the hearing which I conducted, albeit modifications had been made to the model in the light of experience of how it worked. At the time of the hearing, there was also to be a decision by the Trust, which was scheduled for 16 March 2021, as to whether the Hospital would remain a Green site. At the time of writing, I do not know the outcome of that decision.

6. Although alternative provision was made, the Decision has caused significant inconvenience to certain users of the services of the Hospital, including the Claimant. In addition to the closure of the A&E department, a variety of outpatient services were no longer to be provided on site, and two wards of general medical beds (i.e. approximately 70 beds) were no longer to be available. It was estimated that although the majority of the patients who attended the A&E department each year would be able to make use of the UTC, 4600 (19%) would now have to be treated at other hospitals. Around 870 patients who attended the UTC would require admission and be transferred

to another site and 1,198 would no longer be able to make use of beds at the Hospital which were to be withdrawn.

7. I am told that many of the users of the Hospital are vulnerable or elderly and many are not well off and do not have cars. To illustrate the sorts of difficulties which the Decision has caused, the Claimant is aged 54. She suffers from spina bifida and hydrocephalus and uses a wheelchair. The shunt implanted for her hydrocephalus means that at any time she may need emergency surgery, as she has done in the past. She also has osteomyelitis in her leg, leading to frequent infections in her shin bone. She is in acute pain, and the effect of the Decision was that she had to travel 27 miles each way to Boston rather than 7 miles each way to Grantham for consultant appointments.

The issues in the Claim

8. At an oral hearing on 3 December 2020, Collins-Rice J gave permission to the Claimant to argue two grounds, namely that:

   i) In coming to its decision, the Defendant breached section 242(1B)(b) and (c) of the National Health Service Act 2006 by failing to make arrangements which secured that service users were involved (a) in the development and consideration of the proposals for the designation of the Hospital as a Green site and (b) in the making of the Decision itself ("**Ground 1**");

   ii) The Decision was irrational or disclosed an improper purpose or was insufficiently reasoned. In the event, before me the challenge on Ground 2 was limited to a complaint that the Decision was inadequately reasoned which, it was said, *"gives rise to the inference that the decision was irrational and/or was taken for an improper purpose"*. ("**Ground 2**")

9. Permission was refused in respect of a proposed claim against NHS Lincolnshire Clinical Commissioning Group.

10. The Claimant's case is that the Decision had a significant impact on service users. Her principal complaint is that, she argues, service users could and should have been involved in the process which led to the Decision from 12 May 2020, or 22 May 2020 at the latest, whereas the proposal which led to the Decision was not announced to the public until a press release at 3pm on 8 June 2020. The Decision was then taken at a live streamed meeting of the Trust Board on 11 June 2020 at which 30 minutes were allocated to answer written questions submitted in advance by the public. The Claimant says that the duty, under section 242(1B) of the 2006 Act, to involve service users in decision making of this nature is important and yet it appears to have been overlooked by the Defendant. Whether or not as a result of it being overlooked, the arrangements made by the Defendant were wholly inadequate for the purposes of section 242(1B). She and others also suspect that the Trust's approach was influenced by a longstanding agenda to close the A&E department at the Hospital. Whereas initially the Claimant sought to quash the Decision, pragmatically given that things have moved on, she now confines the relief which she seeks to declaratory relief.

11. The Trust denies both Grounds. It says that it was aware of its obligations under section 242 of the 2006 Act and it complied with them. The pandemic made extraordinary

demands on Trust personnel. The deadline for responding to the 29 April 2020 NHSEI letter was a tight one and it was not feasible or appropriate to do more to involve the public in the decision making process given that the Trust's proposed response to that letter was undergoing a constant process of modification and might not have gone ahead. Service users were involved at the earliest practical opportunity, and the arrangements which were made were adequate in the circumstances given, also, the temporary nature of the decision, the fact that it was to be kept under review and the fact that service users had the opportunity to express their views after the Decision had been taken and implemented. There was no agenda other than to respond to the NHSEI letter of 29 April 2020.

12. The Trust also argues that the Claim is academic given that the arrangements at the Hospital have been modified since 11 June 2020 and there have been opportunities for service users to comment on the Green site model since then. It was said that the decision on 16 March 2021 was likely to change the landscape further. The questions raised by the Claim therefore relate to the circumstances, and the Trust's actions, leading up to 11 June 2020 and are no longer of any consequence. Moreover, submits the Trust, relief should in any event be refused on the grounds that greater involvement of service users would not have substantially altered the outcome.

The Hearing.

13. The hearing took place over Microsoft Teams but was a public hearing. Mr Vikram Sachdeva QC, Ms Catherine Dobson and Ms Clara Benn appeared for the Claimant. Ms Fenella Morris QC and Mr Peter Mant appeared for the Trust.

14. The Claimant supported her case with a witness statement dated 14 August 2020, and there were statements from three other service users who gave evidence of how they were affected by the Decision. There were also witness statements from a member of staff at the Hospital and the chair of the SOS Grantham Hospital campaign group, Ms Charmaine Morgan, who is also a District Councillor on South Kesteven District Council.

15. Mr Andrew Morgan, the Chief Executive of the Trust, provided three witness statements, dated 2 October 2020, 24 December 2020 and 17 February 2021 respectively, in support of the Defendant's case. There was also a witness statement from Mr Turner, the Chief Executive and Accountable Officer of NHS Lincolnshire Clinical Commissioning Group, dated 2 October 2020.

The facts in more detail.

Background

16. The Trust provides hospital and community services across Lincolnshire. It has four hospital sites which serve their respective local areas: Lincoln County Hospital, Grantham and District Hospital, Pilgrim Hospital in Boston and County Hospital in Louth.

17. Part of the background is that for a number of years there have been issues in relation to the continuation of the A&E department and certain other services at the Hospital. Over the years, SOS Grantham Hospital and others have campaigned against proposed

changes to services and, indeed, for the reversal of certain changes which have been made. It is not necessary to explore the detail, but it is said on behalf of the Claimant that there were particular flashpoints in 2006/2007, 2013, 2016 and 2017. In 2019 NHS Lincolnshire Clinical Commissioning Group began a review of all health services across Lincolnshire, which included an Acute Services Review, and it is said that those who are conducting it favour closure of the A&E department at the Hospital and its replacement with an UTC which would deal with minor injuries.

18. At the time of the Decision the Trust was aware that it might be perceived as part of an agenda or, at least, that the Decision would be controversial. A *"ULHT 'Green' site communications and engagement plan"*, which is undated but appears to have been created by the Trust shortly before the Decision, states in the *"Background"* section:

> *"The proposal around a 'Green' site for Grantham and District Hospital carries with it some history, which needs to be borne in mind in handling all communications and engagement activity on this subject.*
>
> *In August 2016, the decision was made to alter the opening hours of the A&E department at Grantham hospital, from 24 hours a day to opening only between 8am and 6.30pm.*
>
> *This temporary change, made as a result of severe staffing shortages which resulted in patient safety concerns, was the subject of extensive staff and public engagement.*
>
> *Following that, the local population of Grantham have been keen to establish the long-term future of the A&E service, calling in particular for a 24 hour provision to be re-instated.*
>
> *Relationships with the local population have at times been strained, as a result of a 'temporary' change extending over more than three years, a perceived disadvantage for the population of Grantham compared to other parts of Lincolnshire and tension with local campaign groups. This includes the previous decision being referred to Judicial Review, and therefore any changes without adequate engagement or consultation will be heavily scrutinised with a risk of this being repeated."*

My approach to the invitation to draw inferences

19. In view of the factual issues between the parties, it is necessary to look at the chronology of the Defendant's decision-making process in some detail. The issues in relation to this chronology are whether it would have been feasible to involve service users at an earlier stage, what arrangements were made, and why the Defendant took the approach which it did. My task has been hampered by the lack of detailed evidence from the Trust on a number of points and a lack of contemporaneous documents, despite various requests for disclosure being made on behalf of the Claimant. Mr Sachdeva accepts that the Trust has complied with its duty of candour, and my comments below should be seen in this context, but it goes without saying that ultimately, I have had to work with the evidence which was presented.

The process which led to the Decision

20. As is well known, on 30 January 2020 a Level 4 National Incident was declared in relation to the Covid-19 pandemic. As a result, decision-making in respect of health services became subject to national direction from NHSEI through a "command and control" structure. Under this structure, a team of three executive directors at the Trust, known as "Gold Command", were responsible for leading the Trust's response to the pandemic although little detail is given in the evidence as to the precise scope of their authority.

21. On 17th March 2020, NHSEI wrote to all NHS Chief Executives and Accountable Officers warning that the NHS would come under intense pressure at the peak of the outbreak and instructing Trusts and clinical commissioning groups to maximise their inpatient and critical care capacity. This was to be achieved by, amongst other things, the postponement of all non-urgent elective operations, from 15 April 2020 at the latest, for a period of at least three months. Acting on this letter, the Trust urgently took various steps to prioritise care for Covid-19 patients, including reductions in face to face outpatient appointments and routine elective inpatient services. Non-urgent elective services and routine diagnostics were stopped and treatment for some patients on the cancer pathway was delayed.

22. On 18 March 2020, NHSEI issued guidance on *"Good practice for working with people and communities during the Covid-19 outbreak"* ("the 18 March guidance"). The status of this guidance was said to be good practice advice rather than formal or statutory guidance – *"existing statutory guidance still stands."*. The 18 March guidance included the following passage which appears to have influenced the Trust's approach to the involvement of service users, although there appear to have been other influences, as will be seem below:

> *Q: What if we need to take an urgent decision during the outbreak?*
>
> *A: At the time of writing, the NHS duty to involve the public is unaffected by the outbreak or any emergency legislation. However, where there is a genuine and pressing need to make a decision about, or a change to, services to protect the health, safety of welfare of patients or staff, then the NHS duty to involve the public may be met by very limited public involvement. At the very least changes to services should be announced to the public at the earliest reasonable opportunity."* (emphasis added)

23. The passage continued:

> *"In such circumstances, you are not required to consult your local overview and scrutiny committee prior to taking the decision (but you should still promptly notify the committee of the decision taken and why no consultation has taken place).*
>
> *However, this approach should be used only when necessary and it is likely that regular engagement with patients, staff and other stakeholders will be essential for practical reasons in any event (for example so that patients understand how to access services). It remains important to liaise with your overview and scrutiny committee, local Healthwatch and other key stakeholders, ideally before taking the decision, where possible. Remember too that you may need to carry out further engagement in future if it is intended that temporary changes will become permanent."*

24. I note that this advice was given during the first, rather than the second, phase of the response to the pandemic. In context, it was about the need to take urgent decisions to deal with rapidly rising admissions of patients with Covid-19 infections. What was therefore being addressed was the need to take urgent short-term decisions so as to be able to treat and protect large numbers of acutely ill patients.

25. As noted above, there was then the NHSEI letter of 29 April 2020. This stated that the pandemic continued to be a Level 4 National Incident, and that NHS bodies therefore needed to retain the ability quickly to repurpose and to have 'surge' capacity locally and regionally, should this be needed again. But NHS providers were now required to step up non Covid-19 urgent care over the next six weeks and to consider with partners whether there was additional capacity for non-urgent elective care. An annex to the 29 April letter set out recommended actions. These included providing urgent outpatient and diagnostic appointments, and urgent and time-critical surgery and non-surgical procedures, at pre Covid-19 levels of capacity, as well as ensuring that cancer referrals, diagnostics and treatment were brought back to pre-pandemic levels at the earliest opportunity so as to minimise potential harm to patients, and to reduce the scale of the post-pandemic surge in demand.

26. Between 29 April and 10 May 2020 operational teams at the Trust explored options for the establishment of Green – i.e. Covid-19 free - sites and Green pathways, looking at the four Trust sites as well as local private sector hospitals. No contemporaneous documents in relation to this aspect of the Trust's activity during this period have been disclosed and no more detail than this is provided by Mr Morgan in his witness statements.

27. On 10 May 2020, proposals were presented to an internal Gold Command meeting. The paper set out three options, namely:

    i) converting the Hospital to an entirely Green site i.e. establishing a site that would undertake planned and elective care in a setting that minimised the risk of cross contamination of Covid-19;

    ii) creating a Green pathway at the Hospital i.e. there would be "Green" non Covid-19 related care in a setting that minimised the risk of cross contamination of Covid-19, as well as "Blue" Covid-19 related activity on the same site; and

    iii) converting the Manthorpe Centre into an UTC so that there would be no direct admissions to the Hospital. The Manthorpe Centre is a facility on the Grantham site that is owned and run by Lincolnshire Partnership NHS Foundation Trust. It normally provides in-patient and community mental health services to older adults and it was capable of being effectively isolated from the rest of the site so as to minimise the risk of Covid-19 infection.

28. The impact of the Green site option on service users appears to have been well appreciated at this stage, as the paper states that:

> *"To create a full Green Site at Grantham, this would require considerable reorganisation of services and the closure of emergency care. Much of the site may be rendered redundant for a period of time."*

29. It was also recognised that a move to a Green site model at the Hospital would be potentially controversial. Under the heading *"Risks/Issues"* in relation to this option the first bullet point was:

    - *"Political pressure – withdrawal of emergency care at Grantham Hospital".*

30. The Divisional Recommendation at the end of the paper was a two-stage approach whereby the Trust would initially establish a Green pathway at the Hospital to support early delivery of elective activity, whilst working towards a full Green site. According to paragraph 11 of Mr Morgan's first witness statement, at the 10 May 2020 meeting Gold Command encouraged the Divisional teams to explore further options to deliver a Green site whilst maintaining a UTC. However, no documentary evidence in relation to this meeting has been provided by the Trust.

31. Nor has any evidence of consideration, at this stage, of changes at any site other than Grantham been disclosed. The reader of the 10 May 2020 paper also gains the clear impression that the Trust's discussion about the response to the 29 April 2020 NHSEI letter was now focussed on the Hospital, which was seen as where any Green site or Green pathway model would be introduced. The effect of Mr Morgan's own evidence, read in the context of this paper and the 12 May 2020 paper and other evidence, which I will consider below, is that on 10 May 2020 Divisional teams were not asked to explore options for the introduction of Green site or pathway models at other sites. Nor is there any evidence that they did so.

32. On 12 May 2020, the Green site proposal was updated in a paper entitled *"To scope the delivery of implementing a Green Site with a UTC at Grantham to deliver the 'Restore' Element of Elective Surgery"*. As Mr Morgan puts it at paragraph 11 of his first witness statement:

    > *"Under the revised proposals, [the Defendant] would establish Grantham as a Green site and convert the Accident and Emergency Department into an Urgent Treatment Centre (UTC) that would include a Blue pathway. At that point, the aim was to go live on 1st June 2020 in recognition of the importance of restoring elective surgical capacity as soon as possible. However, a number of preparatory steps were identified, including obtaining Board approval for the arrangements, and developing and implementing a robust communications strategy in respect of the proposed changes"* (emphasis added)

33. The 12 May 2020 paper set out the steps which would need to be taken as part of the proposal. These included:

    - *"Cease ALL activity for all non-confirmed 'Green' Patients. Green being a confirmed negative swab within last 48 hours...*
    - *Cease all non-elective medical or surgical admissions*
    - *Conversion of current A&E (8am – 8pm) to a 24/7 UTC*

- *Create a site wide 'Green' workforce including Radiology, Nursing, Estates & Maintenance, Housekeeping, Administration, Allied Health Professional, Pathology, and Transport etc.*
- *Deliver a Green Outpatient model*
- *Deliver a Green diagnostic pathway*
- *Ante-natal Services to be relocated into a community setting*
- *Community Midwifery and Nursing to have a dedicated pick up area for supplies that does not jeopardise the green site.*
- *The withdrawal of all non-essential services, staff and departments from Grantham hospital…"*

34. Under the heading *"GO LIVE 1st June 2020"* the paper also set out a number of steps which would need to be taken as part of the decision-making process including *"Approval to proceed today (12/5/2020)?"*, obtaining Board approval, establishing a Task and Finish Group, *"Robust Workforce Strategy"* and *"Robust Communications Strategy"*. These entries reinforce the impression that the essentials of the Green site proposal were now in place and that what remained was to work out the detail, to secure approval and to prepare the Hospital for the changes which were to occur. The timescales indicate that there was every intention that the proposal would go ahead.

35. The paper explained the critical role of the communications strategy in delivering to the 1 June 2020 date: *"We also anticipate the need for positive reactive communications input as this message is first shared."* A dedicated communications lead, and the development of a three-stream communications programme, were therefore proposed. The public and staff were two of the streams and the third was partners and neighbouring acute care providers.

36. In the section of the paper on *"Risks and Benefits"* the first two risks identified were *"Political and Community Pressure"* and *"Engagement and Communication"*. This is further evidence that the Trust had well in mind that the proposed changes would be controversial.

37. At paragraph of 12 his first witness statement, Mr Morgan explains that the Defendant recognised that *"communications would be crucial to the successful delivery of the proposed changes"*. His references to the changes being *"revised proposals"* and *"proposed"* at this stage appear to be consistent with the contents of the paper as a whole and with the following entry in the Defendant's Action Log in relation to an event on 12 May 2020 at 5.15pm:

> *"Gold Command gave approval to proceed to the next level of detail for Green/blue site."*

38. Mr Morgan does not actually deal with what happened at the Gold Command meeting on 12 May 2020 and, other than the Action Log, no minute or other notes of the meeting and decision of Gold Command that day have been disclosed. I also note that the 12 May 2020 paper does not consider any option other than the proposal for a Green site

at the Hospital. Mr Sachdeva submits that this reflects the reality that, from this date, this was the only option under consideration by the Trust. At paragraph 35 of her skeleton argument, Ms Morris states that this is:

> *"wrong…The fact that a "green site" may have been identified as the recommended option at divisional level did not mean that other options had been ruled out. The full options appraisal had not, at this stage, been presented to the Gold Command or the Board, and no formal decisions had been made."*

39. However, she does not point to any evidence of other options being considered or developed after this point. I deal with the options appraisal below.

40. Although the issue is clearly raised in the Statement of Facts and Grounds (see e.g. paragraph 70(g)), Mr Morgan does not deal in any detail at all with what happened between 12 May and 2 June 2020 in any of his witness statements. At paragraph 13 of his first witness statement, he says that:

> *"Over the subsequent weeks, [the Defendant] continued to develop its plans for implementing a green site and a UTC at Grantham."* (emphasis added)

41. At Paragraph 16 of his second witness statement he also refers to *"the work on developing that option being ongoing"* during the period from 10 May 2020.

42. These passages strongly support Mr Sachdeva's submission that, from 12 May 2020 at the latest, the Trust was working on a particular plan rather than assessing different options. So does Mr Sachdeva's analysis, from the documents, of the events from 12 May 2020 to 2 June 2020 about which Mr Morgan has little or nothing to say. This analysis starts with the Action Log, the entries in which through to 11 June 2020 relate only to the Green site plan at the Hospital.

43. On 14 May 2020 a Task and Finish Group with programme support from KPMG was established to progress through to a *"Go live date"* of 1 June 2020.

44. It appears that, on 18 May 2020, the executive team of the Trust then briefed key stakeholders involved in developing the model including NHSEI and the NHS Lincolnshire Clinical Commissioning Group. According to the Action Log, it was also *"decided it would be helpful to share the green site model with Staff Side"* representatives at their weekly update meeting on 21 May 2020. Understandably, Mr Sachdeva asks: if the proposal or model was sufficiently detailed, and likely to come to fruition, to brief the Staff Side, why was it not feasible to comply with section 242(1B) of the 2006 Act at this stage, if not earlier? No answer to this question is supplied by Mr Morgan.

45. On 20 May 2020, an update paper was presented to Gold Command. Again, there is no evidence about what was discussed or decided at this meeting other than some entries in the Action Log. Mr Morgan does not refer to this meeting at all. The paper set out the *"programme governance structure"* including five individuals from KPMG, a *"programme overview"* and the various *"programme workstreams"*, with their designated leads. One of these workstreams was *"Communications"* and its designated lead was a Ms Anna Richards, she having been nominated on 12 May 2020. The *"programme"* referred to appears to have been the proposal of 12 May 2020 and I agree

with Mr Sachdeva that there is no sign of any other proposal being under active, or indeed any, consideration at this stage. The paper suggests that a good deal of preparatory work was being done in relation to this proposal by a significant number of people within the Trust.

46. The presentation included a *"critical path"* diagram, or timetable, which set out the steps required to reach a revised *"go live"* date of 15 June 2020. These steps included preparation of the *"Case for Change"* for the Board. The first draft had apparently been prepared on 18 May 2020, i.e. the date on which it had been decided that the Staff Side representatives should be notified of the plan, and the draft was scheduled to be completed by 20 May 2020. Clinical models and workforce models were to be signed off by Gold Command by 26 May 2020 along with internal and external communications. There was also to be a presentation to the Board on 26 May 2020 at which there would be a decision whether to proceed.

47. Although the 20 May 2020 document is not entirely clear on this point, it also appears from the *"critical path"* that there was no intention to communicate the proposal to the public until June, by which time it was envisaged that there would have been a decision to go ahead with it in any event. There was, however, concern about leaks. In the paper, this was said to be an issue rather than a risk, with members of the workforce *"asking when the site is going green"*.

48. On 21 May 2020, the Trust apparently told Staff Side of the Green site plan at the weekly meeting but no other information about this has been vouchsafed by the Trust or Mr Morgan.

49. On 22 May 2020, a draft of the Board paper which was ultimately presented on 11 June 2020 was considered by Gold Command. This is apparent from the final draft of the paper, which refers to it previously having been considered by Gold Command on this date, and by the Board on 2 June 2020. But the 22 May 2020 draft itself has not been disclosed. Mr Morgan does not deal with the 22 May meeting at all in any of his three witness statements and nor is there any disclosure in relation to this meeting other than the Action Log.

50. Notwithstanding this, paragraph 36 of Ms Morris' skeleton argument dismisses the Claimant's assertion that *"all the information shared with the public on 8 June 2020- i.e. the Board Paper- was available to the Trust by 22 May at the latest"* as *"demonstrably wrong"*. Understandably, given that there is no evidence about this, she does not say what actually happened at the 22 May meeting other than that *"it is accepted that a draft of the Board paper appears to have been considered by Gold Command on 22 May 2020"* (emphasis added). But she argues that the entries in the Action Log *"indicate that it still had to be reviewed in detail at this stage"* (emphasis added). In this regard, she relies in particular on the entry "*Full document to be reviewed in detail before it can be signed off by Gold. Karen Dunderdale, Simon Evans and Paul Matthews to look at the document. To be discussed at 1715 meeting on Tuesday 26 May."* And she says that the Action Log shows that various actions were agreed at that meeting. But it is a little surprising, if there was a compelling case to be made by the Trust that there were significant differences between the proposal as it stood on 22 May and the proposal in its final form, that it has confined itself to relying on Ms Morris' arguments about what the limited disclosure shows, rather than submitting evidence, from one of the many members of the team who worked up the plan, to explain what

the position actually was. The inference I draw from this, in the context of the evidence as a whole, is that there were no differences which would have prevented the Trust from informing the public of its proposal at this stage if it had not already done so.

51. Between 25 May and 2 June 2020 there were apparently face to face discussions with staff, led by Divisional management teams, during which limited information was shared with affected staff as the proposed models of care were developed. Again, no information about the contents of these discussions has been vouchsafed by the Trust.

52. On 26 May 2020, a document or deck of slides entitled *"Case for Change"* was presented to Gold Command. Again, apart from pleaded assertions and argument, the only actual evidence about this is the document itself and the Action Log. However, the document ran to 30 pages of slides and fairly clearly appears to be the draft *"Case for Change"* referred to in the *"critical path"* on 20 May 2020. It was therefore effectively a draft of the Board paper which was to form the basis for its decision.

53. The document described the options which had been considered by the Trust, the options appraisal process which had been undertaken and the preferred option. Slide 20 of the document set out the conclusion to the options appraisal section which ended in bold as follows:

> ***"Grantham is chosen as it has the greatest potential as the largest site, offering economy of scale factors with clinical capacity, the estates and staffing to deliver elective care and diagnostics whilst maintaining IPC excellence."***

54. The final *"Conclusions and Recommendations"* section of the document concluded that:

> *"Having considered all of the available options, we believe that the only viable option is the temporary reconfiguration of services at Grantham as a Green site with a Blue isolated UTC."* (emphasis added)

55. There is very little evidence about the options appraisal process and when it took place. The 26 May 2020 *"Case for Change"* document set out an analysis of the options, but it did not say when the options appraisal process had been undertaken and Mr Morgan does not deal with this issue in any of his statements. The relevant parts of the document, read in the context of the other documents which have been disclosed, are perfectly consistent with this process having been undertaken before 10 May 2020, after which the Trust was focussed on developing its Green site plan in relation to the Hospital.

56. In her skeleton argument Ms Morris frankly admits that:

> *"34. The Claimant has pressed the Defendant to identify precisely when the options appraisal was undertaken. However, for the reasons set out above, it is not possible to ascertain the relevant date"*

57. This is in line with the Trust's pleaded case, including the Part 18 Information which it provided on 19 February 2021. Having been pressed on this topic, the Trust's answers included the following passages:

> *"As indicated in the Defendant's response to question 1 above the Defendant was considering the possibility of establishing a Green site at Grantham on 10th May 2020 although as at that date the divisional recommendation was initially to implement a Green pathway at Grantham rather than a full Green site option.*
>
> *The slide deck presented to Gold Command on 26th May 2020 explained at slide 20 that Grantham had been chosen as the proposed site for the Green Site as it had the greatest potential as the largest site, offering economy of scale factors with clinical capacity, the estates and staffing to deliver elective care and diagnostics whilst maintaining IPC excellence. Grantham was the only option that fully met all conditions set in the options appraisal. It was described at slide 29 as the only viable option.*
>
> *Accordingly, whilst the Defendant is unable to confirm a precise date when Grantham was identified as the optimal location for the Green site, it was identified as such by the Gold Command at some point between 10th and 26th May 2020."* (emphasis added)

58. The word *"accordingly"* suggests that the conclusion in the third of these paragraphs was arrived at by a process of deduction from what is said in the first two. Unfortunately, however, the conclusion does not follow from the premises. The fact that the Trust was down to one option by 10/12 May 2020 suggests that an appraisal of the options was carried out, and a decision was taken, before rather than after this point. The fact that the decision making was subsequently explained in a draft of a document, dated 26 May 2020, which was to form the basis of the Board's decision in due course did not give any real indication of when the thinking had taken place, either.

59. It is easier to accept, at least in part, the following passage from the Part 18 Information given that the decision as to the preferred option appears to have been taken between 29 April and 10/12 May 2020 at the latest. But, again, there is no evidence that any appraisal of other options was ongoing or took place after 10 May 2020:

> *"The options appraisal was carried out between 29th April and 26th May 2020. The slide deck presented to Gold Command on the latter date describes the options appraisal process at slides 12 to 16."* (emphasis added)

60. Notwithstanding this, Ms Morris goes on to say, at paragraph 34 of her skeleton argument, that:

> *"The Claimant's assertion that it can be inferred from the disclosed documents that the options appraisal had been completed prior to 12 May 2020 is wholly unsustainable.... Whilst a recommendation for a "green site" at Grantham was made by the divisional team as early as 12 May 2020 there is no clear evidence of the finalised options appraisal being presented to the Gold Command before 26 May 2020. The Claimant suggests that it is possible to conclude that the appraisal was completed before 12 May from a review of the Gold Command logs. However, these logs are limited in their content and scope and provide no clear indication of when the options appraisal was carried out".* (emphasis added)

61. With respect, the passages I have highlighted miss the point, which is that there is no evidence of any consideration of any option other than a Green site or pathway at the

Hospital after 10 May 2020. The only evidence of any consideration of any option which has been disclosed, apart from the 26 May 2020 paper, is of consideration of this option. As I have pointed out, Mr Morgan's evidence is that between 10 May and 2 June 2020 the Trust was working on this *"proposal"* or *"plan"*, as he put it. The fact that the Action Log, which runs from 12 May 2020, may not be comprehensive does not detract from the point that a document which was apparently intended to log the decision making of Gold Command, and what was required to be done at each stage, does not show any discussion of any other options, or any steps other than in relation to this particular option. This strongly supports the contention that the decision that this should be the proposal had been taken on or before 12 May 2020. As I have pointed out, the 26 May 2020 document explains that other options had been considered and rejected but it does not say when. It was also a draft of a paper which was to go to the Board to explain the thinking of the management team, rather than a paper asking for Gold Command to make a decision as to the preferred option.

62. The 26 May 2020 *"Case for Change"* document also indicates that the *"Full Trust board paper"* was circulated to others, including clinical commissioning groups, on 26 May 2020 *"with caveat that further minor revisions can still be made"* (emphasis added) and that it, the document, was a slide deck version of that paper. The stated timetable indicated that it was intended that there would be sign off and circulation of the paper to the Board on 29 May 2020. There would then be an extraordinary Board meeting in the week commencing 1 June 2020 and the assumed "go live" date had been brought forward to 8 June 2020.

63. The Action Log suggests that, at the Gold Command meeting on 26 May 2020, there was a question as to whether there needed to be four operating theatres at the Hospital and there was a handful of matters of detail in terms of what the Board paper said, explained or emphasised i.e. drafting points. An indication of the Trust's thinking about involvement of service users can be derived from the following suggestion:

> *"Ensure that the language within the proposal does not suggest that the model will go to consultation and emphasise that this is a temporary measure".*

64. This is despite the fact that the paper already contained the following passage under the heading *"NHSE/I Change Protocols"*:

> *"The proposed change to a Green site at Grantham for elective services and diagnostics would ordinarily constitute 'service change' and require consultation under the public involvement and consultation duties of commissioners as set out in s.13Q NHS Act 2006 (as amended by the Health and Social Care Act 2012) for NHS England and s.14Z2 NHS Act 2006 for CCGs, and require the subsequent service change assurance process as detailed in the 'NHS Planning, assuring and delivering service change for patients' 2018 guidance.*
>
> *However, these proposed changes are being made as part of the level 4 incident response and are deployed in response to Covid-19, as such, they are not subject to the usual legislative process.*
>
> *The changes proposed are temporary in nature as part of the level 4 incident response. Any proposal to make them permanent would be subject to formal consultation."*

65. As Mr Sachdeva points out, the Trust appears to have been at pains to emphasise that there was no obligation to consult service users, rather than referring to its obligation, under section 242 of the 2006 Act, to involve them in its decision making and then setting out arrangements to do so. This is an aspect of his argument that the Trust either ignored, or was ignorant of, its obligations in this regard.

66. On 2 June 2020, the proposal for a Green site at the Hospital was discussed by the Trust Board at a private meeting. A paper setting out the case for change and a detailed options appraisal was presented. As Mr Morgan explains at paragraph 16 of his first witness statement:

> *"This meeting gave Board members an opportunity to raise questions about the proposal, and also to suggest changes to the formal paper proposing the change which would be submitted to the ULHT Trust Board for a decision at its public meeting on 11th June 2020"*

67. So the purpose of the meeting appears to have been for the members of the Board to be better informed, and to suggest drafting points in relation to the document which the public was to see. Mr Morgan does not suggest that, at this meeting, the Board could realistically have said that some other option should be considered, and nor could it have been. Nor does he say what changes were suggested by the Board. The draft that was considered by the meeting has not been disclosed, but there are some indications of some of the suggested changes in the minutes of the meeting. These show that it was considered that there was a *"need to take time to further develop the proposal"* before it was made public. However, the development appears mainly to have been concerned with the drafting rather than the substance of the document. The view was expressed that *"the benefits of the changes had not been captured as clearly as the detriments"* and the minutes record that a Mrs Dunnett expressed the view that the communications plan *"felt organisationally focussed rather than patient focussed"*. Furthermore:

> *"Having read the communications plan Mrs Dunnett felt that this mixed two elements, the temporary arrangements being put in place regarding the pandemic and the longer-term aspirations linked to the Acute Services Review (ASR). This could potentially invite anxiety from communities by discussing formal consultation and ASR alongside temporary changes."*

68. Perhaps linked to this apparent concern about the reaction of service users to the decision, and the way in which it was being communicated to them, the minutes note that:

> *"The Chief Executive noted that there had been some initial discussions regarding the UTC and that the Clinical Commissioning Groups were supportive. There would be a need to manage stakeholder expectations regarding the release of public information ahead of a public Board meeting in order to ensure the reputation of the organisation was managed and maintained."*

69. The 2 June 2020 meeting approved a proposal that the recommendations be presented to a public Board meeting on 11 June 2020. It was also proposed that the Board paper would be published on 8 June 2020.

70. The undated communications and engagement plan referred to at paragraph 18 above appears to have been created at about this time, as it assumes a Board meeting on 11 June with papers made available on 8 June 2020. The communications and engagement plan set out the approach which would be taken and commented as follows under the heading *"Engagement"*:

> *"As a Trust, we have a Duty to Involve our patients and public in any service change that will impact upon their experience of the service, as outlined in Section 242 of the Health and Social Care Act 2006.*
>
> *During this exceptional time, we have made a number of short-term service changes for patient safety/service requirement reasons which we have not engaged our public around.*
>
> *Going forward, as some changes become more long-term, engagement will need to be carried out to ensure that our patients and public are not negatively impacted by any change, and to ensure that we put mitigation in place if this is the case.*
>
> *The proposed move to a 'Green' site model at Grantham and District Hospital is a part of planning for the Restore phase of the COVID 19 pandemic, which is currently expected to run until the end of July 2020. The situation will then be reviewed again as we move into the Recover phase, which is presently expected to last from August 2020 to end of April 2021.*
>
> *Therefore, this change would be classed as temporary and not currently be subject to a full public consultation. .....*
>
> *Of course, as part of the extensive public engagement exercise already carried out as part of the ASR, including the Healthy Conversation 2019, there have been a number of relevant findings…*
>
> *We recommend, however, that further engagement on this temporary change is carried out, at a level that is proportionate to the level of change and the fact that this is a temporary change, with an expectation of a full public consultation as part of the ASR in the near future.*
>
> *In reality, this means fairly low-level engagement to test out 'what do you think' and 'what are your experiences?' once the temporary arrangements are in place, to explore mitigating actions we can take to limit the impact."* (emphasis added)

71. These passages appear to accept that no public engagement would take place before the changes were made, but to justify this on the basis that the changes would be temporary and there would be low-level engagement once they were in place.

72. At paragraph 17 of his second witness statement Mr Morgan says:

> *"17. Up to the private board meeting on 2 June 2020 it was not at all clear that the proposal for a green site would proceed. After that meeting, although our plans continued to be refined, we were in a position to start communicating about the proposals. I therefore referred to the possibility of a green site during a radio interview on 3rd June. There then followed various staff and stakeholder meetings*

(including face to face meetings with affected staff) which we considered should be completed before discussing the Green site proposal more widely."

73. On 3 June 2020, Mr Morgan took part in his regular interview with BBC radio Lincolnshire. According to paragraph 23 of his first witness statement he explained that the Trust:

> *"was looking at establishing a 'green' site and expanding our urgent care offer. At this stage I did not confirm that the proposed Green site was Grantham because this was still subject to Board approval".*

74. The explanation for not disclosing that the Green site would be located at the Hospital does not make sense given that, logically, it would mean that this fact could not be revealed before the final decision had been taken by the Board and given that the location was then disclosed on 8 June 2020, before Board approval. In any event, it is difficult to see how the 3 June 2020 interview could amount to meaningful involvement of service users given that they would not even know where the proposed Green site was to be located and, therefore, whether it would affect them and, if so, how.

75. At 3pm on Monday 8 June 2020, a press release was issued to local media and published on Trust's website, advertising a Trust Board meeting on 11 June 2020 and providing a link to the Board papers. The press release said that *"Members of the public are invited to observe the meeting via Microsoft Teams"* and a link was provided. The release also stated that *"Board meetings, whilst held in public, are not public meetings. Public questions are permitted, submitted in advance"* and a link was provided which explained how this could be done. The Trust also issued a one-page stakeholder briefing message to a wider stakeholder mailing list briefly summarising the proposals that would be considered by the Board and, again, providing a link to the Board papers.

76. On 9 June 2020, Mr Morgan gave interviews to BBC Radio Lincolnshire, the Lincolnshire Echo, ITV Calendar and Lincs FM in which he discussed the Green site proposal. No transcripts of any of these interviews have been provided so it is not possible to assess what information was provided to the wider public.

77. The extraordinary Board meeting of the Defendant took place at 10am on 11 June 2020. It was live streamed, *"in order to enable members of the public to observe the proceedings"* (emphasis added), as Mr Morgan accurately puts it at paragraph 26 of his first witness statement. He adds:

> *"In addition, the public had been invited to submit questions in advance of the meeting and we allowed 30 minutes at the start of the meeting to respond to some of these questions. Because of the volume of questions received it was not possible to respond to all of them during the Board meeting and therefore outstanding questions received a written response after the meeting."* (emphasis added)

78. In the light of the second sentence of this passage Ms Morris' claim, in her oral submissions, that all of the questions which were submitted by members of the public were dealt with in the 30 minutes, and that there were no other questions, was surprising and I reject it. Mr Morgan's statement also reflects what was said in the report to the Board for the purposes of the first review in October 2020. Contrary to Ms Morris' suggestion that there were barely any objections to the proposal, it appears that there

were significant concerns about it, just as the Trust itself anticipated there would be in deciding how to approach its communication strategy.

79. Mr Morgan then took the Board members through the proposal, which was set out in a detailed Board paper. This summarised the case for the temporary reconfiguration of the services provided by the Trust as part of the next stage of its response to the Level 4 incident declared on 30 January 2020, described the options considered and the preferred option (which was again described as *"the only viable option*"), outlined the legal basis for the change, described the clinical leadership and governance established to oversee and enact the proposed changes, and provided assurance that the quality and equality impact of the proposed changes had been considered. The Hospital would be a Green site from 22 June 2020 until *"at least"* 31 March 2021 but there would be quarterly reviews against the criteria for establishing the Green site and *"to ensure any and all alternatives for improvement of services are actioned"*.

80. Interestingly, the paper again made no mention of the duty to involve service users under section 242(1B) of the 2006 Act but it did include the passage, under the heading *"NHSE/I change protocols"*, which I have cited above at paragraph 64. It was therefore emphasised that there was no duty to consult. There was also reference in the paper to a communications and engagement strategy, but in the context of internal communications and staff engagement actions. It appears, from one of the Tables in the paper, that this strategy also applied to *"the public, the media and other third parties"* but that it would be implemented <u>after</u> the decision to proceed had been taken by the Trust Board.

81. The proposal was approved. Following the Board's decision, the Trust then communicated its decision to staff, stakeholders and the public through various means including emails, briefings, a press release and interviews and FAQs on the Trust website.

<u>Why was more not done to involve the public and at an earlier stage?</u>

82. As to why more was not done to involve service users in the Trust's decision-making process, unfortunately the disclosed documents only shed limited light on the Trust's thinking. In his first witness statement Mr Morgan explained, under the heading *"[The Trust's] approach to public involvement/consultation"*, that the Trust was mindful of the fact that there would ordinarily be an obligation to consult pursuant to section 14Z2 of the 2006 Act, but that the Trust was advised that this provision did not apply because the changes were temporary and that it could therefore proceed with the changes subject to quarterly reviews. He did not refer to the Trust's duty under section 242 of the 2006 Act.

> *"Notwithstanding this, as I referred to in paragraph 12 above, ULHT recognised that effective communication with the public, staff and partner organisations both before and after the decision to make the temporary changes would be crucial. The Trust therefore prepared and implemented a detailed plan of communications and public involvement activities"* (paragraph 22)

83. He then went on to explain that the view was that staff and stakeholders should be *"informed about the proposals before they were shared more widely with the public"* and he then relied on the events from 3 June 2020 onwards which I have summarised

above. He did not suggest that the steps which had been taken by the Trust were in any way deficient or that any other explanation of the approach was needed. Still less did he suggest that there were inadequate resources, owing to the pandemic or for any other reason, and that this accounted for the lack of any greater involvement. His position appeared to be that no criticism could be made of the Trust's *"detailed plan of communications and public involvement activities"*.

84. In his second witness statement, however, Mr Morgan accepted that public involvement prior to the Decision was *"limited in scope"*. He emphasised, at paragraph 14, the guidance given on 18 March 2020 which I have highlighted above at paragraphs 22-23 i.e. that the duty to involve could be discharged by very limited public involvement but that, at the very least, changes to services should be announced to the public at the earliest reasonable opportunity. At paragraph 15 he emphasised that the changes were temporary and a response to the Level 4 national emergency:

> *"The Trust did not believe it was possible in the circumstances we were facing at the time, including the short timeframe for implementing our plans and the pressure on Trust resources in managing the response to Covid-19, to conduct an extensive consultation exercise with the public. It made what it felt were reasonable arrangements to involve the public as far as it could in the circumstances."* (emphasis added)

85. This was the extent of his evidence about why there were insufficient resources to secure greater involvement of the public in the development of the proposal for a Green site at the Hospital. It may also be thought that this passage suggests a false dichotomy between *"an extensive consultation exercise with the public"* and what actually happened.

86. At paragraph 16 of his second witness statement Mr Morgan explained, in response to the suggestion that the Trust could have involved the public earlier than it did that:

> *"our plans were constantly changing and developing over this period. The feasibility of using the Grantham site as a Green site in this way had been progressed during the 4 weeks from when the possibility of establishing a Green site was first raised in the Gold Command meeting on 10 May. Even at the point that the Board was presented with a recommended option, the work on developing that option was ongoing. At any point during the development period the proposal could have been dropped. Our view was that it would not have been appropriate to share the proposals with the public at an earlier stage as this risked messaging that could have been confusing, disruptive and potentially dangerous as the proposed model changed during the process"* (emphasis added)

87. Here, the suggestion is that the reason for not doing more, and earlier, was that the *"messaging"* could have been confusing etc because of modifications to the Green site proposal as it was developed and/or because the proposal might have been dropped. This explanation, rather than lack of resources, is also emphasised by Ms Morris at paragraphs 37-39 of her skeleton argument. Why the Trust was unable to produce *"messaging"* which was not confusing and/or which made clear that there might be modifications to the proposal is not explained. How the messaging could have been disruptive and potentially dangerous is not explained, either. Nor do the disclosed documents explain this directly although, as I have highlighted, there clearly was a

concern on the part of the Trust that there would be suspicion of, and opposition to, the Green site proposal. The Trust also had in mind the risk of political and community pressure and, it appears, a claim for judicial review.

88. In his witness statements, Mr Morgan also emphasises that:

i) *"The clinical case for running a Green Site at Grantham was overwhelming…other options would have put patients at unnecessary risk of harm and cost lives*".

ii) Overall, the Decision was highly beneficial to the Lincolnshire public. For example, as at October 2020 there had been a 69% increase in overall activity at the Hospital and the Trust was on track to achieve 90% of its pre Covid-19 run rate for elective and day case surgery. This was possible because the relevant patients felt safer in availing themselves of the services because of the measures which had been taken to ensure that the risk to them of Covid-19 infection was minimised. There has also been a broadening of the outpatient and specialist services which are available at the Hospital including surgical services. The services which were previously, but are no longer, provided at the Hospital are available elsewhere, albeit they may be less easy to access for some service users.

iii) The Decision was temporary and subject to quarterly reviews which have taken place on 6 October 2020 and 2 February 2021. At these reviews, the Green site model was considered carefully in the light of experience, the views of patients and modifications to the model which had been made. The decision was to keep the model in place.

iv) The views of the public have since been sought and taken into account through a variety of methods. These include feedback in relation to the UTC, public messaging and briefings and patient interviews and surveys.

v) Modifications have been made to the model in the light of experience and the views of service users. These include:

a) The implementation of dedicated transport services for patients to and from the Hospital via a new Patient Transport Service contract;

b) Maternity and paediatric services have been restored at the Grantham Family Health Centre and additional services have been put in place at the Hospital itself for the most vulnerable patients;

c) Additional outpatient services have been restored at the clinical assessment and treatment centre at Gonerby Road in Grantham, reducing the need for patients to travel to services at Pilgrim and Lincoln hospitals;

d) Additional theatre capacity has been installed in the form of two Vanguard Modular Theatres to support cancer operating;

e) Children's services are restarting with Green pathways at the Hospital and additional pathway services are in development at Gonerby Road;

f) In addition to Green Site surgical services, the Independent Sector are supporting the Trust at the BMI facility in Lincoln, Ramsey in Boston and St Hughes in Grimsby.

89. Ms Morris also sought to suggest that service users generally had no real objections to the Decision or, at least, would not have had much or anything to say had they been involved earlier:

i) Part of this argument was the claim that all questions from the public were dealt with in the 30 minutes allocated at the beginning of the Board meeting on 11 June 2020, which is not borne out by Mr Morgan's own evidence.

ii) She took me to an email dated 10 June 2020 from the chair of SOS Grantham Hospital which stated that *"Never before have we been so appalled at the proposals put before us..."*, that the Trust was putting 120,000 lives at risk, that the damage done to services would likely be irreversible and that the proposal to replace A&E with a UTC was *"an absolute insult"*. Ms Morris submitted that this constituted involvement in the development of the Green site proposal and that it was an illustration of the point that service users were not concerned about the fact that they had been given short notice of the decision and had not asked for, or needed, more time to respond.

iii) She also relied on the views of the Overview and Scrutiny Committee at its meeting on 17 June 2020, the minutes of which, she said, showed that the Committee had no issues with the process. However, the Committee minute states: *"Welcome the return of 24/7 access to care at Grantham, along with the elective and planned treatment, but that we also put on record the Committee's concerns that the restoration plan will have a significant impact on patients throughout Lincolnshire in terms of travel from their local to other sites, and the downgrading of Grantham A&E."* Mr Sachdeva also pointed out correspondence which indicated that many members of Lincolnshire County Council did in fact have concerns about the decision making process, and particularly the short notice and the lack of consultation, as well as the merits of the Decision itself.

iv) Ms Morris took me to evidence of a patient survey which was available at the time of the review in October 2020. But this was a survey to which 110 patients had responded, and the passage in the report itself indicated that it was an *"extremely small sample"*.

90. I accept that there is other evidence that numerous patients welcomed the changes. This is unsurprising given that the Decision itself had a good deal to commend it and appears to have been beneficial to many members of the community in Lincolnshire. But the issue in this case is as to the process by which the Decision was reached and, in particular, whether there was adequate involvement of service users, rather than the merits of the Decision itself.

Legal Framework.

Issues on the construction of section 242 of the 2006 Act

91. Section 242 National Health Service Act 2006 is one of a number of provisions in the 2006 Act which place obligations on NHS bodies make arrangements to secure the involvement of service users in decision-making about services (see e.g. sections 13Q and 14Z2). Section 242 provides, so far as material, as follows:

> *"**242 Public involvement and consultation***
>
> ....
>
> *(1B) Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in–*
>
> > *(a) the planning of the provision of those services,*
> >
> > *(b) the development and consideration of proposals for changes in the way those services are provided, and*
> >
> > *(c) decisions to be made by that body affecting the operation of those services.*
>
> *(1C) Subsection (1B)(b) applies to a proposal only if implementation of the proposal would have an impact on– (a) the manner in which the services are delivered to users of those services, or (b) the range of health services available to those users.*
>
> *(1D) Subsection (1B)(c) applies to a decision only if implementation of the decision (if made) would have an impact on– (a) the manner in which the services are delivered to users of those services, or b) the range of health services available to those users*
>
> *(1G) A relevant English body must have regard to any guidance given by the Secretary of State as to the discharge of the body's duty under subsection (1B)."* (emphasis added)

92. There was no dispute that sub-sections 242(1B) (b) and (c) were engaged in this case but there were various issues between the parties as to their construction. Taking the issues in the order in which I propose to address them, rather than necessarily the order in which they were presented, these issues were as follows.

93. First, Ms Morris submitted, and Mr Sachdeva disputed, that arrangements for service user involvement after a decision may be relied on to discharge the section 242 duty. This was the foundation for Ms Morris's reliance on the fact that there had been patient surveys and other channels of communication with service users after the introduction of the Green site by the Trust. ("**Issue 1**")

94. Second, Mr Sachdeva argued that the test as to what do, or do not, constitute adequate arrangements to secure involvement etc is one of fairness and that the principles in **R**

(Moseley) v Haringey London Borough Council [2014] 1 WLR 3947 apply by analogy. Applying these principles to the present case, he submits that:

> *"as a minimum, the statutory duty of involvement required making arrangements so that service users were given an opportunity to provide input when proposals were still at a formative stage and in adequate time so that the input could be taken into account in finalising proposals and prior to taking the ultimate decision. These minimum requirements of involvement follow from: the nature of the decision; the scale of and duration of the change; the impact on users; and the valuable contribution which service users could have made to gathering information relevant to the decision."*

95. Ms Morris, on the other hand, submits that it is for the relevant body to decide the form which the involvement of service users will take. This decision is subject to challenge on the basis of **Wednesbury** irrationality only. But once the decision as to form has been taken, the manner of implementation is subject to challenge on fairness grounds. She relies on a remark made by Kerr J in **R (Glatter) v NHS Herts Valleys Clinical Commissioning Group** [2021] EWHC 21 (Admin) [72]. She also submits that her proposed construction is consistent with **R (Hinsull) v NHS Dorset Clinical Commissioning Group** [2018] EWHC 2331 (Admin) [40], where Sir Stephen Silber noted that where a statute leaves the matters which are to be consulted about to the decision maker, the exercise of that discretion is subject only to **Wednesbury** review. ("**Issue 2**")

96. Third, there is also a question as to the extent to which the consequences of the Covid-19 pandemic may be relied on to justify any deficiencies in the arrangements which were made by the Trust. Mr Sachdeva accepted that temporary or emergency measures may require a lesser degree of involvement but submitted that what happened in this case was, on any view, inadequate. In this regard, he relied on the decision of the Court of Appeal in **R (Article 39) v Secretary of State for Education** [2020] EWCA Civ 1577, where an argument that the pandemic provided a justification for failure to consult was rejected. Ms Morris points out that that was a case about the duty to consult and that, on the facts, it was clear that there was time to do so. ("**Issue 3**")

97. Fourth, there were differences of emphasis between the parties as to the relevance of the question whether a relevant body is aware of its section 242 duty at the relevant time. Ms Morris submitted that this question is irrelevant – what matters is whether the relevant body in fact complies with its obligation – but that, in any event, the Trust was aware of the existence of the duty. Mr Sachdeva agreed that awareness or otherwise of the duty is not decisive but submitted that it may be relevant. A public body which can show that it considered how it should discharge its duty under section 242, and acted on the basis of a clear understanding of its duties, may be in a better position to defend itself from a challenge than one whose case is that it unwittingly complied with its duties. ("**Issue 4**")

98. Finally, there were also differences of emphasis between the parties as to the importance of the section 242 duty. Mr Sachdeva emphasises its essentially democratic function and submits that the involvement of service users is particularly important in the context of the health sector: see **R (Pat Morris) v Trafford Healthcare NHS Trust** [2006] EWHC 2334. Ms Morris did not dispute that the duty is an important one but, relying on **R (A) v South Kent Coastal CCG & Others** [2020] EWHC 372 (Admin) at [74]-

[75], she argued that it is one of a *"suite of high level duties"* which may impose competing demands on decision makers within the NHS.

Analysis of s242 and its application in the present case.

Overview

99. The key requirement under section 242(1B) of the 2006 Act is that each relevant body makes arrangements to secure the involvement of service users in the matters specified in subsections (a)-(c). The section contemplates that there may be standing machinery for service user involvement in the form of established procedures, channels of communication, user groups and committees etc, but the obligation is capable of being discharged by arrangements for service user involvement in relation to a particular planning process, proposal and/or decision. The arrangements may secure involvement directly by service users, or through representatives.

Issue 1

100. In relation to the first issue referred to above, it seems to me that on its face section 242 answers the question whether arrangements for subsequent involvement will do. They clearly will not. There is a requirement to secure involvement in the planning of the provision of services which, in my view, contemplates involvement before the plans have been finalised. There is a requirement to secure involvement in *"the development .....of proposals for changes"* which, by definition, can only take place whilst the proposals are under development rather than in final form. There is a requirement to secure involvement in the *"...consideration of proposals for change"* which, by definition, must entail involvement whilst an idea is still a proposal, as opposed to having been decided upon. And there is a requirement to make arrangements to secure involvement in "*decisions to be made*", as contrasted with decisions which have been made. This view is confirmed by section 242(1C) which clearly refers to proposals which, if implemented, would impact on services, and section 242(1D) which refers to the decision *"(if made)"*. Both subsections therefore contemplate service user involvement before the event and at the formative stage.

101. I accept, however, that in a case where the matter is urgent, and a decision is taken on a genuinely short term or provisional basis, the fact that the decision is genuinely open to reversal or modification, and also that arrangements are put in place for further service user involvement, may mean that less before the event involvement is required. This is a function of the fact that, as I discuss below, section 242 is subject to principles of fairness and proportionality: the greater the impact of a decision, the higher will be the requirement of service user involvement in the decision-making process. This aspect or feature of a case will also be relevant to issues of relief in the event of a judicial review. However, for reasons which I explain below, the scope for application of this principle is limited.

No arrangements for service user involvement in the "development" of the Green site proposal

102. Although subsections 242(1B) (a)-(c) overlap, and therefore should not be seen as hermetically sealed compartments, they do establish requirements as to what service users are to be involved in. In the context of the present case, it therefore seems to me that the section entitles the court to ask:

i) Under section 242(1B) (b), what arrangements did the Trust make to secure the involvement of service users in the development and consideration of the proposal to establish the Hospital as a Green site? and

ii) Under section 242(1B) (c), what arrangements did the Trust make to secure the involvement of service users in the decision which was to be made by the Board on 11 June 2020?

103. No real evidence of generally applicable arrangements or machinery for securing involvement in the matters specified by section 242(1B)(a)-(c) was presented or relied on. Rather, the Trust relied on the specific steps which it took in relation to this particular proposal and the Decision. The relevant steps taken prior to the Decision were said to be:

i) The initial communication of the fact that the Trust was looking at establishing a Green site in Mr Morgan's regular interview with BBC Radio Lincolnshire on 3 June 2020;

ii) The press release issued to local media, and published on the Trust's website on 8 June 2020, which advertised the forthcoming Board meeting and provided a link to the Board papers, as well as the email to stakeholders of that date;

iii) The media interviews given by Mr Morgan on 9 June 2020;

iv) The live streaming of the Board meeting on 11 June 2020, with the opportunity for members of the public to submit written questions in advance;

v) Publication of the Decision through a press release and media interviews etc.

104. It seems to me that none of these steps could sensibly be said to be arrangements to secure involvement in the *"development"* of the Green site proposal which, I have found, was under consideration and development by the Trust from 10 May 2020 at the latest and was posted in its final form on the Trust's website at 3pm on 8 June 2020. The only alleged involvement prior to 8 June 2020 was the Radio Lincolnshire interview on 3 June 2020. But what, precisely, was said and who heard it are unknown, and it is accepted by the Trust that Mr Morgan did not identify the location of the proposed Green site. The evidence also suggests that the proposal was in substantially its final form at this stage in any event: the outstanding issues were primarily matters of drafting.

105. On this basis, there was a total failure on the part of the Trust to comply with one of the requirements of section 242(1B)((b). The remaining issues are whether the pandemic may be relied on by the Trust to avoid a finding of breach of the section for this reason alone and/or whether the steps taken from 3 June 2020 complied with the duty to make arrangements to secure involvement in the *"consideration"* of proposals and the "*making"* of the Decision.

Issue 2

106. This brings me to the second issue identified above, which is essentially as to the scope for intervention by the court where, arguably, at least some relevant arrangements have

been made. Here, it seems to me that, again, the terms of the section itself provide a large part of the answer. There is an obligation to make arrangements which secure involvement in the matters specified in section 242(1B) (a)-(c). The arrangements *"must"* be made, and they must *"secure"* that service users *"are involved"*. This formulation was introduced by section 233(2) Local Government and Public Involvement in Health Act 2007 and it replaced the *"must make arrangements with a view to securing"* formulation in what was then section 242(2) of the 2006 Act, albeit what had to be secured before the amendment was that the relevant persons were *"involved in and consulted on"* the specified matters.

107. The key concept is *"involvement"*. The sufficiency of any arrangements which are relied on as discharging the obligation under the section should therefore be assessed by reference to the question whether they do in fact secure involvement for services users in the specified matters. The section cannot have been intended to require a relevant body to secure actual involvement by service users on pain of being held to be in breach, and the formulation must therefore contemplate that what is required is the *opportunity* to be involved of which service users may or may not choose to avail themselves. Self-evidently, that opportunity must be meaningful.

108. As to what constitutes meaningful involvement, sections 242(1B) (a)-(c) obviously specify the processes in which involvement must be secured, but they also indicate the essentials of meaningful involvement in decision making about the provision of services. Involvement in planning, in development and consideration of proposals for change, and in decisions to be made about the operation of services, are the essentials of meaningful and fair participation in decision making. The statute contemplates that there will be the opportunity for involvement in planning and the development of proposals when they are at a formative stage and in the making of decisions about the relevant matters. It also contemplates that this involvement will potentially influence outcomes and that the views of service users are therefore taken into account by decision makers.

109. As to the methods by which involvement is secured, I do not regard the words "*involved (whether by being consulted or provided with information, or in other ways)"* as indicating that involvement is necessarily a weaker concept than consultation. The section is aimed at securing meaningful participation in the relevant decision-making processes. This may mean that the service users or their representatives are party to the decision, rather than merely being consulted about it, but it may mean that at a given stage in the process of involvement it will be sufficient to provide information. However, it would be an unusual case in which it could be said that the provision of information, without more, amounted to securing involvement in decision making: usually it will do so if it facilitates participation in that decision making but not if service users are merely told what the plan, the proposal or the decision will be and they are to have no further involvement. It is inherent in the fact that the section is concerned with *"arrangements…which secure involvement"* that part of those arrangements will be the provision of information so as to facilitate involvement and that there may be stages in a given decision making process where this is sufficient at that stage. But ultimately the question is whether the arrangements, looked at as a whole, have secured the opportunity for meaningful involvement or participation in the specified matters.

110. I therefore agree with the following passage from the statutory guidance issued by what was then the Department of Health, in October 2008, pursuant to section 242(1G) –

"Real involvement working with people to improve health services" – although there was some uncertainty as to whether it remains in force:

> *"Involvement can be viewed as a continuum with different levels. The level of involvement should be matched to the circumstances and context in which it is to be used. For example, giving information to local people in order that they can become more informed about an issue might be the most appropriate level of involvement when an organisation is beginning to think about redesigning a service. Certainly, it is more difficult to involve people in a meaningful way if they are not well informed. Similarly, a more participative technique is likely to be appropriate when the same organisation is determining priorities."*

111. It will have been noted that my analysis of section 242 echoes the approach of Lord Reed in the **Moseley** case in that it answers the question of the quality of the involvement required by reference to the statutory context, and the terms of the section, rather than common law principles of procedural fairness. Borrowing his words, my view is that *"The purpose of this particular statutory duty ...[is] to ensure public participation in the ...decision making process"* (paragraph 38) and that it is against this yardstick that fulfilment of the duty to make arrangements to secure involvement should be measured.

112. Even if the section is merely concerned with procedural fairness to service users whose interests may be affected, I agree with Mr Sachdeva that the purposes which the duty to consult aims to serve apply here. These purposes were eloquently stated by Lord Wilson at paragraph 24 in the **Moseley** case:

> *"First, the requirement "is liable to result in better decisions, by ensuring that the decision-maker receives all relevant information and that it is properly tested" ... Second, it avoids "the sense of injustice which the person who is the subject of the decision will otherwise feel" ... Such are two valuable practical consequences of fair consultation. But underlying it is also a third purpose, reflective of the democratic principle at the heart of our society. This third purpose is particularly relevant in a case like the present, in which the question was not: "Yes or no, should we close this particular care home, this particular school etc?" It was: "Required, as we are, to make a taxation-related scheme for application to all the inhabitants of our borough, should we make one in the terms which we here propose?"*

113. It seems to me that quite apart from the democratic value, in itself, of involving service users in decisions about the services which are available to them through the National Health Service, section 242(1B) of the 2006 Act contemplates that involvement of service users will improve the quality of decision making. The perspective and concerns of the consumer of the services will lead to better informed decisions and it will increase the likelihood that the human impact and implications of plans, proposals and decisions are taken into account. The present case also illustrates how failure to involve service users in decision making will foster a sense of injustice or, worse still, undermine confidence in the good faith of the decision maker.

114. I also note that there may not be a material difference in the approaches of Lord Reed and Lord Wilson in terms of the result, as Baroness Hale and Lord Clarke pointed out at paragraph 44 of the **Moseley** case:

> *"44. We agree that the appeal should be disposed of as indicated by Lord Wilson and Lord Reed JJSC. There appears to us to be very little between them as to the correct approach. We agree with Lord Reed JSC that the court must have regard to the statutory context and that, as he puts it, in the particular statutory context, the duty of the local authority was to ensure public participation in the decision-making process. It seems to us that in order to do so it must act fairly by taking the specific steps set out by Lord Reed JSC, in para 39. In these circumstances we can we think safely agree with both judgments."*

115. The analysis which I have set out above is consistent with the decisions of the Court of Appeal in **R (Keep the Horton General) v Oxfordshire CCG & others** [2019] EWCA Civ 64 and **R (Nettleship) v HNS South Tyneside Clinical Commissioning Group** [2020] PTSR 928 on which Mr Sachdeva also relies, although they were primarily concerned with the quality of consultation exercises which had been conducted by clinical commissioning groups pursuant to their equivalent duty under section 14Z2 of the 2006 Act, rather than the question whether the sort of steps which were taken in the present case would be sufficient to comply with the duty to secure involvement. I also note that it was common ground in the **Horton General** case that *""fairness" underpins all"* (paragraph 18).

116. I consider that my analysis is also consistent with the decision in **R (Fudge) v South West Strategic Health Authority** [2007] EWCA Civ 803 on which Mr Sachdeva relies, albeit that case was concerned with section 11 Health and Social Care Act 2001 under which the duty was in essentially the same terms as section 242 of the 2006 Act before it was amended by section 233(2) Local Government and Public Involvement in Health Act 2007 (see paragraph 106 above). Moses LJ said of section 11:

> *"51..... It is not a duty to involve and consult but rather an obligation 'to make arrangements with a view to securing', those objectives. The very use of different terms, involvement and consultation only makes sense if something less than consultation may be appropriate in certain circumstances. The two concepts of involvement and consultation reflect the different stages at which the obligation may be triggered. There is no warrant for construing s 11(1) as imposing an obligation to consult on each and every occasion one of the circumstances identified has occurred. The arrangements which bodies responsible for health services must make must be designed both to secure public involvement and public consultation. Whether mere involvement or something more, namely consultation in the full Gunning sense, is required, will depend upon the circumstances identified in s 11(1)(a) to (c). It is comforting that this construction of the section is consistent with the department's own guidance, although the latter has no statutory force."*

117. That guidance included the following passage, which Moses LJ cited at paragraph 43:

> *'Involvement can be viewed as a continuum ranging from minimum to maximum involvement. The level of involvement should be matched to the circumstances and context in which it is to take place. For example, working at a minimum level by giving information about a health development might be the most appropriate level of involvement at a particular time and in specific circumstances. Certainly, without being well informed, the patients and the public can never be properly involved.'*

118. As I have noted, under the current formulation of the duty, the arrangements must be made and they must secure the involvement of service users, rather than merely being made *"with a view to securing"* involvement. Moreover, consultation is now an example of a means by which involvement is achieved rather than the section being concerned with *"involvement in and consultation on"* the specified matters. But the overall point that the provision is concerned with the making of arrangements which will require different steps according to the stage of the process of involvement which has been reached and/or the overall circumstances of the case including the nature and impact of the proposal or decision, holds good.

119. It will be apparent that I therefore agree with the broad thrust of Mr Sachdeva's argument, albeit on the basis of a slightly different analysis. I also reject Ms Morris' proposed interpretation of section 242 which treats the *"form of involvement"* as a discretionary matter, subject only to a challenge on **Wednesbury** grounds, but accepts that once the form has been chosen, the *"manner"* in which it is deployed is subject to a duty of fairness. This subdivision of the section into two questions, with different standards of review for each, is unwarranted by its terms. It also seems to me to ignore the facts that the section is concerned with the making of *"arrangements"* and that the governing requirement is to secure the *"involvement"* of service users. The method or form of involvement, whether it be consultation, the provision of information or some other method, must secure meaningful involvement rather than the question being, as Ms Morris in effect submits, whether information has been provided fairly or even consultation has been conducted fairly.

120. Nor, in my view, does **Glatter** say otherwise. The particular passage on which Ms Morris relies is paragraph 72 of the judgment of Kerr J, where he said this in relation to an argument that *"involvement"* under section 242 necessarily entails a full consultation exercise:

> *"However, I do not agree that the passages from the two guidance documents Mr Wolfe relied on bear the weight he places upon them, elevating the duty of public involvement to a duty to carry out a formal consultation exercise. It would be inconsistent with the wording of the statutory duty for me to decide that the only way the CCG and the Trust could perform it is by full public consultation. If that conclusion could ever be properly reached, there would have to be no rational alternative, an unlikely proposition I roundly reject."* (emphasis added)

121. As I read this passage, Kerr J was making an obvious point about the construction of section 242. On the wording of the provision the duty is not to carry out a full consultation in every case. The question in every case is whether arrangements have been made to secure involvement etc. The proposition that it could only be said that involvement could only be achieved by full consultation if there was no rational alternative does not mean that breach of the section can only ever be established if it would be irrational to say that there were arrangements which secured the involvement of service users in the specified matters. Moreover, Kerr J does not appear to have had any intention of establishing such a principle.

122. Nor is my analysis of section 242 inconsistent with the following passage at paragraph 40 of **Hinsull**. In that case the court was concerned with a particular statutory duty to consult and Sir Stephen Silber noted that:

> *(f) "...where a statute conferring discretionary power provides no lexicon of the matters to be treated as relevant by the decision-maker, then it is for the decisionmaker and not the court to conclude what is relevant subject only to Wednesbury review. By extension it gives authority also for a different but closely related proposition, namely that it is for the decision-maker and not the court, subject again to Wednesbury review, to decide upon the manner and intensity of enquiry to be undertaken into any relevant factor accepted or demonstrated as such"* ***Khatun v Newham BC*** *[2005] QB 37 at paragraph 35 per Laws LJ."*

123. Self-evidently, this passage was making a rather different point. It is superficially possible to make an analogy between choice of method of involvement and choice of matters which are to be enquired into and with what degree of intensity. But the present case arises in the particular statutory context of the terms of section 242, under which the issue is whether involvement in the specified matters has been secured by arrangements made by the Trust, and examples of how that may be achieved are given. As pointed out above, there is no discretion as to whether to make arrangements, nor as to whether they secure involvement. The issue in relation to compliance with the section in the present case is whether this has been achieved.

No meaningful involvement in the consideration of the Green site decision or the making of the Decision

124. Applying these principles, subject to the third issue which I consider below, I do not consider that the arrangements which the Trust made and implemented from 3 to 11 June 2020 complied with section 242(1B) by securing meaningful or fair involvement of service users in development or consideration of the proposal for a Green site at the Hospital or the making of the Decision.

i) As I have commented, Mr Morgan's 3 June 2020 radio interview did not enable service users to understand the proposal, still less did it give them a fair opportunity to respond.

ii) Rather than notify service users of a proposal which was under development, or give them a meaningful opportunity to be involved in its consideration, the posting of the Board Paper at 3pm on 8 June 2020 gave service users less than 3 days to respond to a detailed proposal which was in final form and which the Trust had apparently taken nearly 4 weeks to prepare.

iii) Services users were then limited to written questions and not all of these were answered before the Decision was taken given the allocation of 30 minutes at the meeting to do so. Other than this, service users were observers (to use Mr Morgan's word) of the Board's decision rather than meaningfully involved in the consideration of the proposal and the making of the Decision.

iv) The interviews which Mr Morgan gave on 9 June 2020 may well have increased public awareness of the proposal but in the context of the overall approach of the Trust, it is hard to see that they materially added to the level of service user involvement.

v) Publicising the Decision after it had been taken did not amount to meaningful involvement in the making of the Decision.

Issue 3

125. This brings me to the third issue in relation to the construction of section 242, namely the relevance of the Covid-19 pandemic and the availability of any related or other justification for the Trust's approach. Ms Morris defends that approach on the basis that, she argues:

i) The Decision had to be made quickly and in circumstances which were evolving. A significant proportion of non-Covid work had been cancelled or delayed and there was an urgent clinical need to increase capacity whist minimising infection control risk;

ii) Resources were stretched owing to the pandemic;

iii) The Decision was temporary;

iv) Overall, the Decision increased the services offered to the public, it did not involve closure although it involved relocation. The changes were intended to enable the Defendant to: (i) meet the demand for cancer surgery on an ongoing basis through the next phase of the pandemic; (ii) increase delivery of urgent diagnostics in a low risk environment; (iii) resume elective surgery and prevent further deterioration in waiting times, whilst permitting treatment of clinically urgent patients; and (iv) increase access to urgent care for patients.

v) The Decision was subject to quarterly review;

vi) The approach to involvement was part of an ongoing process which informed decision making at each stage.

126. In relation to the arguments based on the Covid-19 pandemic, it is necessary to be clear about what aspects or consequences of the pandemic are referred to. For example, in the course of the hearing I pointed out that it might mean that a Trust was required to go further and/or make additional arrangements given that lockdown measures may mean that existing arrangements are ineffective because, for example, service users are not able to attend meetings in person. But what was ultimately at issue was whether the Trust could rely on urgency and alleged lack of resources to justify "limited" arrangements to involve service users.

127. Given the mandatory terms of section 242 and the lack of any express defence to failure to make the requisite arrangements, and given that no statutory exemption has been enacted for the purposes of the pandemic as the 18 March 2020 guidance points out, I asked Counsel to identify a principled basis on which the matters relied on by the Trust could be relevant. Mr Sachdeva said that a pragmatic approach was appropriate and conceded that there could be attenuated arrangements in urgent cases but said that this was not such a case on the facts. Ms Morris submitted that, as a matter of statutory interpretation, section 242 had to be read in the context of the Trust's other, potentially competing, statutory duties such as the duty, under section 25(1) of the 2006 Act *"to provide goods and services for the purposes of the health service"* and the under section 26 to *"exercise its functions effectively, efficiently and economically"*. Under section 275, the functions of a Trust include both its powers and its duties.

128. In my view, considerable caution should be exercised in relation to an argument that Trust personnel were, in effect, "too busy with other things" to comply with section 242. Such an argument runs contrary to the purpose and importance of the section. I would not be minded to accept such an argument in the absence of clear evidence that a Trust would be unable to comply with others of its duties were it to devote resources, or more resources, to compliance with section 242. Even if the question squarely arose as to which statutory duty a Trust should breach, it would not follow that section 242 should be sacrificed given its importance: see **Trafford**.

129. But, in my view, the evidence does not establish that there were insufficient resources to do more to comply with section 242, nor that this was the reason for the Trust's limited approach. As I have highlighted, the evidence of lack of resources is thin. Although I have no doubt at all that front line staff were under a huge amount of pressure, there were resources available to do more to involve service users – for example, in the form of the Trust's communications team – and in any event the evidence that the question of resources contributed to the approach is unconvincing for the reasons I have summarised at paragraphs 84-87 above. The reason for the approach which was adopted appears to have been a concern about *"messaging"* and the reaction of service users if they were notified of the proposal earlier and the proposal was then modified or abandoned, combined with a belief that the pandemic and the fact that the changes were "temporary" justified limited involvement.

130. As for urgency, I can see two bases on which this may justify attenuated arrangements to secure involvement in a given case. First, as a matter of statutory construction it may be possible to argue that because section 242 is concerned with the interests of all users of the relevant services, the section contemplates, or the principle of fairness requires, that the arrangements should not be protracted if this will mean that service users will be deprived of the benefits of a proposed change or decision and/or if those benefits should be introduced as a matter of urgency. This point was not argued, however, and I therefore do not express a concluded view.

131. Second, and to my mind more plausibly, in an urgent case or an emergency it may be necessary to take decisions urgently which will apply only for a short period and will be to the obvious benefit of the vast majority, if not all service users. As I have accepted at paragraph 101 above, the fact that such a decision includes a decision that there will be further involvement with immediate effect, and that the decision may then be modified in the light of the views and experiences of service users, may also mean that more limited involvement before the decision is permissible. This basis for the view that urgency may be relevant focusses on the sort of decision which may be taken in an emergency and is consistent with the requirement of fairness and proportionality in this context. As noted above: the more impactful and the longer term the proposal or decision, the greater the degree of involvement of service users' section 242 will require.

132. In the present case, however, I agree with Mr Sachdeva that the Trust's case is weak on the facts. I accept that there was a degree of urgency given the six-week deadline which was set by NHSEI but, as I have found, Gold Command had decided to propose a Green site at the Hospital by 12 May 2020 at the latest. On that date, or shortly afterwards, steps could and should have been taken to involve service users in the development and consideration of the proposal. There was no good reason why the steps which the Trust eventually took in terms of publicity for the proposal, virtual public meetings, surveys

etc could not have been taken at this stage. I do not accept that the fact that the detail of the proposal was being developed meant that it was unnecessary or inappropriate to involve service users at this stage. Insofar as this argument relies on the fact that the draft of the proposal which was to go to the Board had not been finalised, this assumes, incorrectly, that the only way in which services users could be informed of the proposal was by provision of the Board paper. Obviously, it would have been possible to prepare an appropriate document for the purposes of discharging the section 242 duty.

133. Insofar as this aspect of the Trust's argument rests on changes in the substance of the proposal, from what I can see of the evidence the essentials of the proposal did not alter from 12 May 2020. What altered was some of the detail. By 18 May 2020 there was a draft Board paper and the proposal was sufficiently detailed for it to be decided that the Staff Side would be notified on 21 May 2020. Even if this point were unsound, and further delay in notifying service users was truly necessary, it seems to me that it was incumbent on the Trust to do as much as it reasonably could if the period of involvement was to be short. Yet key stages came and went on 20, 22 and 26 May 2020. Even when the Trust was, on its own case, ready to involve the public on 2 June 2020, it did not even arguably do so for another 6 days.

134. It seems to me to be wholly inconsistent with the statutory requirement to involve service users in the *"development"* of proposals to argue that until the proposal was in final, or virtually final, form no involvement could take place. Similarly, the argument that disclosure of a proposal which would have undergone development could have been confusing, disruptive or dangerous for service users is not supported by evidence. It is also inconsistent with the aims and requirements of section 242 which assume a competent and measured approach on the part of the Trust and a rational reaction from service users.

135. Insofar as the Trust's argument relies on the possibility that Gold Command might have changed its mind and decided not to pursue the proposal, again the statutory obligation to involve service users in the *"development and consideration of proposals"* for changes in services seems to me to contemplate involvement in proposals which, after consideration and/or development, may not be put forward for final decision. But, in any event, there is no sign that I can see in the evidence that the position from 12 May 2020 was anything other than that there was a proposal or plan which was being developed and for which Board approval would then be secured. The evidence does not suggest that there was a decision to investigate further with a view to a possible proposal in due course. The Trust was obliged to take steps in response to the 29 April 2020 NHSEI letter and, as I have found, there is no sign of any other potential options being considered. The only real changes were to when the proposal would "go live" rather than there being an issue as to whether it would "go live" at all.

136. Insofar as the Trust's argument relies on the possibility that the Board would not approve the proposal, I have made the point that the logic of this argument is that it would only be disclosed once the decision had been taken. On this argument there would be no role for the service user in the development or consideration of proposals although this is what the statute requires.

137. As for the point that the Decision was beneficial to the service users as a whole, I have accepted that there is a good deal to be said in favour of it. But this point has limited force in relation to compliance with section 242. The section does not require

arrangements for the involvement of service users only in relation to changes which are adverse to all, or even some, of them. Rather, it reflects a broader, essentially democratic, principle that service users should be involved in decisions about the health services which are available to them. I agree that where a proposal or decision is entirely or almost entirely beneficial, or its adverse features have very limited impact, this may mean that less protracted or detailed arrangements are required. But, here, the Decision did have a material adverse impact on a substantial number of service users. Indeed, the fact that the Trust recognised that the proposal was likely to be controversial is a reflection of this.

138. As for the point that the proposal was "temporary" in nature and subject to quarterly review, the Trust appears to have set great store by the designation of the changes as "temporary". There has been no challenge to its view that this meant that certain statutory obligations to consult were not triggered. But I do not consider that the fact that a proposal or decision is said to be temporary, of itself, is the important consideration in deciding the adequacy of arrangements for service user involvement. What matters is what impact the decision will have and for how long. I have dealt with the former and, in relation to the latter, the Decision was to take effect for *"at least"* 9 months. That seems to me to be a significant period of time, with no guarantee that there would be no extension.

139. I have accepted that the fact that a decision may be subject to quarterly review and that the plan may also be to involve service users in the interim may be relevant to the question whether given arrangements are meaningful, proportionate and fair. This is consistent with the requirement that the service user involvement takes place before the decision is taken but also with the point that the degree of involvement required will be affected by the nature and impact of the decision. But I agree with Mr Sachdeva that, in many cases, once a decision has been taken and implemented the status quo is different for as long as it is in force and the default position in relation to any subsequent involvement is materially different. Moreover, the longer the change remains effective, the greater risk that the status quo ante will be incapable of being restored. This is particularly so in the present case where substantial changes were made which affected the provision of existing services at the Hospital but also at the other hospitals in the area and this, in turn, affected the workforce of the Trust and the use and deployment of premises and equipment. For example, in total, around 600 Trust staff and an additional 50-75 staff members from third party tenants were identified for relocation under the Green site proposal. Once implemented, the proposal was unlikely to be reversed before 31 March 2021.

Issue 4

140. For all of these reasons, then, I am satisfied that the Trust breached both section 242(1B)(b) and (c) of the 2006 Act. This means that the fourth issue, referred to above, does not strictly arise. But I agree with both parties that the issue under section 242 is whether the required arrangements were made, rather than whether the Trust was aware of its legal obligation to make them. I also agree with Mr Sachdeva, however, that a Trust is likely to have more compelling evidence to explain any shortcomings in its arrangements if it is clear that the matter was considered and that it acted on reasons for not doing more which were appreciated at the time and were considered in the context of an awareness of the relevant obligations.

141. In the present case I do not propose to go behind the Trust's Part 18 response, which indicates that it was aware of the duty under section 242, albeit without saying when. Certainly, the duty was referred to in the *"ULHT 'Green' site communications and engagement plan"* to which I have referred at paragraph 70 above, which appears to have been in existence at the beginning of June 2020. But even on the assumption that this was so at all material times, although this assumption is not clearly justified on the evidence, there is no evidence of the implications of this duty being considered prior to early June. On the contrary, the strong indications from the evidence are that the Trust very much wished to emphasise that it had no duty to consult the public because the changes were temporary, and that it saw a need to communicate its decisions effectively to the public rather than to involve service users in its decision making. Any communication with the public appears to have been seen as voluntary "messaging" and/or for information only.

142. In relation to the Trust's evidence that it had in mind the 18 March 2020 guidance, this guidance does not actually refer to section 242 but, in any event, the Trust seems very much to have taken to heart the statement that the duty to involve might be met by *"very limited public involvement"* if it was necessary to take an urgent decision. However, as I have pointed out, the 18 March 2020 guidance was given in the context of the first, rather than the second, phase of the response to the pandemic and therefore with urgent short term decisions in mind i.e. decisions which were of a nature which did not require protracted involvement because there could not be sensible disagreement with them and they were clearly short term. As I have also said whether it is permissible to make very limited arrangements for public involvement will depend on the nature, impact and duration of the proposal or decision. The words of the 18 March 2020 guidance appear to have been embraced by the Trust, perhaps because it preferred not to engage with the opposition to its proposal which it anticipated, but those words ought to have been read in context and, even then, what mattered were the words of section 242 rather than the words of the guidance.

Conclusion on Ground 1

143. I therefore uphold Ground 1.

Ground 2

144. For completeness, I deal with Ground 2. The contention is that there was a failure to provide sufficient reasons to explain why the decision was to last for at least 9 months when the objective of returning to pre pandemic waiting lists was expected to be accomplished much sooner. Mr Sachdeva cites **Oakley v South Cambridgeshire District Council** [2017] 2 P & CR 4 [58]-[59], **Dover District Council v CPRE Kent** [2017] UKSC 79 [51] and **South Buckinghamshire District Council v Porter (No 2)** [2004] 1 WLR 1953, 1964. The alleged inadequacy of the reasons is said to support an inference that the Decision was irrational or made for an improper purpose.

145. I reject Ground 2. The reasons for the proposal set out in the Board paper, and further explained in the Board meeting of 11 June 2020, are sufficiently detailed. As to the point about the duration of the Decision, I accept that this was not explained in detail but I also accept that the reason for the changes being in place for at least 9 months, subject to quarterly review, reflected the projected duration of the third, "Recover", stage of the national response to the pandemic and the need to maintain non Covid-19

related services and patient confidence in their ability to make use of them. There is no basis for an inference that the period of time for which the Decision would apply and/or any lack of an explanation for this period of time is indicative that the Trust was in bad faith, or acting for an improper purpose, or that the Decision was irrational. The Decision itself was perfectly rational and was taken in good faith and for proper purposes.

Relief.

146. As noted above, in relation to Ground 1 the Claimant limits the relief which she seeks to a declaration that the Trust's decision, dated 11 June 2020, was in breach of section 242 of the National Health Service Act 2006 and unlawful. Ms Morris argues, however, that in the event that Ground 1 is made out I am nevertheless required by section 31(2A) Senior Courts Act 1981 to refuse relief *"if it appears to the court to be highly likely that the outcome for the applicant would not have been substantially different if the conduct complained of had not occurred."* That, she submits, is the position here.

147. Ms Morris reminds me of the following passage from the judgment of Coulson LJ on **Gathercole v Suffolk County Council** [2020] EWCA Civ 1179:

> *"It is important that a court faced with an application for judicial review does not shirk the obligation imposed by Section 31 (2A). The provision is designed to ensure that, even if there has been some flaw in the decision-making process which might render the decision unlawful, where the other circumstances mean that quashing the decision would be a waste of time and public money (because, even when adjustment was made for the error, it is highly likely that the same decision would be reached), the decision must not be quashed and the application should instead be rejected. The provision is designed to ensure that the judicial review process remains flexible and realistic."* (emphasis added)

148. Ms Morris submits that the Trust's appraisal of the available options for stepping up non-Covid-19 urgent services was clinically led and it found that a Green site at the Hospital was the only option that would fully meet its criteria of infection control excellence, capacity to deliver at scale and resilience. Whilst more extensive service user involvement could have provided additional information about the likely impact on individual patients, this would not have affected the overall appraisal of the options. She says that this is borne out by the fact that the service user involvement which has taken place since the Decision has not produced information which has materially altered the Trust's assessment of the appropriateness or necessity of the Green site model. She says that the suggestion that there were any other feasible options *"has an air of unreality"*.

149. Mr Sachdeva reminded me of various authorities on section 31(2A) of the 1981 Act, but the key points seem to me to be the following:

i) The burden of proof is on the defendant: **R (Bokrosova) v Lambeth Borough Council** [2016] PTSR 355 [88];

ii) As to the standard of proof, self-evidently, the hurdle remains a high one: **R (PCSU) v Minister for the Cabinet Office** [2018] ICR 269 [89];

iii) The court is required to address, on the evidence, the hypothetical or counterfactual question whether it is highly likely that the outcome would have been substantially the same had the conduct complained of not occurred: **R (PCSU) v Minister for the Cabinet Office** (supra) [89];

iv) That necessarily involves undertaking its own assessment of the decision making process (**R (Goring-on-Thames PC) v South Oxfordshire District Council** [2018] 1 WLR 5161 [47]) although the court should proceed with caution given the high standard of probability and the hypothetical nature of the inquiry, and it should be careful not to trespass into the domain of the decision maker: **R (KE) v Bristol City Council** [2018] EWHC 2103 [140].

150. Whilst I accept that the Board paper sets out what, on its face, appears to be a cogent case for the Green site model and for its location at the Hospital, the Trust has not satisfied me that it is highly likely that the outcome would not have been substantially different if it had complied with section 242(1B) of the 2006 Act prior to its decision on 11 June 2020:

i) The starting point is that there has been very little disclosure and limited witness evidence from the Trust in this case, as I have pointed out. That disclosure and evidence does not include evidence about the option appraisal process other than in the form of what ultimately became the Board paper.

ii) The 26 May 2020 Case for Change and the Board paper state the conclusions which the divisional managers of the Trust and Gold Command had come to in relation to the criteria which they had decided upon and applied, but the documents themselves do not reveal a great deal of the underlying evidence on which these conclusions were based, and particularly the evidence about other options.

iii) This is a case of wholesale failure to comply with the obligation to secure service user involvement in the development and consideration of the Green site proposal rather than minor or technical flaws in compliance with the Trust's statutory obligations. In such cases, reconstructing the world which never was will necessarily be more difficult. There was also very little involvement of service users in the making of the Decision itself.

iv) Here, as a consequence of the almost complete lack of involvement of service users in the decision making process one does not know a great deal about what precisely would have been argued or suggested had the Green site proposal been drawn to the attention of the Lincolnshire public on or shortly after 12 May 2020, and arrangements had been made to secure their involvement. One does, however, know that the Trust's own view, and indeed concern, was that the proposal would have been met with resistance and political and community pressure, and that there was a risk of an application for judicial review. It would be a strong thing to find, on the available evidence, that these matters are nevertheless highly likely to have had no substantial impact on the criteria for decision making, the proposal itself or its development and/or highly unlikely to have led management, and particularly the Trust Board, to a substantially different view.

v) Indeed, ironically, Mr Morgan's evidence was that until 2 June 2020 the proposal was very much subject to alteration and could have been dropped at any point. As I have noted at paragraph 88 above, the Trust itself also positively relies on the point that, in the light of experience and patient views expressed after the Decision, it has made significant changes to the original model. These changes appear to be substantial in that they have a material impact in reducing some of the inconvenience to service users resulting from the original model. As Mr Sachdeva also points out, even if the decision was to proceed with a Green site and to do so at the Hospital rather than elsewhere, there might have been other variations to the model such as it being for a shorter duration.

vi) The fact that the Trust has since retained the model after two quarterly reviews and that there is evidence that the Decision has been welcomed in some quarters, and has been beneficial to many service users, seems to me to have limited weight. What one has to do is to ask what the outcome would have been had section 242 been complied with in the run up to 11 June 2020, at which point hindsight would not have been available to the parties.

151. I therefore do not consider that granting declaratory relief in this case would be a waste of time or public money. On the contrary, I consider that it is just and convenient to grant declaratory relief.

Is the claim academic?

152. Although the question whether the Claim is academic is strictly a preliminary issue, neither Counsel suggested that it be dealt with as such at the beginning of the hearing and I therefore heard full argument on the Claim. I deal with the question whether the Claim is academic at this stage of my judgment because I did not consider that it is and because the findings and conclusions set out above indicate why.

153. Ms Morris submitted that on 16 March 2021 a decision would be taken as to whether to restore the status quo ante and there was a "significant likelihood" that the Trust would decide to do so. Such a decision would alter the position fundamentally. Even if this was not the decision, Mr Sachdeva concedes that the issues in any given case are fact sensitive. The situation has moved on and future decisions will take place in different circumstances and after significant public involvement as described in the second and third witness statements of Mr Morgan. There are, in truth, no issues of principle which will be determined by this case. She relies on **R (Zoolife International Limited) v Secretary of State for the Environment, Food and Rural Affairs** [2007] EWHC (Admin) 2995 [36] and submits that there are no exceptional circumstances which would warrant a decision by the Court in this case.

154. I do not agree that the Claim is academic. At the time of the hearing there had been some modifications to the Green site model but the services available at the Hospital before the Decision had not been restored. Nor was the Trust's position that they would be restored on or before 31st March 2021. It was merely that there was a significant likelihood that they would be. Nor did the Trust accept that it had breached section 242 of the 2006 Act. On the contrary, the Claim was contested. The Trust also resisted the grant of relief even if I found that there had been a breach of section 242. It therefore was not the case that the Claimant had obtained all of the practical relief which the Court could grant and that there was no longer any relevant dispute between the parties.

155. The arguments in the Claim also raised issues of principle in relation to the interpretation of section 242. Apart from the public interest in the determination of these issues, it is also apparent that they arise in the context of ongoing concerns amongst some members of the Lincolnshire public about the Trust's intentions in relation to the Hospital, so that there is a distinct possibility of future proposals or decisions of the Trust to which my decision in the present Claim is relevant. The parties had fully prepared the case and the matter was fully argued. Even if I had considered that the matter was academic, then, as a matter of discretion I would have been minded to decide it: compare **R (L, M and P) v Devon County Council** [2021] EWCA Civ 358 [48]-[53].