

GLS Administrative Law Webinar

CASE REFERENCE

R. (on the application of Smith) v East Kent Hospital NHS Trust

**Queen's Bench Division (Administrative Court)
04 December 2002**

Westlaw Case Analysis 4 pages

Official Transcript 26 pages

Status:  Positive or Neutral Judicial Treatment

R. (on the application of Smith) v East Kent Hospital NHS Trust

Queen's Bench Division (Administrative Court)

04 December 2002

Case Analysis

Where Reported

[2002] EWHC 2640 (Admin); (2003) 6 C.C.L. Rep. 251; [Official Transcript](#)

Case Digest

Subject: Health

Keywords: Amendments; Consultation; Legitimate expectation; NHS trusts; Public opinion; Reorganisation

Summary: Decision on reorganisation of health services in East Kent after public consultation - Consultation adequate and no duty to re-consult on proposal which was not significantly different - No duty to consult further on amended proposal which itself emerged from consultation process - Defendants did take into account product of consultation when making decision - Duty to consult did not include duty to obtain agreement or consensus of consultees - Community Health Council Regulations 1996 reg 18.

Abstract: S challenged E's decision to reorganise its health services, contending that E had failed to (1) institute fresh consultation given that the proposal adopted was so fundamentally different from the four options consulted on; (2) show how the proposal adopted arose from the public consultation; (3) consult on the risks associated with the provision of elective surgery, other than day surgery, without critical care support at the hospital, the use of patient rather than specialty selection and the extent to which the proposal affected cancer service provision; (4) allow views to be presented on matters other than the four options presented in the consultation document; (5) subject the proposal to public consultation since the detail of the proposal had not been settled when it was adopted, and (6) take account of S's legitimate expectation arising from a representation by the Secretary of State that full specialist cancer services would be provided at the hospital.

Held, dismissing the application, that (1) whether viewed individually or cumulatively, the differences between the proposal and the option consulted on were not fundamental and the interests of fairness did not require reconsultation, [R. v Shropshire HA Ex p. Duffus \[1990\] 1 Med. L.R. 119](#) and [R. v Islington LBC Ex p. East \[1996\] E.L.R. 74](#) followed; (2) the duty to consult did not include a duty to obtain the consensus or agreement of consultees. E had fulfilled its obligation of conscientiously taking the product of the consultation into account, [R. v North and East Devon HA Ex p. Coughlan \[2001\] Q.B. 213](#) applied; (3) the risks specified applied similarly to the proposal consulted on. Alternatively, there was no need to consult where the amended proposal emerged from and reflected the consultation process, *Ex p. East* applied; (4) even if E had prevented or inhibited comments unrelated to the four options, a duty to reconsult would only arise if it proposed to adopt a significant variation of the options; (5) it was unnecessary and undesirable where major options were being considered for the initial consultation to include too much detail, and (6) no such representation had been made, but even if it

had, it could not in the circumstances have founded a claim for a breach of legitimate expectation.

Judge: Silber, J.

Counsel: For S: Richard Clayton Q.C. and Fenella Morris. . For the trust: Neil Garnham Q.C. and Angus McCullough.

Solicitor: For S: Fisher Meredith. . For the trust: Capsticks.

Significant Cases Cited

R. v North and East Devon HA Ex p. Coughlan

[\[2001\] Q.B. 213](#); [\[2000\] 2 W.L.R. 622](#); [\[2000\] 3 All E.R. 850](#); [\(2000\) 2 L.G.L.R. 1](#); [\[1999\] B.L.G.R. 703](#); [\(1999\) 2 C.C.L. Rep. 285](#); [\[1999\] Lloyd's Rep. Med. 306](#); [\(2000\) 51 B.M.L.R. 1](#); [\[1999\] C.O.D. 340](#); [\(1999\) 96\(31\) L.S.G. 39](#); [\(1999\) 143 S.J.L.B. 213](#); [Times, July 20, 1999](#); [Independent, July 20, 1999](#); CA (Civ Div)

R. v Islington LBC Ex p. East

[\[1996\] E.L.R. 74](#); QBD

R. v Shropshire HA Ex p. Duffus

[\[1990\] 1 Med. L.R. 119](#); [\[1990\] C.O.D. 131](#); [Times, August 16, 1989](#); [Independent, August 29, 1989](#); [Guardian, September 22, 1989](#); QBD

All Cases Cited

R. v Secretary of State for Education and Employment Ex p. Begbie

[\[2000\] 1 W.L.R. 1115](#); [\[2000\] Ed. C.R. 140](#); [\[2000\] E.L.R. 445](#); [\(1999\) 96\(35\) L.S.G. 39](#); [Times, September 14, 1999](#); [Official Transcript](#); CA (Civ Div)

R. v North and East Devon HA Ex p. Coughlan

[\[2001\] Q.B. 213](#); [\[2000\] 2 W.L.R. 622](#); [\[2000\] 3 All E.R. 850](#); [\(2000\) 2 L.G.L.R. 1](#); [\[1999\] B.L.G.R. 703](#); [\(1999\) 2 C.C.L. Rep. 285](#); [\[1999\] Lloyd's Rep. Med. 306](#); [\(2000\) 51 B.M.L.R. 1](#); [\[1999\] C.O.D. 340](#); [\(1999\) 96\(31\) L.S.G. 39](#); [\(1999\) 143 S.J.L.B. 213](#); [Times, July 20, 1999](#); [Independent, July 20, 1999](#); CA (Civ Div)

R. v Islington LBC Ex p. East

[\[1996\] E.L.R. 74](#); QBD

R. v Shropshire HA Ex p. Duffus

[\[1990\] 1 Med. L.R. 119](#); [\[1990\] C.O.D. 131](#); [Times, August 16, 1989](#); [Independent, August 29, 1989](#); [Guardian, September 22, 1989](#); QBD

R. v Inland Revenue Commissioners Ex p. MFK Underwriting Agents Ltd

[\[1990\] 1 W.L.R. 1545](#); [\[1990\] 1 All E.R. 91](#); [\[1990\] S.T.C. 873](#); [62 T.C. 607](#); [\[1990\] C.O.D. 143](#); [\(1989\) 139 N.L.J. 1343](#); [Times, July 17, 1989](#); [Independent, August 4, 1989](#); [Independent, August 7, 1989](#); [Financial Times, July 19, 1989](#); [Guardian, July 20, 1989](#); QBD

R. v Brent LBC Ex p. Gunning

[84 L.G.R. 168](#); [Times, April 30, 1985](#); QBD

Legg v Inner London Education Authority

[\[1972\] 1 W.L.R. 1245](#); [\[1972\] 3 All E.R. 177](#); [71 L.G.R. 58](#); [\(1972\)](#)

[116 S.J. 680](#); Ch D

Key Cases Citing

Applied

R. (on the application of Elphinstone) v Westminster City Council

[\[2008\] EWCA Civ 1069](#); [\[2009\] B.L.G.R. 158](#); [\[2009\] E.L.R. 24](#); [Official Transcript](#); CA (Civ Div)

R. (on the application of Elphinstone) v Westminster City Council

[\[2008\] EWHC 1287 \(Admin\)](#); [Official Transcript](#); QBD (Admin)

R. (on the application of Wandsworth LBC) v Secretary of State for Transport

[\[2005\] EWHC 20 \(Admin\)](#); [\[2006\] 1 E.G.L.R. 91](#); [\[2005\] 8 E.G. 191 \(C.S.\)](#); [Times, February 22, 2005](#); [Official Transcript](#); QBD (Admin)

Followed

R. (on the application of Robin Murray & Co) v Lord Chancellor

[\[2011\] EWHC 1528 \(Admin\)](#); [\[2011\] N.P.C. 64](#); [Official Transcript](#); QBD (Admin)

All Cases Citing

Followed

R. (on the application of Robin Murray & Co) v Lord Chancellor

[\[2011\] EWHC 1528 \(Admin\)](#); [\[2011\] N.P.C. 64](#); [Official Transcript](#); QBD (Admin)

Mentioned by

R. (on the application of Baird) v Environment Agency

[\[2011\] EWHC 939 \(Admin\)](#); [Official Transcript](#); QBD (Admin)

Mentioned by

Devon CC v Secretary of State for Communities and Local Government

[\[2010\] EWHC 1456 \(Admin\)](#); [\[2011\] B.L.G.R. 64](#); [\[2010\] A.C.D. 83](#); [Official Transcript](#); QBD (Admin)

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R. (on the application of Elphinstone) v Westminster City Council

[\[2008\] EWCA Civ 1069](#); [\[2009\] B.L.G.R. 158](#); [\[2009\] E.L.R. 24](#); [Official Transcript](#); CA (Civ Div)

Applied

R. (on the application of Elphinstone) v Westminster City Council

[\[2008\] EWHC 1287 \(Admin\)](#); [Official Transcript](#); QBD (Admin)

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R. (on the application of Greenpeace Ltd) v Secretary of State for Trade and Industry

[\[2007\] EWHC 311 \(Admin\)](#); [\[2007\] Env. L.R. 29](#); [\[2007\] J.P.L. 1314](#); [\[2007\] N.P.C. 21](#); [Times, February 20, 2007](#); [Official Transcript](#); QBD (Admin)

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R. (on the application of Edwards) v Environment Agency (No.2)
[\[2006\] EWCA Civ 877](#); [\[2007\] Env. L.R. 9](#); [\[2007\] J.P.L. 82](#); [\(2006\) 103\(30\) L.S.G. 32](#); [Official Transcript](#); CA (Civ Div)

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R. (on the application of Wandsworth LBC) v Secretary of State for Transport
[\[2005\] EWHC 20 \(Admin\)](#); [\[2006\] 1 E.G.L.R. 91](#); [\[2005\] 8 E.G. 191 \(C.S.\)](#); [Times, February 22, 2005](#); [Official Transcript](#); QBD (Admin)

Legislation Cited

[Community Health Councils Regulations 1996 \(SI 1996/640\) Part .52](#)
[Community Health Councils Regulations 1996 \(SI 1996/640\) r.18\(4\)](#)
[Community Health Councils Regulations 1996 \(SI 1996/640\) r.18\(5\)](#)
[Community Health Councils Regulations 1996 \(SI 1996/640\) r.52\(3\)](#)
[Education Act 1944 \(c.31\) s.13](#)
[Health and Social Care Act 2001 \(c.15\)](#)
[Human Rights Act 1998 \(c.42\)](#)

Journal Articles

Regeneration projects can be held up by judicial review - it will help if you can show your decisions are fair and unbiased

Administrative decision-making; Judicial review; Public authorities.

[Building 2006, 45 Supp \(Regenerate\), 29](#)

Consultation criteria

Closure; Consultation; NHS trusts; Public authorities.

[N.L.J. 2006, 156\(7248\), 1706-1707](#)

Books

De Smith's Judicial Review 6th Ed.

Chapter: Chapter 7 - Procedural Fairness: Entitlement and Content

Documents: [Section 9. - Consultation and Written Representations](#)

Case No: CO/2862/2002, NEUTRAL CITATION NUMBER: [2002] EWHC 2640 (Admin)
IN THE HIGH COURT OF JUSTICE
IN THE QUEENS BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand,
London, WC2A 2LL

Wednesday 4th December, 2002

B e f o r e:

THE HONOURABLE MR JUSTICE SILBER

THE QUEEN ON THE APPLICATION OF MAUREEN SMITH

Claimant

– v –

(1) EAST KENT HOSPITAL NHS TRUST
(2) KENT AND MEDWAY HEALTH AUTHORITY

Defendants

(Transcript of the Handed Down Judgment of
Smith Bernal Reporting Limited, 190 Fleet Street
London EC4A 2AG
Tel No: 020 7421 4040, Fax No: 020 7831 8838
Official Shorthand Writers to the Court)

Mr. Richard Clayton QC and Miss. Fenella Morris (instructed by Fisher Meredith for the claimant)
Mr. Neil Garnham QC and Mr. Angus McCullough (instructed by Capsticks for the defendant)

J U D G M E N T
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Overview

1. Mrs. Maureen Smith ("the claimant") is seeking to quash the decision ("the March 2002 decision") made on 18 March 2002 by East Kent Hospital NHS Trust and Kent and Medway Health Authority ("the defendants") to reconfigure, namely to reorganise, the provision of health services in East Kent, and, in particular, the services at Kent and Canterbury Hospital ("KCH") in Canterbury. The defendants had set out four options for the reorganisation of those services in a consultation document entitled *Modernising Hospital Services in East Kent* ("the consultation document"), which was subject to public consultation from December 2001 to February 2002. The result of this consultation was inconclusive. The defendants decided in the March 2002 decision to provide a combination of services which, according to the claimant, was significantly different from the combination of services proposed in the consultation document; the defendants contend that they actually selected the services in Option D of the consultation document, together with some additional features when they accepted the proposals in the March 2002 decision.
2. In a nutshell, the previous history is that after consultation concerning the provision of health facilities in East Kent in 1998, recommendations were made for the reduction of services offered at KCH to the Secretary of State for Health ("the Secretary of State") who approved them in a letter of 22 December 1998 ("the December 1998 letter"), subject to certain conditions. There were then changes made in the approach to the provision of health services and this, together with other factors led to the publication of the consultation document in December 2001.
3. I must stress that this application is not concerned with the merits or defects of the March 2002 decision, but it deals with the very different issue of whether that decision should be quashed on a public law ground because of the way in which it was reached. Those challenges do not include an argument that the March 2002 decision was Wednesbury unreasonable or that it was not rational. Of course, appeals on questions of fact cannot be pursued on judicial review applications. Most of the issues on this application centre on the adequacy of the public consultation leading up to the March 2002 decision and whether the defendants should have re-consulted before reaching the March 2002 decision. There is additionally a contention that the defendants did not acknowledge or take into account the legitimate expectation of the claimant in relation to the provision of cancer services.
4. Before describing the issues, I must explain some of the terms that were frequently used in the evidence during submissions and which I will use in this judgment. A "critical care unit" deals with patients who require intensive care or have a high dependency on medical support. "Elective surgery" is surgery for which the date of which has been pre-arranged and it is therefore to be contrasted with emergency surgery. "Day surgery" is a form of elective surgery in which the patient does not stay in the hospital overnight. "Diagnostic and Treatment Centres" ("DTC") deal with the diagnosis and treatment of patients, but, as I shall explain, the attributes of a DTC do not have a clearly defined meaning with the result that there is no universal agreement as to what constitutes a DTC. "Accident and Emergency Services" ("A and E Services") involve providing a wide range of professional specialties, all available 24 hours a day to deal with anybody, who has been injured (accident) or who has become acutely ill (emergency).

The Parties

5. The original claimant, Concern for Health in East Kent ("CHEK"), is a campaigning organisation, which was established in January 1999 in order to respond to the proposed reconfiguration of health services in East Kent and the reduction of services at KCH. Its

members comprise current and potential patients of the health services in East Kent. Its constitution commits it to campaigning for the retention of A and E services at KCH and two other hospitals in East Kent, full cancer services at KCH and the maintenance of high quality health services throughout East Kent. After the closure of the A and E Services at KCH, the nearest A and E unit was 16 miles away.

6. After permission to pursue this application was obtained, CHEK was unable to continue to finance this claim for judicial review. As Mrs. Smith, unlike CHEK, could receive public funding and had received an offer for it, she then applied to become the claimant. In September 2002, Ouseley J ordered that the present claimant be substituted for CHEK as the claimant and I will therefore refer to her in this judgment as "the claimant".
7. The claimant has been active in local campaigns against the proposed changes in health care provision in East Kent for some time. She has been a member of CHEK since its inception in 1999 and she was co-opted to its management committee from 2000 to 2001. Since 2001, the claimant has been a full committee member of CHEK. No point is now taken by the defendants concerning her right to be the claimant in these proceedings, but the nature of her interest may become relevant in respect of her claim that her legitimate expectation in respect of the cancer service at KCH has not been complied with.
8. The first defendant, East Kent Hospital NHS Trust ("EKHT") is the NHS Trust responsible for the three hospitals in East Kent, including KCH. It was formed in 1999 by the merger of the three NHS Trusts that previously each had responsibility for one hospital. The second defendant, Kent and Medway Health Authority ("KMHA") is the health authority which has responsibility for purchasing health services in the Kent and Medway area. It was formed in 2002 by the merger of two health authorities, including East Kent Health Authority ("EKHA") and it has the responsibility for purchasing health services in the East Kent area, including those provided by the NHS Trusts. Identical claims are raised against both defendants, who both put forward identical defences. It is now necessary to describe the events leading up to the March 2002 decision, in order that the issues raised on this application can be understood.

The initial proposal for KCH

9. In early 1998, EKHA first consulted on its proposals for the future provision of health care in East Kent and in particular, on the future of KCH; they were set out in a document entitled *The Future of Hospital Services in Kent*. At that time, KCH functioned essentially as a district general hospital with 370 beds, a full 24 hour accident and emergency service, full surgical and medical in-patient services, full maternity services, a day surgery and out-patients service as well as specialities treating patients from the whole of Kent, not just East Kent, including neonatal care, neurophysiology, haemophilia services, renal services and a specialist cancer services unit. The other main hospitals in East Kent are and were Queen Elizabeth, the Queen Mother Hospital in Margate ("QEQM"), William Harvey Hospital in Ashford ("WHH") and the Buckland Hospital in Dover.
10. EKHA's preferred option for the future provision of healthcare in the area was for a reduction of services at KCH and the transfer of some services from KCH to the other hospitals in East Kent. It was proposed that at KCH there would be only 65 beds, a minor injuries unit but no A and E services, although there would be day-care treatment, out-patients units, a low-risk births unit and renal dialysis for out-patients only. Another proposal was that there would be no in-patient or emergency medical or surgical admissions, while the specialist cancer services would be reduced.

11. Having consulted on those proposals, EKHA then published on 29 June 1998 a report entitled *The Future of Hospitals Services in East Kent* setting out its recommendations, which were for a concentration on acute services at QEPMH and at WHH with a minor injuries unit instead of a full A and E Unit and a day surgery unit at KCH. The local Community Health Councils ("CHCs") were not satisfied with the outcome of the consultation process and they referred the matter to the Secretary of State.

The Secretary of State's response

12. The Secretary of State responded by explaining in the December 1998 letter that he would only endorse the proposal of the EKHA provided that a number of conditions were satisfied and I mention five of them. First, the proposals for A and E services and local emergency services across East Kent would have to be improved as they were not satisfactory. Second, as the proposals for haemophilia services and renal medicine were not satisfactory, the Secretary of State said that they too had to be improved. Third, the EKHA had to guarantee that on-site consultant anaesthetic, surgical and medical cover would be provided at KCH during the day, together with the provision of on-call cover in these specialities out of hours and at weekends. Fourth, the Secretary of State also required that more than 70% of the patients then being treated in the existing KCH A and E should be treated locally. Finally, he stated that KCH had to have 232 beds compared with the 65 beds originally proposed. The Secretary of State also wrote that "overall, 90% of the patients who would today expect to go to [KCH] should continue to be treated there".
13. The Secretary of State also recommended that there should be consultation on the possible merger of the three East Kent Hospital NHS Trusts. After consultation on this proposal, it was duly recommended. The Secretary of State's approval was sought and he wrote a letter on 17 March 1999 ("the March 1999 letter"), referring again to his December 1998 letter to EKHC stating, amongst other things, that:

"My overriding concern is that any new Trust structure in East Kent supports the implementation of the changes to hospital services which I announced in December ×

It is clear that some of the respondents to the consultation have seen a single Trust as a means of renegotiating my decision on service changes in East Kent.

I made it clear when I announced the service changes that my decision was not negotiable.

×

Turning to cancer, it is clear that many of the respondents to consultation were under the misapprehension that the proposal was to move specialist cancer services, rather than simply the management of those services, to Mid Kent Healthcare Trust from Kent and Canterbury Hospitals Trust. Let me repeat that the decision I announced in December on service changes in East Kent was final. The retention of specialist cancer services at Kent and Canterbury Hospitals was part of that decision. Specialist cancer services at Canterbury, therefore, have a firm future".
14. It will be necessary to consider these letters in greater detail when I consider the suggestion that they contained a representation that a "full specialist cancer" service would remain at KCH in the legitimate expectation issue in paragraphs 80 to 86 below.

The consequence of the Secretary of State's decision

15. In January 1999, CHEK was established and following the Secretary of State's approval, the three Hospital NHS Trusts were merged to form EKHT on 1 April 1999. Inpatient services were focussed at QEPMH and at WHH while KCH retained a day surgery, a 24 hour minor

injuries unit and it also provided other services. In the document, *Moving Forward* produced by EKHT as a Strategic Outline Case for its proposals in November 2000, it described the "proposed service option" at KCH. According to the claimant, it did not consider some of the more detailed requirements laid down by the Secretary of State in his December 1998 letter and in consequence, it is said by the complainant that it was impossible to assess whether they were to be met or not. The document did, however, expressly state that EKHT's objective was to fulfil the requirements of the Secretary of State. The issues raised by the claimant on this application do relate to the consultation process in 2001 and the way in which the March 2002 decision was reached, to which I now turn.

The 2001 proposals and the new round of consultation

16. I should explain that changes had occurred in 2000 as the NHS Modernisation Plan had come into effect in July 2000, setting out Government plans to modernise the National Health Service and at the same time national standards were being set. The National Cancer Plan had been published in September 2000. In 2001 various meetings within the EKHT had taken place, during which twenty-two different options had been considered for the reorganisation of its services. In June 2001 a report had been obtained by SIGMA HB who were consultants on Service Models following the involvement of clinicians. There was also on 11 June 2001 a Cancer Services Seminar considering how cancer services might be developed and supported under each option for reorganisation. A report had been produced by Professor James, the Director of Cancer Services for Kent highlighting the difficulties with each of the options because of recruitment problems. A number of options were considered during the course of interviews with staff and there were also a series of workshops at which about 60 clinicians and others involved with health services were invited to give their views. A decision was made on 9 August 2001 that as the option appraisal process had failed to demonstrate a clear preferred option, the views of other stakeholders, patients and the public should be sought.
17. On 30 October 2001, an adjournment debate took place in the House of Commons and during the course of it, Ms. Hazel Blears MP, the Parliamentary Under-Secretary for State for Health, stated of the medical services provided in East Kent, that:—

"the chosen option for configuring acute services which was endorsed by [the Secretary of State in the December 1998 letter] was right at the time it was taken. However, we are three years on and we have seen the introduction of the whole agenda for clinical guidance. We must therefore consider whether that configuration would still be able to meet present-day needs".
18. At the beginning of the consultation document it was stated that there would not be any further consultation on the decision made in 1998 "to concentrate acute inpatient services at Ashford and Margate" and not at KCH. The consultation document then stated that they proposed to consult on "the right mix of services to be provided at KCH and the effect of that choice on services and patients across East Kent". Four options were suggested in the consultation document for the mix of services to be provided. Consultation commenced on 5 December 2001 and was completed by 28 February 2002.
19. Each option included a provision that KCH would provide a 24 hour nurse-led minor injuries unit, day surgery, out-patient paediatrics, services for older people, midwifery-led risk maternity services and some cancer services. Option A was in accordance with the Secretary of State's decision except that it provided fewer beds and it had a reduced cancer service but it had a critical care unit, while Option B provided for elective surgical services at KCH for hip and knee replacement, urology and breast surgery and a critical care unit. Option C had the same elective surgery as in Option B, together with medical emergency admissions referred

by GP, as well as critical and coronary care units. Option D only had the core services provided at KCH with all acute in-patient facilities being distributed to QEQQMH and WHH; it is contended by the defendants that the March 2002 decision had the features in Option D and some others.

The genesis of the March 2002 decision

20. The consultation paper is a detailed document consisting of about 30 pages of text dealing with the consultation issues and it contained 13 appendices. There was extensive consultation with every member of the Trust's 8,000 staff receiving a summary consultation leaflet and a letter from the Chief Executive inviting their views in a range of ways which could be communicated at seminars, by e-mail, by fax and by phone. In addition, three rounds of staff seminars were held at each of the Trust's five hospitals.
21. A further twelve thousand summary leaflets were distributed to members of the public through a wide range of outlets which included GP surgeries, hospitals and pharmacies. The full consultation document was also made widely available. The summary leaflet was also published in a wrap-around form being attached to a free newspaper delivered to 227,000 households around East Kent and in the Local Health Authority's own newspaper for patients, *The East Kent Health News*. There was also extensive and regular media coverage. More than one hundred voluntary groups were invited to take part in seminars and about thirty of them took up the invitation, either for their own group or by means of joint events. Eleven public meetings were held with one taking place in each of the main towns in East Kent and the attendance at all these meetings totalled around two thousand people.
22. It is common ground that there was a poor response to the consultation with little positive support for any of the proposals. A total of 756 responses were received from the public and almost half (369) of them rejected all four options. Options C and D received considerably more support than A and B receiving 21.2% and 17.1% support respectively. A summary of responses from individuals and organisations showed that there was no consistent view of which option best met the needs of the East Kent population. It is striking that the total of 756 responses received in the 2001 consultation exercise contrasted with the 20,000 responses received in the 1998 consultation, to which I referred in paragraph 9 above.
23. On 6 February 2002, a meeting of the Medical Staff Committee ("MSC") took place in the light of the developing work of the Clinical Policy Board ("CPB") and the consultation process. Some members of the MSC were very hostile and they wanted to demonstrate that hostility. Thus an extraordinary meeting of the MSC was called for 4 March 2002 and it was then decided that a postal vote would take place. On the subsequent postal vote, Option A got three votes, Option B got ten votes, Option C got twenty votes, Option D got fifty nine votes while fifty six votes were for the category which was for none of the options. Thus, those voting considered by a substantial margin that Option D was the most popular of the options in the consultation document.
24. On 6 March 2002, a full day meeting of EKHT took place to consider the option. On 7 March 2002, an extraordinary meeting of the CPB took place and it approved the model that was finally approved as the March 2002 decision by the East Kent Hospital Trust on 18 March 2002. This option entailed elective surgery without critical care and the need for patient selection. As I have explained, "elective care" entails treatment, the date of which had been pre-arranged and unlike day-care, it entails the patient staying overnight and this feature has been the basis of one of the grounds of challenge, as requiring a fresh consultation to which I return in paragraphs 47 to 57 below.

25. On 18 March 2002, an extraordinary meeting of the East Kent Hospital Trust Board took place to consider the response to consultation. There was a presentation of the update on the Private Finance Initiative, together with reports on the results of consultation and on the proposal of elective surgery for carefully pre-selected patients. A discussion took place concerning the risk of elective surgery and the need for careful patient selection, as well as the lack of a high dependency unit treatment with ambulatory radiotherapy. The proposal for the March 2002 decision was carried by ten votes to two and it is that decision, which is the subject of the present challenge.
26. The proposal so selected had a number of elements in common with Options A to D. It included day surgery with dedicated theatres, out-patients facilities, midwifery-led low risk maternity services and renal dialysis. There were also some additional features of the proposals approved that were not included in any of the options, of which the claimant says the most significant is in-patient surgical beds for elective patient rather than specialty selected surgery; this is said by Mr. Clayton to be a feature, which justified fresh consultation. The other additional features were in-patient Rheumatology and Dermatology beds (which were not in Option D, but were in Options A–C), in-patient radiotherapy and non-acute rehabilitation. According to the defendants, many of these features were added as a result of the responses to consultation. There were also provisions made for some certain further details to be agreed.
27. On 25 March 2002, EKHA met to consider the proposals accepted in the March 2002 decision and it adopted them. It, however, decided that there should be further consultation on the arrangement for specialist services, such as renal and vascular care, since they represented a change from the "original decision of the Secretary of State".
28. On 9 April 2002, the Canterbury and Thanet CHC, as well as the South East Kent CHC referred the March 2002 decision of the defendants to the Secretary of State, who has subsequently indicated that he does not intend to respond to that referral until the present application for judicial review is determined.
29. CHEK then brought this application for judicial review. Harrison J gave permission for it to proceed. The defendants have undertaken not to implement the March 2002 decision without first giving reasonable written notice to the claimant. No such notice has yet been given. Before dealing with the grounds of challenge, it is appropriate that I should describe the statutory framework against which the reconfiguration has to be considered.

The Statutory Framework

30. The Secretary of State is under a statutory duty to provide, to such extent as he considers necessary to meet all reasonable requirements, hospital accommodation and other health services by section 3 National Health Service ("NHS") Act 1977. Most of the Secretary of State's functions in relation to the provision of such services are delegated to local health authorities pursuant to s8, 13, 16D and 17 of the NHS Act 1977 and NHS (Functions of Health Authorities and Administration Arrangements) Regulations 1996. Health authorities then enter into arrangements, NHS contracts, with NHS Trusts for the provision by them of health services.
31. The Community Health Council Regulations 1996 ("1996 Regulations") set out a scheme whereby local health authorities are required to consult with their local CHCs when significant changes are made to local health services, although there will be changes when the relevant part of the Health and Social Care Act 2001 comes into force, this has not yet occurred. Rule 18(4) of the 1996 Regulations provides:

In any case where a Council is not satisfied that × consultation on any proposal referred to in paragraph (1) has been adequate, the Council shall notify the Secretary of State in writing who may require the Health Authority to carry out such further consultation with the Council as he considers appropriate.

Rule 18(5) of the 1996 Regulations provides:

Where further consultation has been required under paragraph (5), the Health Authority shall, having regard to the outcome of such further consultation, reconsider any decision it has taken in relation to the proposal in question.

The Grounds of Challenge

32. There were many grievances raised in the claimant's skeleton argument, but during the course of the hearing, Mr. Richard Clayton QC for the claimant stated that he did not wish to pursue a substantial number of points, including the contentions first that the consultation process was flawed because of inaccuracies and inconsistencies in the consultation documents and second, that there were references to DTC in documents compiled before the consultation document was published and this showed that the preferred option was then under active consideration and should have been consulted on. This second point was not pursued as there is much uncertainty on the meaning of a DTC with the result that it cannot be shown that the preferred option was a DTC and that it had been considered as a preferred option before the consultation process started: the claimant accepts now that there is a range of views of what constitutes a DTC.
33. I should record that Mr. Clayton raised some new grounds of complaint in his reply. Mr. Neil Garnham QC for the defendant did not object when I indicated that he would be allowed to comment on these points in a further written skeleton document, which he helpfully submitted. I have been greatly assisted by counsel's written and oral submissions, for which I am grateful. The written submissions led to a substantial saving of court time, especially as there were a very large number of documents in this case.

The Issues

34. The March 2002 decision was initially challenged by Mrs. Smith and by her predecessor as the claimant, namely CHEK, on a large number of grounds. By the time when Mr. Clayton made his reply, as I have explained, many of those grounds had correctly and properly been abandoned, but instead other new grounds were relied upon. Before Mr. Clayton commenced his reply, I drafted a list of what I perceived to be his outstanding complaints. With the benefit of his amendments to that list, I summarise the grounds of challenge as being that:—
 - (i) the proposal in the March 2002 decision was so different from those options contained in the consultation document that there should have been fresh consultation about it before it was adopted by the defendants;
 - (ii) the defendants have failed to show how the proposal adopted in the March 2002 decision came into existence as a result of the public consultation especially as the defendant had extended the consultation period solely for the benefit of the doctors;
 - (iii) the defendants failed to consult (a) on the risks of elective surgery (other than day surgery) at KCH without critical care backup, (b) on the use of patient–selected elective surgery at KCH rather than specialty–selected elective surgery and (c) on the extent to which the selected option would affect cancer services at KCH or fail to fulfil the promise of the Secretary of State made in 1999;

- (iv) the defendants failed to allow the consultees to give their views on matters other than the four options specified in the consultation paper and failed to draw the attention of the consultees to the issues set out in issue (iii) above, especially as they were considered by the clinicians during and after the meeting on 4 March 2002 and so they should have been included in the consultation with the public;
- (v) the proposals selected in the March 2002 decision were so fluid when adopted by the defendants that they were still being evolved at that time without the benefit of public consultation;
- (vi) the failure of the defendants to acknowledge or to take into account in the consultation and in the decision-making process, the legitimate expectation of the claimant emanating from a representation made by the Secretary of State that a full specialist cancer service would remain at KCH.

The duty to consult

35. As many of the grounds of challenge relate to the obligation of the defendants to consult, it is appropriate to deal at this stage with Mr. Clayton's submission that the obligation on the defendants to consult was a strong one. It is common ground between the parties in this case that public consultation played a substantial role in the overall consultation exercise with interested parties, as well as in the decision-making process.
36. I do not understand the defendants to dispute the contention of Mr. Clayton that the obligation to consult on the part of the defendants was a strong one in this case. Indeed, in a Department of Health, guidance document published in 1999 and entitled *Patient and Public Involvement in the New NHS* which builds on the patient partnerships strategy, it is stated that:–

"× NHS bodies, staff and health professionals alike, will need to work in partnership with *all* parts of the local community, not just those groups they have traditionally had links with (important though those are) so that those who have in the past been marginalised or ignored can have a voice.

It is also important that public and patient partnership is genuine, not token, so that people at a local and national level, are fully involved in decisions both on their own care and on the way in which services are provided. The NHS needs to ensure that it systematically engages with, and listens to, its local communities. [It needs to] involve the public as citizens in health and health service decision making processes ×

× patient and public partnership "should not be a discrete 'add on' task, but part of the way all NHS organisations work", permeating all areas of the NHS and health".
37. In determining the claimant's complaints on the adequacy of consultation in this case, it is important to bear those principles in mind and I will do so, as I now turn to consider each of the grounds of challenge in turn.
 - (i) The proposal in the March 2002 decision was so different from the options contained in the consultation paper that there should have been fresh consultation about it before it was adopted by the defendants
38. The March 2002 decision differed in certain respects from the options which were contained in the consultation paper. The thrust of the complaint of Mr. Clayton is that the decision actually made was so *fundamentally* different from the proposals consulted on, so as to render that public consultation futile with the result that there should have been fresh consultation by the defendants on the proposals under challenge before they made the March 2002 decision to adopt them. Mr. Garnham disagrees by contending that the difference between what was consulted on and the contents of the March 2002 decision was slight and did not require fresh consultation.

The need for re-consultation - the legal principles

39. It is appropriate at this stage to consider the circumstances in which there should be a further round of consultation. Mr. Clayton says that there should be fresh consultation if a new proposal is fundamentally different in nature or effect from the proposals consulted on. Mr. Garnham submitted that an obligation to consult on the proposal which was finally adopted only arose if that proposal was fundamentally different from the subject matter of the options consulted on that the law demanded that the whole process should start again. Thus, the defendants contended the threshold for requiring a fresh consultation was for the consulting party to have made a wholesale rejection of the original proposals put forward in the consultation paper and to have replaced it by something different.
40. The basis of the defendants' submission was that it was in accordance with the approach advocated by Megarry J in *Legg and Others v. ILEA* [1972] 1 WLR 1245, in which he had to determine whether a proposal for re-organising schools could be regarded for the purposes of section 13 of the Education Act 1944 as amended, as a "modification" of an original proposal. He explained, with my italicised emphasis added, that:—
- "To some extent the matter must be one of impression. Nevertheless, however widely one construes 'modification', it seems to me that the difference between the proposals is so great that one cannot reasonably regard the second as a 'modification' of the first. (For brevity, I may say, I use the word 'of' as including 'in'; the statutory words are, of course, 'modifications therein'). For one proposal to be fairly regarded as a modification of another proposal, one must be able to perceive enough in it of that other to recognise it as still being that other proposal, even though changed. The temptation is into metaphysics, into considering how much of a table can be changed or replaced or modified without it ceasing to be the same table, and so on. The line may well be hard to draw, but there comes a point where the modifications have swamped or eaten away so much of the original that it is impossible to regard what is there as still being the original in a modified form.
- Analogies must no doubt be used with caution; but they may help to illustrate the point. A motor car may remain the same motor car, though modified, even if extensive alterations are made to the coachwork, the upholstery, the engine, the exhaust system and a dozen other things. Yet if the engine were to be removed from the car and dealt with separately, nobody would regard that engine as being the car with modifications, or as a modification of the car. Again, to turn from chattels to concepts, a proposal that A should sell his house to B with vacant possession plainly includes the obligation for A to vacate his house. Yet if it were then to be proposed that A should merely vacate his house, I find it impossible to regard the second proposal as being the first proposal with modifications. True, it was part of, and implicit in, the first proposal, and an important part at that. Yet it was only a part of a proposal which contained many other important parts, and it does not seem to me that the abstraction of a mere part of a proposal can, *unless it is at least a very substantial part, be regarded as being the same proposal with modifications* ×. In a crude way I suppose one could say that if what is at present proposed amounts to the original proposal with bits knocked off, it can be regarded as the original proposal with modifications, whereas if more has to be knocked off than is left behind, it cannot" (pages 1257A–G).
41. Mr. Clayton stresses that although that test of Megarry J provides some assistance, it was formulated in relation to a specific statutory provision and, in particular, it is only an authority on the meaning of the word "modification" in a particular statutory provision. That is correct but significantly, for the purposes of the present application, the Divisional Court

subsequently applied the approach of Megarry J to the common law duty of consultation in connection with changes in proposals put forward by a health authority for hospital facilities (R v. Shropshire Health Authority and Secretary of State ex parte Duffus [1990] 1 Med L R 119). A similar view to that expressed by Megarry J was also stated by Hodgson J, who said, with my italicised emphasis added, in R v. Brent LBC ex parte Gunning (1985) 84 LGR 168 at 198 that consultees had "a legitimate expectation that if *entirely different proposals* were made from those consulted on, they would be again consulted".

42. I consider that the approach of Megarry J approved as it was by the Divisional Court (Lloyd J and Schiemann J) in the Shropshire Health case to be of great assistance in determining how a consulting party should consider whether the terms of a proposal require fresh consultation. I also accept Mr. Clayton's further submission that in determining whether there should be a further consultation, I should also bear in mind the statement of Keene J (as he then was) in R v. London Borough of Islington ex parte East [1966] ELR 74 at 88D that "the extent and method of consultation must depend on the circumstances .. Underlining what is required must be the concept of fairness which in turn implies that those with a right to be consulted must be given an adequate opportunity to express their views and so influence the decision maker". The concept of fairness forms the basis of the comments of Megarry J, of Hodgson J and of the Divisional Court that I have quoted, because a right to be consulted is not of any value if the consulting party does not consult on the most basic features of a proposal that he ultimately wished to adopt, even though he has previously consulted on something totally different.
43. A matter of crucial importance in determining whether the defendants in this case should have re-consulted on the proposals under challenge was the nature and extent of the difference between what was consulted on in the consultation paper and the proposal accepted in the March 2002 decision. Clearly, if all the fundamental aspects of the decision under challenge had not been consulted on but ought to have been, that would indicate a breach of the duty to consult, while at the other extreme, trivial changes do not require further consideration. In approaching this issue, it is necessary to bear in mind not only the strong obligation of the defendants to consult, but also the dangers and consequence of too readily requiring re-consultation, as those dangers also flow from the underlying concept of fairness, which underpins the duty to consult.
44. As Schiemann J, as he then was, (with whom Lloyd LJ agreed) pointed out in explaining these dangers in Shropshire Health Authority (page 223):-

"A consultation procedure, if it is to be as full and fair as it ought to be, takes considerable time and meanwhile the underlying facts and projections are changing all the time. It is not just a question of an iterative process, which can speedily be run through a computer. Each consultation process if it produces any changes has the potential to give rise to an expectation in others, but they will be consulted about any changes. If the courts are to be too liberal in the use of their power of judicial review to compel consultation on any change, there is a danger that the process will prevent any change - either in the sense that the authority will be disinclined to make any change because of the repeated consultation process which this might engender, or in the sense that no decision gets taken because consultation never comes to an end. One must not forget there are those with legitimate expectations that decisions will be taken".
45. So I approach the issue of whether there should have been re-consultation by the defendants in this case, on the proposals now under challenge on the basis that the defendants had a strong obligation to consult with all parts of the local community. The concept of fairness should determine whether there is a need to re-consult if the decision-maker wishes to accept a fresh proposal but the courts should not be too liberal in the use of its power of judicial

review to compel further consultation on any change. In determining whether there should be further re-consultation, a proper balance has to be struck between the strong obligation to consult on the part of the health authority and the need for decisions to be taken that affect the running of the Health Service. This means that there should only be re-consultation if there is a fundamental difference between the proposals consulted on and those which the consulting party subsequently wishes to adopt.

46. Turning to the facts, the defendants contend that no further consultation was required because the March 2002 decision was, in essence, a version of Option D and Mr. Garnham described it as "Option D Plus", in the sense that there were additional features offered to patients in the decision under challenge over and above Option D. It therefore now becomes necessary to compare Option D with the proposal that was actually selected in the March 2002 decision.

The differences between Option D and the March 2002 decision

47. The consultation document explains that Option D "distributes all acute in-patient facilities across the two main hospitals in Ashford and Margate. Canterbury would have no medical emergency admissions, coronary care unit, critical care unit or acute rehabilitation care for older people" (page 35 of consultation document). I stress the absence of a critical care unit. The proposal under challenge had those features, as well as additional services in the form of rheumatology and dermatology beds, in-patient radiotherapy, non-acute rehabilitation and additional IT connections to the rest of the Trust.
48. It is contended by Mr. Clayton that the March 2002 decision is crucially different from Option D because it additionally created first, an elective care facility without a critical care unit, which provides more than just day surgery without a critical care unit and second, that use of this facility is based on patient selection, rather than specialty selection. It is submitted that this change called for further informed dialogue for three reasons, namely, first because of the safety implications, second because an elective care facility without a critical care unit was then untried in the United Kingdom and third, because the facility selects not by medical specialism but by reference to the characteristics of the patients with a result that it excludes the physically vulnerable, particularly the elderly. Mr. Garnham replies by submitting that on the evidence, none of those three elements individually or cumulatively can be categorised as a material change, let alone a change which was so fundamental that further consultation was required. I must now consider these three elements, which Mr. Clayton contends justified fresh consultation.

(a) Safety implications of the option selected

49. My task is to compare the safety of the elective surgery in the option selected with the safety of day surgery, as stated in Option D and to assess the significance of those differences. Mr. Garnham submits that the March 2002 decision did not have "safety implications" because the proposal was no less safe than Option D. I was concerned about the submission as initially before the consultation document was published, the idea of elective surgery without a critical care unit was rejected on safety grounds, but there have been developments between that time and March 2002. Dr. Noel Padley, who is a Consultant Pathologist and Medical Director at the EKHT, explains that he attended a seminar on 29 November 2001, during which some delegates from the United States of America had described their extensive experience of stand-alone surgery centres and which had allowed for stays of up to 72 hours. He explained that those delegates considered that in those centres that although there was a risk of patients in those centres requiring emergency services, that risk was minimised by rigorous control both of the procedures that were performed and of the selection of the patients on whom the procedures were to be applied. Dr. Padley concluded that although

some element of risk remained in the case of elective surgery, which was more than day surgery, it seemed from the experience of those delegates that it was possible to manage the element of risk to a level which compared favourably with the more conventional models of care. Mrs. Cracknell, the Director of the Private Financing Initiative at KCH was involved in the defendants' decision-making and she explained that she regarded this evidence as being compelling on reducing risk. The defendants attached importance to the ability to manage the risk by patient selection and controlling procedures of elective surgery without a critical care unit.

50. Dr. Padley also referred to a meeting of the Clinical Policy Board on 28 February 2002 at which it was agreed that a short stay in-patient surgical unit could be "safely run" at KCH. Mrs. Cracknell says of that meeting that "it was felt quite clearly that the short stay surgery unit would respond to the concerns expressed during consultation to retain more services at KCH and also enable the clinicians to work with what they felt was an acceptable level of risk". Dr. Padley has also explained that although the decision under challenge envisages more elective surgery at KCH than in Option D "there is no suggestion that it involves surgery with a higher chance of a patient needing critical care than envisaged under Option D and so the risks associated with [the proposal under challenge] are no different than those consulted on". Of course, Option D was for day surgery without a critical care unit.
51. The claimant's case is that the surgeons still remain deeply concerned about safety implications, however carefully patients are selected. Dr. Sewell, who is a very experienced doctor, but not a surgeon, holds that view, while other consultants, Mr. Collins and Mr. Heddle do not think that Option D is safe. It must be remembered that the actual ground of challenge on this point is not based on Wednesbury unreasonableness or on irrationality grounds, but it is focused on whether the safety factors involved in elective surgery, as compared with day surgery, meant that the option selected was so different from the options in the consultation paper (and, in particular, Option D) as to require re-consultation.
52. I have come to the conclusion that re-consultation was not required for safety reasons, not only in the light of what Dr. Padley explains about the American experience, but also in the light of the views of the Clinical Policy Board supporting the proposal under challenge that led to the proposal being put forward and accepted later, on 18 March 2002. I appreciate that Professor Pollock, who is, as I will explain, an expert on public health who made a witness statement on behalf of the claimant, states that there were no elective surgery services running in isolation from acute hospital services and critical care facilities in the United Kingdom, but she explained that a unit, which would provide a very restrictive menu of elective surgical treatment was being built in Kidderminster, remote from a critical care facility which is 18 miles away in Worcester. I infer from Dr. Padley's evidence that other bodies have regarded this form of treatment as being a safe option. I was impressed by his evidence that in America, it has proven possible to control the element of risk by patient selection and procedures so that the level of risk compared favourably to the more conventional models of care and have concluded that I should accept it as correct. If I had been in any doubt, I would have reached the same conclusion because the report before the EKHT before its meeting on 18 March 2002 said of the proposal which was accepted "the key issue would be to ensure that only patients who represented an acceptable risk were accepted for elective surgery". Thus, I am unable to accept the claimant's submission that the selection of the option included in the March 2002 decision embraced "controversial safety" issues so different from the day-surgery without a critical care unit specified in Option D as to require re-consultation. On the contrary, I consider that elective surgery could be managed so that the level of risk could be managed, as Dr. Padley says, to be of comparable level to conventional models of care.

(b) The proposal under challenge was untried

53. The next ground was that the proposal to create an elective surgery facility, more than day surgery without a critical care unit was to adopt an untried option. I have already referred to the evidence of Dr. Padley concerning the American experience of this facility and the support of the clinicians for this proposal. I accept this and I am unable to accept the notion that the defendants were adopting an "untried configuration" and that this required reconsideration. Alternatively, even if it was an untried option, I do not believe that this fact in itself would require re-consultation, because there had been consultation on an option with so many similar important features, such as the absence of a critical care unit near the operating theatre, as set out in Option D.

(c) The facility of day surgery in the proposal under challenge entailed selection not by reason of specialism, but because of the patient's characteristics

54. The third reason why the claimant contends that the proposal under challenge was fundamentally different from that in Option D is that it entails patient selection rather than specialism selection. Mr. Clayton submits that this prevents the physically vulnerable prospective patients from using KCH and that this is an issue on which there should have been further consultation.
55. In their written skeleton argument put in at the course of their reply, the claimant's counsel explained this point by saying that its impact was that:—
"Individuals who cannot make use of the elective surgery at KCH without a [critical care unit] (i) will need referral to other hospitals where they will be subject to delays and cancellation and delays caused by combining acute surgery with elective surgery and (ii) they will have to travel further. This has a particularly adverse effect on the elderly as there are those who are otherwise physically vulnerable who are a significant constituency in East Kent ..".
56. I am unable to accept that submission for two reasons. First, there had been adequate consultation about the absence of a critical care unit, which had been a salient feature of Option D. Second, even under the day-surgery issue consulted on in Option D, there was inevitably, as Mr. Clayton ultimately accepted, a selection process of patients taking into account their personal characteristics and not merely the specialism concerned. Clearly, some day surgery might well have been perfectly suitable for a fit person in his early twenties, but that day surgery might not be regarded as suitable for somebody aged in their nineties or for a person who had, say, a serious heart or other major health problem. The same would apply to non-day elective surgery and the report before the EKHT at its meeting on 18 March 2002 stated of the option accepted that "the key issue would be to ensure that only patients who represented an acceptable clinical risk were accepted". Put in another way, I do not consider patient selection rather than specialism selection became a more important feature in elective surgery than in day-surgery for the simple reason that similar selection criteria must always have been a feature of day surgery under Option D.
57. No re-consultation was required for this or for any other reason whether taken individually or cumulatively as the difference between the proposal under challenge and Option D was very slight and they were clearly not such that fairness required re-consultation, even on Mr. Clayton's criterion for requiring fresh consultation. There are two further but discreet reasons why re-consultation was not necessary. First, Professor Alyson Pollock, who is a Public Health Physician with special interest in the delivery of health care and who made a witness statement on behalf of the claimant, considered the terms of the option in the consultation

document and of the proposal ultimately selected. She concluded that "the services described in the preferred option can be accurately described as a mixture of the service provision identified in the four options". This comment further undermines the claimant's complaint that there should have been a fresh consultation before the March 2002 decision was taken. Second, as I will explain in paragraph 61 below, the March 2002 decision emerged from consultation and Keene J (as he then was) stated in *R v. London Borough of Islington ex parte East* ([1996] ELR 74 at 88) there was no duty "to consult further on [an] amended proposal which had itself emerged from the consultation process. It was a proposal reflecting the consultation process itself". As I will explain, that was the position here.

(ii) The defendants have failed to show how the proposal adopted in March 2002 came into existence as a result of the public consultation, especially as the defendants had extended the consultation period for the benefit of the clinicians

58. The claimant contends that it is for the defendants to show that the proposal under challenge "emerged" from consultation as opposed to by means of some other independent process. The case for the claimant is that the defendants failed to show that the revised proposal came into existence as a result of public consultation because they appear to have emerged instead from the defendants' Clinical Policy Board and PFI Project Board. So it is said that the proposal under challenge failed to satisfy the consultation criteria recently laid down by the Court of Appeal in *R v. North East Devon Health Authority ex parte Coughlan* [2001] QB 213 for two reasons. The first is that it failed to take into account the product of consultation, while the second reason is that the defendants extended consultation, but only for the clinicians and not for the public.

(a) Failing to take into account the product of consultation

59. In the skeleton argument used for the claimant's reply, it was submitted by Mr. Clayton that:—
"A proposal can properly be said to emerge from public consultation first, if the final proposal is based on a consensus or agreement *arrived at* by the consultees and second, that it is arrived at as a result of the consultees' discussions".
60. The basis of the claimant's submission is that those carrying out a consultation exercise, in this case the defendants, had an obligation only to adopt a proposal that first, was not merely arrived as a result of the public consultation but second, was one which enjoys consensus or the agreement or consensus of the consultees. So it would seem that the duty of the defendant was not merely to consult, but thereafter only to adopt what the consultees wanted. In other words, the defendants needed something like a positive mandate from the consultees before they could make the decision under challenge.
61. I cannot accept that submission as the authorities establish a very different and more limited obligation on the consulting party, namely that "the product of consultation must be conscientiously taken into account when the ultimate decision is taken" (*Coughlan* (ibid) [108] per Lord Woolf CJ) or that the result of consultation "is conscientiously taken into account in finalising any × proposals" (*R v. Brent LBC ex parte Gunning* (1985) 84 LGR 168 at page 189 per Hodgson J) and that this must be done with "a receptive mind" (*R v. Camden LBC ex parte Cran* (1996) 94 LGR at page 38 per McCullough J). No authority was cited to show that the obligation goes any further and the National Health Guidance document does not say so. It refers to the need for Health Authorities to engage and to listen to local communities. Indeed, if the claimant were right, it would mean radically recasting the principles of administrative law so that the duty to consult would be extended to also include a duty not to make a decision without prior agreement or consensus of the consultees. As there is no authority to support the claimant's submission, I consider that, as recently stated by

Lord Woolf in essence, a duty to consult does not comprise a duty to obtain the agreement or consensus of the consultees before acting.

62. The evidence shows that the defendants did comply with the duty as enunciated in the authorities referred to in paragraph 61 above in that they took the product of consultation into account by considering it and by adding additional services on to Option D. Dr. Noel Padley, the Medical Director of EKHT was, as I have explained, closely involved in the consultation process and the process in which the decision under challenge of March 2002 was made. He explains in his witness statement that the community of Canterbury and its environment had expressed the view clearly in wanting more services at KCH than Option D. Against that background and taking those views into consideration, the provision of short stay surgery units (as compared with the day surgery) constituted a response by the defendants prompted by those concerns, as it enables many more operations to be conducted at KCH than had been envisaged with day surgery in Option D. Nevertheless, significantly it was necessary for the defendant to ensure that it could be achieved safely; that was an aspect of the proposed decision on which the clinician's views would be of value to the defendants. The clinicians agreed to that at their meeting of 7 March 2002. Dr. Padley explains that the decision of March 2002 took account of the views that emerged during the consultation and it was supported by the CPB. I have no reason not to consider that to be correct and this means that I am unable to accept the claimant's challenge on this point.

(b) The wrongful extension of consultation for the benefit of the clinicians

63. It is appropriate at this stage to deal with a further complaint by the claimant, which is that the defendants decided to extend the consultation to 7 March 2002, as the defendants were then considering with the clinicians the defendants' proposals in the light of what had emerged from the consultation. The reasons for this further consultation are of relevance, as it seems that but for the views of those in the locality of Canterbury, Option D would probably have been preferable. As I have explained, the defendant, however, sought to take account of the views of the Canterbury constituency that there should be more services in Canterbury than in Option D and it was felt that short-stay surgery would respond to those concerns. The safety aspects were considered at the meeting of 7 March 2002, which was called as a consequence of the product of response. The purpose of the meeting on 7 March 2002 was to see if the use of elective surgery could meet the concerns of those who wanted more services at KCH while at the same time providing a safe form of treatment. The clinicians at the meeting were in a pre-eminent position to respond. The claimant's criticism seems to be based on a notion that all parties entitled to be consulted should not only be consulted initially, but should also be entitled to be consulted equally thereafter. This proposition is unsupported by authority or principle and must be rejected on that ground.
64. I have no reason not to accept this assertion of the defendant that the responses were taken into account, especially as I have explained in paragraph 22 above, that the consultees had been unfavourable to all of the proposals. In other words, the defendants did what they were required to do and I suspect that if the defendants had not discussed the safety aspects of elective surgery with the clinicians, the claimant would have seen this as a ground for challenging the decision on the grounds that they had not discussed these issues with those most knowledgeable about them. I therefore reject this criticism.

(iii) The defendants failed to consult (a) on the risks of elective surgery, other than day surgery at EKCH without critical care backup, (b) on the use of patient-selected elective surgery at KCH rather than specially selected elective surgery and (c) on the extent to which the selected option would effect cancer services at KCH or fail to fulfil the promise of the Secretary of State made in 1999

65. The claimant's contentions that the defendant should have consulted on the matters set out in (a) and (b), namely on the risks of elective surgery without critical care backup and on the use of patient-selected elective surgery at KCH, rather than specially selected elective surgery is another way of putting her first complaint, which I considered and rejected in paragraphs 49 to 56 above, which was that the proposal in March 2002 was so different from those contained in the consultation document on these grounds that there should have been fresh consultation about it before it was adopted by the defendants. As I have already explained in paragraphs 49 to 52 in respect of issue (a), this complaint is unfounded because the risks were not so different from those in Option D. By the same token, allegation (b) that the defendants failed to consult on the use of patient selected elective surgery is also unsustainable for the reasons set out in paragraphs 54 to 59 above. A second and alternative reason why there was no need to consult was, as I have explained in paragraph 57, Keene J (as he then was) stated that there was no need to consult further where, as here, the amended proposal emerged, as I have explained in paragraph 62, from the consultation process and in particular, the need for more services in Option D.
66. I nevertheless must consider in more detail the third leg of this submission which is that the defendants failed to consult on the extent to which the selected option would effect cancer services at KCH or fail to fulfil the promise of the Secretary of State made in 1999.
67. The consultation document contained in its Appendix II proposals for cancer services contained in the consultation paper. It was also pointed out in the consultation document that KCH "is part of the Kent Cancer Network" and remains so in all of the East Kent options (page 15 of the consultation document). It was also explained on that page of the consultation document that under all the options "cancer patients needing day surgery could continue to be treated at their local hospitals". The March 2002 proposal embodies what was proposed and explained in the consultation document as applying to all the options in that document, but subject to some additional service for cancer patients at KCH in the form of in-patient beds for oncology patients. As Professor James, the Director of Cancer Services for Kent has explained, the proposals for cancer services in the decision under challenge were not different upon those which public consultation had taken place and nothing said by the claimant casts doubts on this.
68. The December 1998 and March 1999 letters from the Secretary of State containing his decisions appeared in appendices VIII and IX respectively of the consultation document and consultees were therefore able to comment on the relationship between the options proposed and those documents. As I have already indicated, the evidence shows that the views of the consultees on these issues were taken into account, but for the purpose of the issue now under consideration, all that needs to be said is that the defendants did not have any obligation to consult further on cancer services, as the proposal selected contained all the features set out in the consultation document, together with some additional features and these could, in any event, be compared by consultees with the Secretary of State's letters. Thus, this ground of challenge also fails.
- (iv) The defendants failed to allow the consultees to give their views on matters other than four specified options in the consultation and failed to draw the attention of the consultees to the issues set out in issue (iii), especially as they were considered by the clinicians and should have been the subject of public consultation
69. The basis of the claimant's case is that comments of the consultees were sought *only* on the four options in the consultation document and at public meetings. Mr. Clayton points out that at page 2 of the consultation document, prospective consultees are told that "your views on

the options [A–D] will be considered carefully before the decisions on the organisation of service is made". At page 3 of the consultation document, it is said that all responses about "the four options" will be analysed and considered.

70. Mr. Clayton relies strongly on what some witnesses say was said by representatives of the defendants at the public meetings. I will give some examples. Mr. Richard Collins, a consultant, said that he attended public meetings held by the defendants in Canterbury and at those meetings, the Trust Management "made it clear that consultation was limited to the four options and that these were separate models". Another consultant surgeon at KCH, Mr. Robert Heddle, says that he attended a public meeting in Canterbury, at which those representing the defendants "made it clear that no options other than the four options A–D could be considered and that these options were strictly limited". The Chairman of CHEK, Mr. David Shortt, says that he attended most of the public meetings held during the consultation period and "each public meeting the public were told that they could only consult on options A–D and that there was no indication there could be a mix and match of services from options A–D". Mr. Vye, a local councillor who was a member of CHEK said that he attended meetings of Kent County Council and "we were told quite clearly we were limited to considering the four options and that any other proposal would not be countenanced".
71. Other evidence put in by the claimant indicates that prospective consultees understood the four options under consultation were discreet and one would be chosen (as appears in the evidence of Dr. John Sewell, the claimant and Mr. Thomas Bulger, the Assistant General Secretary of the Royal College of Nursing of the United Kingdom).
72. The assertions of what was actually said at meetings is challenged by the defendants. It is difficult on applications for judicial review without the benefit of cross-examination to ascertain the truth about what was said at meetings, especially as even the most eminent doctors can be mistaken in their recollection. Initially Mrs. Elizabeth Cracknell said in a witness statement that participants at the meetings had been invited to consider other ways in which the Trust could provide medical services. Subsequently, in a later witness statement, she explained that she had listened to the tapes of several public meetings, again for the purpose of ascertaining the true position and she then realised that the contention put forward by the claimant that consultees were expressly excluded from considering options outside A–D was wrong because "the point was not expressly raised either positively or negatively". Clearly, the tapes would be the best evidence available to me of what precisely was said. Although the claimant or her advisors could have asked to listen to the tapes so as to challenge Mrs. Cracknell's assertion, no evidence refuting Mrs. Cracknell's claim has been adduced and no request was made to cross-examine her. I consider that I should accept Mrs. Cracknell's evidence as it does not depend on recollection, but on listening to tapes, which constituted the best evidence of what was said.
73. I therefore do not consider that anything was said at the meetings to prevent prospective consultees from putting forward any additional proposals, but I also believe nobody was positively encouraged to put forward their own specific proposals. None of the statements in the consultation document or in any other literature distributed by the defendants states either that no matter other than the four options in the consultation document could be or should be commented on or that the consultees had only to vote for one of the four options or that views on any other options would be welcome.
74. Significantly, a substantial number of consultees, such as CHEK, did in fact make alternative suggestions for providing medical services or make general comments. It is noteworthy that although Mr. Vye said that the understanding of Kent County Council was "that we are limited to considering the four options and any other proposal would not be countenanced", it

did, in fact make contrary proposals in the form of amendments to Option C. I conclude that I cannot accept the complaint of the claimant that consultees were prevented from or were inhibited from commenting on anything other than the four options.

75. Even if I am wrong and it was stated or understood at the meetings that consultees had to limit their responses to the comments on the four options, the consequence of this is, as Mr. Clayton accepted, that this meant that a clear obligation on the defendants to re-consult was imposed if the defendant later proposed to adopt a significant variation from any of the four options in those papers. The reason for that was that the public would have been otherwise deprived of the right to be consulted as the only prior consultation would relate to different matters. As I have explained in paragraphs 49 to 57 above, my clear conclusion is that there was not such a difference.
76. The claimant also complains that there should have been public consultation on the three matters referred to in issue (iii) above. I have already explained in paragraphs 65 to 68 above that there was adequate consultation on each of those issues and that two of the matters emerged from the consultation process, this means that this challenge to the March 2002 decision also fails.

(vi) The proposal under challenge was so fluid when adopted by the defendants that it was still evolving without the benefit of public consultation

77. The basis of this allegation was that the proposal for reconfiguring or reorganising the services was still evolving when it was adopted as the March 2002 decision because of the uncertainty on the meaning of the term "DTC" and also because the service mix to be implemented had then still to be decided. It is quite correct that the final proposal required some further decisions to be made in relation to matters of detail and that point was made clear at the time when the March 2002 decision was made, but the defendants submit that this fact does not vitiate the process which led to that decision being taken.
78. There is no obligation for a party to consult on each and every specific item of detail when there is a series of different models available as options. Indeed, there is nothing illogical or unfair about a body first consulting on the main features of reconfigured services so that its structure can be initially determined and then later at a second stage working out the precise detail of the course selected. Obviously there would then have to be a subsequent decision on whether there should be subsequent consultation on the detail but for the purpose of this application, all that needs to be said for the purpose of the present application is that such detail need not have been included in the initial consultation before the decision was made to make the March 2002 decision. Whether there is a need for further consultation about the detail now that the option has been selected is not a question that I have to determine on this application. As I have already noted, at the EKHT Board Meeting on 25 March 2002, it was decided that some further consultation was needed, but the claimant does not have a legitimate complaint that those details had not been consulted on or had not been specified at the time of the March 2002 decision, especially bearing in mind that a consultation document on major options like the one under consideration ought not to become involved in too much intricate detail as it otherwise undermines the consultation process.

(vi) The failure of the defendants to acknowledge or take into account in the consultation or in the decision-making process the legitimate expectation of the claimant emanating from a representation made by the Secretary of State that a full specialist cancer service would remain at KCH

79. The claimant contends that in the December 1998 and March 1999 letters, the Secretary of State promised that a full specialist cancer service would remain at KCH and that this required the defendants to fulfil a number of requirements in the reconfiguration or the reorganisation of health services. It is submitted that as the defendants agreed to fulfil the Secretary of State's requirements, a substantive legitimate expectation was created. The argument of the claimant is that the defendants had acted wrongly in failing to acknowledge this legitimate expectation and consequently in failing to take this expectation into account in the consultation and in the decision-making processes. It is also contended that the defendants have failed to discharge the burden of providing an overriding public interest as justifying their failure to honour this legitimate expectation. The defendants put forward a large number of reasons why this claim must fail and I will mention some of them.

(i) No representation made

80. First, the defendants contend that the representations relied upon by the claimant that "full specialist cancer services" would remain at KCH does not record what is stated in the only two relevant letters from the Secretary of State, which are the December 1998 and March 1999 letters. While the December 1998 letter does not refer specifically to a provision of services in relation to cancer, the March 1999 letter records that the Secretary of State had considered the outcome of the consultation on the proposal to merge various hospital trusts and "the outcome of the separate consultation on the proposal to transfer the management of specialist cancer services at [KCH] to Mid-Kent Health Care Trust".
81. In the sixth paragraph of his March 1999 letter, the Secretary of State says, with my italicised emphasis added, that:
"Turning to cancer, it is clear that many of the respondents to consultation were under the misapprehension that the proposal was to move specialist cancer services rather than simply the management of those services to Mid Kent Health Care Trust from Kent and Canterbury Hospitals Trust. Let me repeat the decision I announced in December on service changes in East Kent was final. The retention of specialist cancer services at Kent and Canterbury hospital was part of that decision. *Specialist cancer services at Canterbury therefore have a firm future*".
82. The Secretary of State makes it clear in the second sentence that I have quoted that his decision about cancer services had already been made in December 1998 and so in order to discover what was decided about cancer services it is necessary, therefore, to turn to the December 1998 letter. That letter makes no express references to cancer services. It certainly contains no reference to "*full specialist cancer service*" as is now asserted by the claimant. The December 1998 letter is the Secretary of State's decision on the Health Authority's proposals on the future of hospital services in East Kent, as is explained in paragraph 1 of the letter. The Secretary of State endorsed those proposals subject to a number of conditions, none of which referred to cancer services.
83. In order to discover what the Secretary of State endorsed it is necessary to examine the proposals before him and they were set out in the minutes of the Health Authority of 29 June 1998 and in particular, resolution 20 which shows that first, the Health Authority confirmed the "*Better Balance*" decision based on the WHH and the QEQM and second, that the decision to provide certain additional services at KCH was subject to possible future changes.
84. The proposal agreed and accepted by the Health Authority and known as "*A Better Balance, WHH and QEQM option*" and confirmed by that resolution is summarised in the table in that document, (which is part of the Health Authority's proposal document "*The Future of*

Hospital Services in East Kent" - 29 June 1998). This table shows that "radiotherapy and chemotherapy" were to be provided at Kent and Canterbury.

85. That proposal is expanded in the text of *"Future of Hospital Services"* in which the cancer services to be provided are described. It is particularly noteworthy that it is stated that:—
- (a) "There are not enough cases in the East Kent area for Canterbury to sustain a complete or self-contained cancer centre" (paragraph 95).
 - (b) "There may be conditions where it would not prove possible to sustain this configuration" (paragraph 249).
 - (c) "There is no hospital in Kent of sufficient size or containing the breadth of clinical facilities to be designated as a Cancer Centre. The implementation of the Calman–Hine principles in the county has resulted in the following configuration × the designation × of a joint Kent Oncology Centre based at both Kent and Canterbury and Maidstone Hospitals × Kent and Canterbury Hospital is not a Calman–Hine Cancer Centre in its own right" (paragraph 11).
 - (d) "This network of surgery will continue except that in the preferred option [the option eventually selected] the inpatient surgical work at the Kent and Canterbury would be transferred to WHH and QEQM × Day surgery would continue at the Kent and Canterbury and QEQM in both options" (paragraph 17).
 - (e) "Cancer units for specific tumours already designated in South Kent Hospitals would continue as before. Cancer units for tumours currently designated at QEQM and K & C would serve the Canterbury and Thanet populations but would normally be based at the "full" district general hospitals serving that part of East Kent" (namely Margate and Ashford since this will be where the main concentration of surgical expertise will be based) (paragraph 19).
 - (f) "East Kent patients may have to be treated out of district by specialist surgical teams, but it must be stressed that this is a possibility irrespective (of) Tomorrow's Health Care" (paragraph 24).
 - (g) "Complex regimes of chemotherapy often require patients to be admitted to hospital on an in-patient basis × typically this will mean that the patient is managed by clinical oncologists × or by medical oncologists × (there are none of these specialities in East Kent but one visits at Maidstone Hospital) × and clinical haematologists × these clinicians must work in Cancer Centre designated departments" (paragraph 26).
 - (h) "As the Oncology Centre at Maidstone develops and other cancer centres functions consolidate on that site the pressure will increase of radiotherapy services at the Kent and Canterbury site to transfer to Maidstone. This would be the situation regardless of whichever option was chosen for the future configuration of acute services" (paragraph 35).
 - (i) "The commissioning specialist cancer services in East Kent, where this is possible × would be achieved by × maintaining complex chemotherapy and radiotherapy at Kent and Canterbury Hospital × by × maintaining medical services in Canterbury which would provide the support services required. The service would continue whilst Tomorrow's Health Care is being implemented for other services and then reassessment would be taken in 3–4 years time" (paragraph 61).
86. In summary, it is these proposals which have been endorsed, as I have explained, in turn by the Health Authority and by the Secretary of State. They do not contain a statement by the Secretary of State or by the Health Authority that "*a full specialist cancer service*" would be maintained at the Kent and Canterbury Hospital. Indeed, the most that is said about cancer services at KCH is that "specialist cancer services have a firm future", which is very different from stating that "*a full specialist cancer service*" would remain at KCH. So I am unable to accept that a representation of the kind alleged by the claimant was made by the defendants or the Secretary of State and that would defeat this claim based on legitimate expectation.

(ii) No clear and unambiguous representation

87. I also agree with the second response of the defendants that even if, contrary to my earlier finding, there was a representation of the kind alleged made by the defendants or the Secretary of State that there would be "a full specialist cancer service", then this representation is not sufficiently clear or unambiguous to found a claim for a breach of a legitimate expectation. It is settled law for there to be a representation giving rise to a legitimate expectation, it must be "clear, unambiguous and devoid of relevant qualification" (per Bingham LJ in *R v. Inland Revenue Commissioners ex parte MFK Underwriting Agents Limited* [1990] 1 WLR 1545 at 1569C).
88. I do not understand what the term "full specialist cancer service" means or what services it would comprise. For example, I am not sure if that service denotes that all or which cancers will be diagnosed, will be treated and how they will be treated. For example, Professor James, who has been Director of Cancer Services for Kent since May 1999, explains that Kent has traditionally transferred to London specialist centres patients with rarer cancers such as children, those with brain and lung cancers and those requiring bone marrow transplants; I am not sure if that means that Kent has never provided a "full specialist cancer service", but I am satisfied that even if a representation was made that there would be "a full cancer service", such a representation was not sufficiently clear as to be capable of giving rise to a legitimate expectation. This is another reason why the legitimate expectation claim has to be rejected.

(iii) The representations made provided for change and there cannot have been a legitimate expectation that they would not change

89. In any event, even if, contrary to my earlier conclusions, an unambiguous representation of the kind and to the effect contended for by the claimant had actually been made, a further difficulty for the claimant is that the representation relied on itself provided for change and it was the one that the Secretary of State endorsed with minor amendments in the "Better Balance" proposals. They specifically stated that the configuration of the cancer services may have to be amended in the light of future events and so they were conditional. The Secretary of State also endorsed the EKHT's decision, subject to conditions and the terms of his decision were, with my italicised emphasis added, that:—
- "in setting this strategic direction, the HA will endorse the "Better Balance" option based on William Harvey Hospital and Queen Elizabeth the Queen Mother Hospital with the additional services described in that option retained at Kent and Canterbury Hospital *until or unless the trends described by the HA prevent the achievement of acceptable service quality on the third site or compromises the viability or quality of the two main acute hospital sites*. The HA is determined to ensure early implementation and sustainability of the chosen option" (unanimously passed).
90. This wording indicates that even if the Secretary of State made any representation, it was conditional and not, in Bingham LJ's words "devoid of relevant qualification"; so there could not have been a legitimate expectation that it would not change.

(iv) Lack of expectation on the part of the claimant

91. Mr. Garnham contends that even if contrary to his case, a representation was made to the claimant, no expectation existed on her part. His starting point for this argument was that the claimant was a committee member of CHEK, which, according to the defendants, had no expectation that the Secretary of State's proposals would be in place. The CHEK position at the time of the consultation was that the Secretary of State's plan was unworkable and it

referred to its "sure and certain knowledge that the Dobson plan could not and would not ever work" while CHEK also said of that plan that "it is simply not possible". Indeed, CHEK's own proposal in response to the consultation paper was to advocate their own proposal, which was called by them Option E and which was wholly inconsistent with the Secretary of State's decision.

92. Mr. Garnham correctly accepts that there is no specific evidence that the claimant was a party to this response, although she was a committee member of CHEK and as I have explained, she replaced them with CHEK's consent as the actual claimant in the present proceeding. What is important, according to Mr. Garnham for the purposes of the present submission is that there is no evidence dissociating her from the CHEK's response which is totally inconsistent with the suggestion that there was any expectation. Mr. Clayton has not put forward any reason why I should dissociate the claimant from the CHEK response and I do not do so. Of course, it is settled law that there is no need to establish that a claimant relied on a promise but where as here there is opposition from a claimant to a proposal who says that it is unworkable, it seems strongly arguable, at least, that there would be no unfairness in permitting a party who proposed it to withdraw from it, which is, after all, what the claimant wanted.

(v) No claim can be brought for failure to give effect to a legitimate expectation if it would mean that the defendant would have to act in breach of statutory duty

93. Mr. Garnham contends that a further obstacle confronting the claimant is that the courts do not give effect to a legitimate expectation if by so doing, it would require a public authority to act contrary to terms of a statute (see *R v. Secretary of State for Education and Employment ex parte Begbie* [2000] 1 WLR 1115). Under the terms of s16(D)(i) NHS Act 1977, the Secretary of State has a number of duties which he may direct to health authorities to exercise. One of those duties imposed on the Secretary of State is to provide to such extent as he considers necessary to meet "all reasonable requirements for (a) hospital accommodation, (b) other accommodation for the purpose of any service provided under that Act, (c) medical, dental, nursing and ambulance services", as well as "(f) such other services as are required for the diagnosis and treatment of illness" (ibid s3(1)).
94. The significance of that is that if there had been an obligation on the defendants, as is contended by the claimant, to provide a full specialist cancer service at KCH, this obligation might conflict with the duties under the NHS Act 1977 which are to provide "to such extent as [the Secretary of State or the Health Authority directed by him] considers necessary to meet all necessary requirements relating to the diagnosis and treatment of illness", which would include cancer. So if the Secretary of State did not consider it "necessary to meet all necessary requirements" and to have any particular type of cancer service, he and the defendants if so directed by him, would be obliged to cease providing such services. So an obligation to require the defendant to act otherwise, might well constitute a breach of its statutory duty. Although I find this argument attractive, I need not give a definite view on it, as for the other reasons that I have given, the legitimate expectation challenge fails. Therefore it is not necessary for me to deal with other contentions made by Mr. Garnham in response to the claimant's submissions, such as that the claimant was not a victim under the Human Rights Act 1998.

Conclusion

95. For the reasons that I have explained, I am unable to accept any of the claimant's grounds of challenge. If I had been in any doubt about my decision, I would have been fortified in

reaching it by the approach of Hodgson J (in ex parte Gunning (ibid) at page 180–181), who said, with my italicised emphasis added that:–

"It is quite vital in the exercise of the jurisdiction of this court to keep to the forefront of one's mind that it is only the most extreme of examples of bad administration which can successfully attract judicial review of a decision otherwise lawfully arrived at. *It follows that the Court should not strain to find technical defects which will make the obligations imposed on local authorities unworkable*".

96. I have no doubt that my decision will cause disappointment to those who strive for an increase of services at KCH or, at least, no further reduction in them. Nevertheless, I stress that it is not the function of this court to reconsider the merits of decisions made by bodies such as the defendants. Its role is limited as the court is concerned only to ensure the bodies such as the defendants act according to the law and in accordance with their proper procedures, for the reasons that I have explained. I have reached the conclusion that the defendants have so acted. In those circumstances and notwithstanding the helpful and clear submissions of Mr. Clayton QC, who put forward every argument open to the claimant, this application must be dismissed.

MR JUSTICE SILBER: I am grateful, Mr McCullough, for your list of corrections. I do not know if you have any, Ms Morris, I am sure you must have?

MS MORRIS: My Lord, rather embarrassingly, try as I might, I have been unable to improve on Mr McCullough's list, so I have no additional ones.

MR JUSTICE SILBER: Yes. Well, I have one or two amendments of my own that I am going to make, and a copy of the judgment will be available later today. But, in my judgment, I dismiss the application and I stress the application is not concerned with the merits or defects of the decision, but it deals with a different issue of whether the decision could be quashed on public law grounds as the way in which it was reached. I finish off my judgment by explaining that I have no doubt that my decision will cause disappointment to those who strive for an increase of services at KCH, and again stress it is a function of the court to consider the merits of the decision but to limit it to ensure that the body has acted according to the law. I concluded that the defendants have so acted. Therefore, for those reasons, I dismiss the application.

MR MCCULLOUGH: My Lord, I prepared a draft order in the light of the terms of your

Lordship's judgment, that has been agreed with Ms Morris, perhaps I could hand it up (Same Handed). My Lord, briefly, to take your Lordship through it, mostly it is self-explanatory.

Paragraph 1: judgment for the defendants with the claim for judicial review be dismissed.

Paragraph 2, relates to an undertaking that the-----

MR JUSTICE SILBER: Yes, I have read that. I have referred to that in my judgment.

MR MCCULLOUGH: Indeed. In the light of your Lordship's judgment the defendants ask to be

released from that undertaking. In terms of costs your Lordship will remember-----

MR JUSTICE SILBER: In other words, check pay up till the time when Mrs Smith took over as claimant because she is publicly funded.

MR MCCULLOUGH: Exactly. Paragraph 3 deals with checks liability, and paragraph 4 in the new terms that are applicable in relation to the public funding regime.

MR JUSTICE SILBER: Paragraph 5, quite rightly, the costs of the claimant are to be detailed assessed?

MR MCCULLOUGH: My Lord, that is right, the old legal aid taxation provision.

MR JUSTICE SILBER: I make that order. Thank you very much.

MS MORRIS: My Lord, I make an application for permission to appeal. I should indicate that I make this really to protect the claimant's position because, plainly, no one has had any opportunity to consider the very lengthy judgment.

MR JUSTICE SILBER: I know, the difficulty is they only know about it an hour beforehand.

MS MORRIS: Precisely, my Lord. What I would say in support of that application is plainly it is a matter of considerable public interest which affects a great number of people, in that sense I say the second limb-----

MR JUSTICE SILBER: There is a difference between public interest and matters of law and public importance.

MS MORRIS: That is certainly right, my Lord. We would say that the particular issue engaged, namely the extent to which safety considerations required further consultation may fall within that second limb. My Lord, that is all I am really able to say at this particular stage without further consideration with my client.

MR JUSTICE SILBER: Do you oppose that?

MR MCCULLOUGH: My Lord, I do oppose it, but I do not propose to elaborate my resistance.

MR JUSTICE SILBER: Can you elaborate, please?

MR MCCULLOUGH: My Lord, the terms of your Lordship's judgment were clear and unequivocal. It cannot be said that an appeal has any reasonable or realistic prospect of success.

My Lord, secondly, the public interest argument does not apply. I was just turning up in order to remind myself of the actual terms of the rule in Part 52. My Lord, it is rule 52(3) which provides at paragraph 6:

"Permission to appeal will only be given where--

(a) the court considers that the appeal will have a real prospect of success, or

(b) there is some other compelling reason why the appeal should be heard."

My Lord, neither limb is, in my submission, satisfied. There is no real prospect of success in this

appeal and there is no other compelling reason.

MR JUSTICE SILBER: Ms Morris, is there anything more you want to say?

MS MORRIS: No, my Lord.

MR JUSTICE SILBER: As I have expressed in my judgment, I have substantial admiration for the way the case was presented on behalf of the claimants, but the more I looked into the case as I prepared for my judgment the more convinced I became of the strength of the defendant's position, bearing in mind that this was of course a public law case and had to be looked at as against the public law background and not as an appeal on fact. I was satisfied that the claimant came anywhere close enough to the threshold required for either limb to obtain permission to appeal. Therefore, the consequence is that this application must be refused. Is that all we have to deal with?

MS MORRIS: My Lord, yes.

MR JUSTICE SILBER: Can you convey my thanks to the other members of your team who are not here today, both of you. They were a very great help, and I particularly appreciated the very useful written documents that you submitted to me. Thank you very much. The final version of the judgment will probably be ready some time this afternoon.