Neutral Citation Number: [2009] EWHC 1824 (Admin)

Case Nos: CO/8460/2007 and CO/6996/2007

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 22/07/2009

Before :

MR JUSTICE CRANSTON

- -

Between :

The Queen (on the application of Mrs Val Compton, acting on behalf of "Community Action for Savernake Hospital")	**Claimant**
- and -	
Wiltshire Primary Care Trust	**Defendant**

- -

(Transcript of the Handed Down Judgment of
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Official Shorthand Writers to the Court)

- -

Neil Garnham QC, Guy Opperman, Mathew Gullick and Caroline Stone (**assigned by the Bar Pro Bono Unit**) for the Claimant
Philip Havers QC and Fenella Morris (instructed by Capsticks) for the Defendant

Hearing dates: 30 June - 3 July 2009

- -

Judgment
As Approved by the Court

Mr Justice Cranston :

INTRODUCTION

1. These judicial reviews concern the lawfulness of decisions in 2007 relating to the Day Hospital and Minor Injuries Unit at the Savernake Hospital in Marlborough, Wiltshire. Clearly the issues are of great importance to the local community. As a matter of law the challenges are to the consultation process which preceded the decisions and the rationality of the decisions. In addition, both decisions are said to be vitiated by apparent bias.

The claimant and her claims

2. The claimant, Mrs Val Compton, is a retired physiotherapy assistant at Savernake Hospital and brings the claims on behalf of the pressure group, "Community Action for Savernake Hospital". She has been and continues to be represented by leading and junior counsel assigned by the Bar Pro Bono Unit. They have done an outstanding job of presenting Mrs Compton's case.

3. In the first judicial review Mrs Compton contends that both the Day Hospital and the Minor Injuries Unit facilities have been closed by the Wiltshire Primary Care Trust ("the PCT"). The PCT accepts that it has closed the unit, but disputes that it has closed the Day Hospital. Mrs Compton contends that the PCT's actions were unlawful. As regards the Day Hospital, Mrs Compton seeks an order that that facility be re-opened or that the decision in respect of it be quashed and the PCT be ordered to reconsider the decision. In respect of the Minor Injuries Unit, she seeks an order quashing the closure decision. In the alternative, she seeks declaratory relief as to the unlawful nature of the PCT's actions.

The PCT and Strategic Health Authority

4. The defendant is the Wiltshire Primary Care Trust ("the PCT"). Primary Care Trusts, as the name suggests, are responsible within the National Health Service ("NHS") for the first level of care, that provided by doctors, dentists, opticians, pharmacists and so on. In this regard they exercise the functions of the Secretary of State for Health: National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002, SI No 2375, ("the 2002 Regulations"), r 3(2)(a). As is evident from the geographical area covered by the PCTs in this case, they are relatively local organisations. Until 1 October 2006 there were three PCTs in Wiltshire, the Kennet and North Wiltshire PCT, the West Wiltshire PCT and South Wiltshire PCT. On that date these PCTs merged into the one, the Wiltshire PCT. For a period prior to the merger the Kennet and North Wiltshire PCT and the South Wiltshire PCT had one chief executive. However, each continued to have a separate chairman.

5. Strategic Health Authorities were created in 2002 to exercise the functions of the Secretary of State at regional level. In the 2002 regulations those functions are exercisable by Strategic Health Authorities but "only to the extent necessary to support and manage the performance of Primary Care Trusts" in the exercise of the functions delegated to PCTs: 2002 Regulations r 3(2)(b). During the period relevant to this litigation, on 1 July 2006 the Avon Gloucestershire and Wiltshire Strategic

Health Authority became part of a larger authority, the South West Strategic Health Authority. In a strategy document it published in early 2006, described below, the Avon Gloucestershire and Wiltshire Strategic Health Authority said that it provided "strategic leadership, direction and support to the twelve primary care trusts and thirteen NHS trusts" in the area.

Savernake Hospital

6. Savernake Hospital is a small community hospital. In 2006 it offered the following services on the site: the Day Hospital, a Minor Injuries Unit, some diagnostic services (x-rays, facilities for basic urine and blood tests, basic blood pressure monitoring and a base for 24 hour ECGs); a 16-bed in-patient unit; rehabilitation and out-patient services, including physiotherapy, occupational therapy, speech and language therapy, retinal screening, dietetics and podiatry; 12 mental health in-patient beds; a community mental health base; and clinic space for child and family guidance. On the site other services were provided by Wiltshire Council and voluntary sector organisations.

(a) The Day Hospital

7. The service specification for Day Hospital services, published by the PCT in April 2005, was as follows:

> "Service description: The Day Hospital service offers 39 places across the PCT in Chippenham, Malmesbury and Savernake Hospitals. Chippenham and Savernake provide a 5-day service, whilst Malmesbury provide a 3-day service. Day Hospital provides multidisciplinary assessment and treatment for clients in order to maintain or regain an optimum level of function.
>
> Service aim: To prevent admission to hospital, to expedite hospital discharge by providing ongoing rehabilitation, and to assist clients to regain and maintain their independence.
>
> Service Objectives: To provide a time limited program of rehabilitation in a hospital environment, which could not be provided in the home.
>
> Other services provided: Blood transfusion, IV infusion, 24 hour ECG, bladder scanning, leg ulcer dressing, monitoring of medical condition and routine and fast track access to consultant geriatrician.
>
> Population served: The population of Kennet and North Wiltshire PCT who meet the criteria for Day Hospital admission."

The Day Hospital at Savernake Hospital was opened in 1981. A substantial rebuild took place at Savernake Hospital in 2004-05, which involved a £9 million investment in the hospital as a whole under a PFI scheme. The Day Hospital was refurbished as part of this. After the refurbishment a press release in July 2005 said that:

> "Day Services
>
> Linking into the new hospital building is the recently refurbished day hospital with 14 places. … The day hospital will be the base for the rehabilitation teams and provide a range of services including physiotherapy, occupational therapy, community intermediate care, speech and language, dietetics and podiatry. It also hosts a dedicated Parkinson's clinic and a falls service."

The Day Hospital was part of a bigger building, called the Lavington Centre. Thus it was a suite of rooms, rather than a stand-alone building on its own. The Day Hospital included six rooms for consultation and treatment, and an associated day or dining room and kitchen. Also in the Lavington Centre are the department of outpatient physiotherapy and a suite of clinic rooms for non-consultant outpatient clinics, such as dietetics and speech and language therapy.

8. The Day Hospital provided a four and a half day a week service providing multi-disciplinary assessment and treatment aimed at helping elderly and infirm patients maintain or regain their level of functioning. It served to prevent admission to hospital, expedited discharge from hospital and assisted patients regain and maintain their independence. It provided additional services such as blood transfusions, ECG, bladder scanning, ulcer dressing and speedy access to a consultant geriatrician. Patients were brought to the Day Hospital at about 10.30am by the PCT funded transport and would be taken home around 3.00pm. In that period they would see whichever clinician they needed to and would be given lunch, cups of tea and somewhere to sit and chat with staff or other patients or watch television, between treatments. The Day Hospital was providing services to on average one new patient a day in the period 2006-7 and each patient had approximately 6 treatment sessions before being discharged from the service. The PCT says that the Day Hospital was providing a service to a very small percentage of the local population. It represented less than 20 percent of Savernake Hospital's activity and 6.32 percent of its total cost.

Procedural history

9. These proceedings have a somewhat lengthy and complex interlocutory history. Judicial review proceedings were brought in August 2007 in respect of the Day Hospital and in September 2007 in respect of the Minor Injuries Unit. Permission was granted by Simon J on the papers in October 2007 in relation to the former, and following an inter partes hearing by Holman J in April 2008 in relation to the Minor Injuries Unit. Directions were given for this hearing to take place in July 2008. That, for reasons which will become obvious, did not happen.

10. Mrs Compton had applied for, and obtained from the judges who granted permission, two Protective Costs Orders ("PCOs") in respect of her claims. Without these orders in her favour Mrs Compton would not have been able to bring these proceedings. The PCT appealed, contending that the grant of the PCOs was wrong in principle. In July 2008 the Court of Appeal upheld the PCOs: [2008] EWCA Civ 749. The PCT then submitted a petition for leave to appeal to the House of Lords, but that was dismissed at the end of November 2008. The result of the PCOs was that if Mrs Compton were to be successful on either claim she does not recover any costs. If the PCT succeeds

on the Day Hospital case, Mrs Compton will have no costs liability but if it succeeds on the Minor Injuries Unit case and Mrs Compton is ordered to pay the PCT's costs, she is liable to pay a maximum of £20,000.

11. For completeness it should be mentioned that earlier this year the PCT applied for summary judgment on both claims, or in the alternative to strike them out, contending that even if Mrs Compton succeeded in showing that the decisions were unlawful there was no prospect of a court granting the remedies Mrs Compton seeks. Those applications were refused by Plender J at a hearing on 1st April 2009.

BACKGROUND

12. The change to the Day Hospital and Minor Injuries Unit at Savernake Hospital, which Mrs Compton challenges, were initiated by the PCT in mid 2005 though a process known as "Pathways for Change". That involved 9 months of "engagement" with stakeholders. It led to a PCT consultation document in April 2006, Taking the next step. This covered a wide range of services provided by the PCT, including primary care, maternity services, community hospitals and Minor Injuries Units. There was a parallel consultation document on mental health, Mainstreaming Mental Health. There then followed a period of public consultation. On the back of that, the PCT Board considered a lengthy report in January 2007. The Board's approval of that led later in the year to the changes challenged. These different stages of the process need to be examined in greater detail.

"Pathways for Change" (May 2005 – April 2006)

13. In May 2005, the two PCTs, Kennet and North Wiltshire PCT and West Wiltshire PCT commenced a strategic review of healthcare services in the area. The press release announcing this said that they were "taking a fresh look at the health services that they purchase and provide for their local communities". The process was known as "Pathways for Change". There was to be public consultation. It would begin with a stakeholders assembly on 19th May in Chippenham. In all there were four stakeholder's assemblies during the May – November 2005 period. At that first assembly on 19th May 2005 Carol Clarke, the chief executive of the PCTs, said that the two PCTs had different organisational cultures but were locked into making ad hoc decisions based on local interest, not the needs of the whole.

> "All groups have different expectations. The Department of Health and Strategic Health Authority want us to balance books, staff want us to modernise services and go forward, stakeholders want us to work to their agenda, and the press want us to continue to provide campaign material. Some patients want no change, and the public don't want to engage unless it is to stop us doing something."

14. For present purposes there is no need to explore the "Pathways for Change" process in detail. Three aspects, however, are worth mentioning. The first is that the proposals which form the subject matter of this litigation were only one part of the agenda for change. It was premised on a need to reconfigure services in the area more generally and that this was likely to lead to decisions to close some centres while changing provisions elsewhere.

15. Secondly, the concept of moving care into the community through neighbourhood teams emerged early as an important theme. As part of this the PCTs carried out a clinically led analysis of all the admissions to community hospitals within the previous 12 months. This enabled them to identify why patients had been admitted and then to analyse those admissions with the advice of senior clinicians as to other appropriate ways of meeting the health needs of the patients. The results of the analysis showed that the overwhelming majority of patients who had been admitted to hospital could have been cared for, supported and treated effectively at home. There was also a review of the different types of nursing and therapy services available. It was found that most services were only available between 9am and 5pm such as the community nursing service, rehabilitation team, occupational therapy and speech and language therapy. In addition the day hospitals were open at various times and days, depending on location.

16. Thirdly, the role of the Professional Executive Committee (PEC) should be outlined. That was to support the PCT in developing strategic direction, commissioning, clinical effectiveness and clinical governance, and leading clinical communications with partners and stakeholders. Its membership was drawn from practising clinicians within the PCT area, including GPs, nurses, therapists, dentists and pharmacists. It included three clinicians working in the Marlborough area.

17. A joint meeting of the PCT and Professional Executive Committee on 14 March 2006 might be noted. It was reported that the neighbourhood team model was complex and was still being worked out. One issue was staff capacity, members not being convinced that staff would migrate from hospital to community. A member of both the PEC and PCT, Dr Vickers, spoke of the day hospitals enabling a range of diagnostic services to be performed on the same day. He raised a question that if this was no longer the arrangement how would receiving diagnostic facilities at home work.

Strategic Health Authority's "Shaping the Future" (January 2006)

18. While the "Pathways for Change" exercise was occurring, the Avon Gloucestershire and Wiltshire Strategic Health Authority published its document, Shaping the Future: An Avon, Gloucestershire and Wiltshire Strategic Framework. That was in January 2006. As described Shaping the Future was "an overreaching strategic framework" within which health and social care organisations could operate in the future. In Shaping the Future one of the key messages was that healthcare was changing, through advances in technology and through changing public attitudes. That would lead to more services being provided in the community and fewer hospital sites. Avon Gloucestershire and Wiltshire health authorities were emerging from a very challenging financial position. Plans had to be affordable and contribute to reducing the recurrent deficit. Ways of providing services needed to be implemented to provide services more efficiently or differently, through new, more economical ways of working. Priority areas for change were identified.

Government White Paper (January 2006)

19. The same month, January 2006, the Department of Health published a White Paper, Our Health our Care our Say. A new direction for community services, Cm 6737.

One aspect of the proposals discussed there was to meet what was said to be the clearer public preference for as much treatment at home, or as near home, as possible.

> "We must reorientate our health and social care services to focus together on prevention and health promotion. This means a shift in the centre of gravity of spending. We want our hospitals to excel at the services only they can provide, while more services and support are brought closer to where people need it most. More care undertaken outside hospitals and in the home" (para 24).

"Taking the next step" (7 April 2006)

20. The PCTs' consultation document was published on 7 April 2006. It was entitled Taking the next step: modern and affordable healthcare for all. Better care, better value for money. Consultation on Pathways for Change ("Taking the next step"). It recorded that hundreds of people had given their views in the Pathways for Change phase. The document outlined their views as part of the proposals to change NHS services in the part of Wiltshire the PCTs covered.

> "These proposals centre on ensuring more patients are treated in their own homes and in state-of-the-art GP practices (called Primary Care Centres), supported by one or more New Generation Community Hospitals. The proposals also focus on getting many more NHS staff out working in the community, rather than in hospitals, so they can care for people in better ways. And, the proposals focus on ensuring fewer people have to visit major NHS hospitals, as more and more services are provided locally in the community."

The document outlined that in this part of Wiltshire, the NHS has spent more than it had received from the Government for many years. That had been done using funds meant for other parts of the NHS. Under the heading "A new approach to caring for NHS patients", the consultation document said:

> "Procedures that could once only take place in hospital are taking place in clinics, GP surgeries or even in people's own homes. For example, patients no longer have to go to hospital for a range of treatments such as blood tests, cardiology and dialysis.
>
> More NHS staff will be out working in the community, so that they can provide more flexible care, when people need it."

21. Taking the next step said that its proposals fitted in with the White Paper approach and were about developing modern health services which were good value for money and which all could access. "Our consultation aims to outline a new way of providing NHS services, more in the community and the home, less in hospitals." The feedback from the Pathways for Change consultation had been essential in the formulation of the PCTs' proposals. Real change was needed so that the PCTs could live within their means. Many of the services were provided in inappropriate settings. There was a

great tradition in Wiltshire of community hospitals, but there was also an understanding that many were no longer appropriate for modern healthcare services. "New, more appropriate services are needed to enable patients to be treated at home or close to their home …"

22. Plans for the new approach described in the Taking the next step consultation document focused on a fundamental shift in the way the NHS provided services. "We will look to ensure more patients are treated in their own homes …" Among the features of the new approach was the establishment of neighbourhood teams.

> "These will provide more healthcare and services in patients' homes. They will be available to provide care 24-hours a day. The teams, which will include nurses, therapists, rehabilitation staff and community matrons will work closely with local GP practices."

The neighbourhood teams would be able to support what many patients had said they would prefer, which was to be treated and cared for in their own homes. For the elderly it was important that they could live independently.

23. As for minor injuries units, these were to be located on two sites to concentrate expertise and to enable a wider range of illnesses and injuries to be treated. Expertise was dispersed under current arrangements. All aspects of the new approach were to ensure that GPs had access to a comprehensive range of services, 24 hours a day. To address the financial problems and ensure a financial recovery change was essential. Services from the existing number of minor injuries units meant higher costs.

24. With respect to services as a whole there was to be consultation on three options. Common to the three options were the new neighbourhood teams and two 24 hour Minor Injuries Units, one at Chippenham and one at Trowbridge. The latter would provide "stronger minor injuries and urgent care services, treating a wider range of conditions". Option 1, unlike the other two options, involved closure of Savernake Hospital. The total savings from the three options were said to be £20.2 million, £18.9 million and £16.4 million respectively, the net savings £8.1 million, £3.2million and £6.8 million respectively. The consultation document noted that there would be consequential changes as well for the workforce.

Public consultation (7 April 2006 – 7 July 2006)

25. Following publication of the Taking the next step consultation document, the PCTs conducted an extensive consultation exercise. This consisted of staff consultation meetings and a series of some 22 public consultation meetings in May and June 2006. The consultation period ran from 7 April to 7 July 2006.

(a) Staff consultation meetings

26. At the staff consultation meeting for the Marlborough Community Area on 26 April 2006 there was a series of slides. The first read:

> "Across England – as well as in Wiltshire – the NHS is proposing changes to ensure more patients are treated and cared

> for in their own homes and in state-of-the-art GP practices (or Primary Care Centres), supported by New Generation Community Hospitals as indicated in the government's recent White Paper."

The second slide read that no change was not an option, many of the services were provided in inappropriate settings, and the proposals centred on caring for more people in different ways and in different settings. The proposals aimed to tackle fundamental issues such as reducing the number of people who needed to attend major hospitals "by treating more people at home, in more modern GP facilities, supported by new generation community hospitals".

27. The new approach centred, inter alia, on neighbourhood teams and minor injuries units. Yet another slide read:

> "At present 400 of our nurses work in our community hospitals, compared to just 92 District Nurses who look after people at home.
>
> In the future New Neighbourhood Teams will provide more healthcare and services in people's homes."

Other slides underlined the theme of treatment in the home. Neighbourhood team 8 was one of the proposed teams, covering Marlborough and the surrounding area. There would be no upper limit to the capacity of each team. The staff were told that neighbourhood teams would provide urgent, managed, frail elderly and palliative care. A Marlborough neighbourhood team would cover the area from which patients attended the Day Hospital.

28. There were also slides on the proposed two Minor Injuries Units. One read:

> "Proposal: Two MIU units
>
> - It is important that we concentrate our resources and expertise so that we are able to offer centres of excellence which can treat a wider range of injuries and illnesses than the MIUs we currently run.
>
> - Concentrating our resources into fewer units also allows us to run them 24-hours, which means that patients will know that the MIU unit is always open.
>
> - With MIUs which are open 24 hours and which offer a wider range of treatment we will become more of an alternative for patients who are not suffering from a major trauma to come to one of our units rather than the bigger emergency departments at a district general hospital."

29. After the presentations there was discussion. One of the questions recorded was as follows:

> "Q. How do they foresee 24hr nursing care in the community? Will District Nurses be pushed to cover this?
>
> A. A number of nurses in the community hospitals will move into the community."

30. There was a further consultation meeting for staff in the Marlborough Community Area on 29 June 2006. Of the diagrammatic slides, one showed "current models" (including day hospitals), with an arrow to "segmenting care", with a further arrow to the heading "create neighbourhood teams" (one being for Marlborough and the surrounding area). Among those attending the meeting were the claimant, Mrs Compton, and others who have supported her with statements in the present litigation: Janice Clay, Gill Davies, Margaret Manley, Karen Roberts and Jean Ward.

(b) Public consultation meetings

31. The first public consultation meeting in Marlborough was held on 8th May 2006. There was a presentation by Carol Clarke, the PCTs' chief executive. It was the presentation shown at all consultation meetings "so you can see the same message at all the meetings we go to." Ms Clarke explained that £20 million more a year was being spent by the PCT than was received from the government. That context was incredibly important. The Strategic Health Authority "has put us into a holding arrangement" to control finance. (In fact all PCTs were subject to that arrangement at the time.) There were slides and then questions and answers. The local Member of Parliament, Rt Hon Michael Ancram MP QC spoke. He said he was dismayed that Carol Clarke had in a sense admitted the problem was not about reform, but money. He did not blame her. He had fought for the Savernake hospital because he felt passionate for community hospitals and would go on fighting.

32. There was a second public consultation meeting in Marlborough, on 26th June 2006. Carol Clarke, the PCTs' chief executive, again spoke. She said that what was being proposed had a context. One aspect of the national context was the trend to treat patients in their homes, GP practices or primary care centres, as evidenced in the government's White Paper. "We really need to reduce our over reliance on hospital beds and we need to modernise some of our services." The new approach centred, inter alia, on neighbourhood teams. At present there were a number of services, which fitted in four broad care patterns: "So we want to put in place neighbourhood teams, prevent admissions to hospital; primary care at home and access to 24 hour 7 day a week nursing services". Among the slides was one entitled "Proposed: Neighbourhood Teams". Under the heading "Current models" was "Day Hospital Service". The heading "Neighbourhood Team" listed Marlborough; Ludgershall, Pewsey and Tidworth. Signatories of the attendance list at that June 26th meeting included the claimant, and three of those who have given evidence in support, Joan Davies, Colonel Paul Lefever, and Margaret Manley.

(c) Written representations

33. The consultation document provoked letters and emails. Thus Colonel Paul Lefever, chairman of Friends of Savernake Hospital, wrote a detailed response, sent with a covering letter of 6th July 2008. Under the heading "Providing Care in People's Homes", he wrote that a stated driver for change was the move to treating patients in

their own homes rather than in hospitals. This decentralisation of care flew in the face of reason in that it required the provision of multiple teams of clinicians scattered across a widely dispersed area, attending to the needs of patients which occurred in a completely unpredictable and unprioritised manner. The rationale for establishing hospitals and medical care centres in the first place had been to concentrate the scarce resources of the clinicians in one place with appropriate facilities and mutual support in order to make best use of their abilities. This was in direct contrast to this plan which dispersed healthcare staff throughout the community, isolated them from mutual support and diluted their efforts through time lost in travelling, thus either reducing their capacity for treating representative numbers of patients or requiring the application of more resources. Faced with this apparently illogical approach to the delivery of healthcare, one was led to the conclusion that the initiative was simply a financial expedient aimed at reducing the cost of maintaining and running community hospitals.

34. The PCT responded to some of the written representations. Thus in a response to a letter from Dr and Mrs Rosedale, the PCT wrote on 17th August 2006:

> "I can assure you that the fate of the Minor Injury Unit at Savernake has been a concern of many who have responded to our consultation, and this part of our proposals is therefore still under review. However, again the low number of patients who use the MIU, and the complex mixture between real MIU patients and those with minor illness who probably should have been seen by their own GPs, makes it more difficult to justify on economic grounds."

(d) Wiltshire County Council's task force

35. Wiltshire County Council's Health Overview and Scrutiny Committee had established a task force for the purposes of overseeing the "Pathways for Change" process. There is no need to consider its history or input into the process except to note that it met over 40 times. For the purposes of the forensic exercise I was directed to one answer it received from the PCT in June 2006, to a question about how neighbourhood teams and other community workers would be introduced.

> "We already have highly skilled and experienced district nursing services covering each of our community areas across the PCT areas, together with our existing intermediate care teams and rapid response teams. These existing community staff will support the phased transfer of staff currently working in community hospitals. The neighbourhood teams will be developed and managed to support the corresponding reduction in in-patient community hospital beds."

<u>Red Bridge appointed to analyse consultation responses (April 2006)</u>

36. The public responses to the consultation during the period 7th April to 7th July 2006 were analysed by a company called Red Bridge Solutions Ltd ("Red Bridge"). The consultation document in April 2006 had said that the responses and other matters raised would be "used by an independent organisation to prepare a report at the end of

the consultation period for the Board of the Primary Care Trust". At a meeting in June 2006, one of the slides shown by the PCT said:

> "Red Bridge Solutions have been appointed to conduct an Independent Analysis of the responses to the Consultation."

The importance of an independent review of the consultation responses was underlined at a meeting of the PCT on 8 August 2006.

37. It was Jane Britton who suggested to Jennifer Edwards at the PCT that Red Bridge was capable of undertaking the analysis of the consultation responses. At the time Ms Britton was associate director of patient and public involvement at the Avon Gloucestershire and Wiltshire Strategic Health Authority. Her domestic partner was Stephen Tanner, one of the directors of Red Bridge. Part of her role at the Strategic Health Authority was to advise PCTs on the process around public consultations over proposed service changes. As part of that she had attended the May 2005 meeting which launched the Pathways for Change consultation. She also advised the PCTs to obtain independent analysis of the feedback after the consultation process in 2006. This was not the NHS practice in most consultations, but it was advice she always gave when a service reconfiguration was particularly contentious, as this was. She gave Ms Edwards at the PCT details of three consultants known to her, one of which was Red Bridge. She informed Ms Edwards of the relationship with Mr Tanner and did not express any views about the comparative merits of the consultants.

38. A panel met comprising the chairman of one of the PCTs, Professor Alistair Bellingham, two senior managers of the Pathway for Changes process, Nicholas Gillard and Ms Edwards, and a manager from the Wiltshire NHS Mental Health Trust, Peter Brabner. Mrs Shiena Bowen, chairman of the other PCT, was to attend the panel meeting but was unable to do so. Two of the three firms Ms Britton had mentioned tendered for the work. One of the three firms had quoted in excess of the budget for the work and therefore was not interviewed. Mr Brabner recalls that one of the factors in the decision was that the panel was concerned that a fourth contender for the contract, Wiltshire County Council, worked closely on health matters with the PCTs, and the public might not consider a report it produced as being independent. Red Bridge was chosen. Ms Edwards has said in a witness statement that she had previously informed Mr Gillard and then the Panel of Mr Tanner's connection with Ms Britton. Mr Gillard says specifically that he was told of the relationship and Mr Brabner has said in his witness statement that he is happy to agree with Ms Edwards' recollection. But Professor Bellingham says that he was never told of the Britton – Tanner relationship.

39. It is necessary to go back one step. The PCT board had appointed the panel to decide which of the four tenderers should be chosen at a meeting on 6 April 2006. In the draft minutes there is a reference to a possible conflict of interest, although there is no further explanation and no reference to the relationship between Ms Britton and Mr Tanner being raised. This reference to a conflict of interest does not appear in the final version of the minutes and the original manuscript version of the minutes has been destroyed. Professor Bellingham's suggestion is that the draft minutes could refer to a conflict of interest between those assessors involved in the Strategic Health Authority's previous consultation regarding PCT reconfiguration. Another suggestion

is that the reference to conflict of interest alludes to the involvement of Wiltshire County Council.

40. As I have said, Professor Bellingham says that he was not told of the Britton – Tanner relationship. His statement is in accordance with the recollection of five other non-executive members of the PCT board – Julian Sturgis, Gill Stafford, Peter Salter, Ron Crook and Ann Tew – four of whom were at the 6 April meeting. As against that is the evidence of Ms Edwards and Mr Gillard. Moreover, Mrs Shiena Bowen, who was the chairman of the other PCT before the two PCTs merged later in the year, specifically recalls being told of the relationship at the time of the tendering process. Dr Ann Shelly, then director of public health of one of the PCTs, says that the Britton – Tanner relationship was raised at the board meeting on 6th April, and there was a short discussion as to whether it constituted a conflict of interest. Mr Dennis Bridges, the director of estates for the PCTs at the time and a board member, recalls being briefed at some point about the relationship.

41. Judicial review proceedings are not designed to decide on disputes about evidence such as this. At one time the claimant had applied to adduce oral evidence about the matter, but there is an order by a deputy High Court judge that this not be pursued. In the absence of oral evidence I am in no position to decide what the PCT board was told on 6 April or to resolve the ambiguity in the draft minutes. However, the decision to appoint Red Bridge was delegated to the Panel. The weight of the evidence of those who attended the Panel meeting, coupled with the clear recollection of Shiena Bowen, who was to attend, has led me to conclude that the Panel knew of the Britton-Tanner connection when Red Bridge was chosen.

Red Bridge reports (October 2006)

42. The Red Bridge report was published in October 2006. It is entitled An independent report of what local people said during the consultation on Pathways for Change: An independent analysis of consultation feedback. The findings were said to be aimed at describing what people had said during the 13 week consultation phase. Views and opinions elicited were qualitative, from a range of methods, and all evidence had been forwarded for analysis. Red Bridge believed the consultation process had been wide-ranging and successful. 790 people had completed an anonymous questionnaire.

43. Analysis in the Red Bridge report was presented through tables and charts. Thus just over a third of respondents were patients, users or carers. The main themes raised at the public meetings were set out: access and travel (16.68%); finance (11.80%); closure of Savernake Hospital (7.32%); closure of Westbury Hospital (6.31%); closure of all hospitals (4.07%); consultation (3.87%); minor injuries units (3.76%) and rejection of all three proposed options (3.26%). Each of these issues – for example, closure of Savernake Hospital – was then illustrated with quotations from the meetings. The quotes were said to be representative of the themes identified. Similar analysis was set out of the main themes raised at meetings of staff, the formal responses by stakeholders, correspondence, petitions and consultation meetings by the groups. Appendices to the report contained matters such as the anonymous questionnaire and the names of those responding and of stakeholders.

44. Supplementing the Red Bridge report in November 2006 was a report produced by the PCT in-house entitled Pathways for Change. Analysis of correspondence received

following the closure of the consultation period, November 2006. The content of that report is evident from the title.

The Alberti Report (December 2006)

45. Sir George Alberti's report, Emergency Access, was published by the Department of Health in December 2006. Sir George was National Clinical Director for Emergency Access in the NHS at the time. The report noted that increasingly many of the patients who currently attended the Accident and Emergency Department ("A&E"), but who did not need the full services of an acute hospital, would be dealt with in an urgent care centre, either a walk-in centre or a minor injuries unit, either on the hospital site or in a community setting. These centres would have agreements with other hospitals in a regional network to ensure that all emergencies were covered. The intention was that more nurses, paramedics and emergency care practitioners (nurses or paramedics with additional training) would assess and treat people in their home or workplace.

Proposals formulated post consultation (7 July 2006 – 30 January 2007)

46. With the public consultation as background the PCT drew up a new model of care, predominantly based on option 3 of the April 2006 consultation document. Amongst other changes the model proposed neighbourhood teams and two Minor Injuries Units for Wiltshire. The result was that the Minor Injuries Unit at Savernake Hospital would close. The proposals were incorporated in a report, which was to go to the PCT board in January 2007. But this is to anticipate events. Let me return to the end of the formal consultation period which ended on 7 July 2006.

47. There was a meeting of the PCT board on 8 August 2006, when it was reported that there had been a meeting with the new South West Strategic Health Authority to discuss performance, particularly financial recovery. The outcome was a request for investigations into the work being done on Pathways for Change to be checked against the White Paper to ensure it was in line with the recommendations. Support was being given by the Strategic Health Authority and they did not wish to stop progress. The Authority's request demonstrated that the PCT's plans for change were different from those being pursued in different parts of the country.

48. On 24 August 2006 Dr Paul Jakeman, the medical director of the PCT, wrote to Sir Ian Carruthers, the chief executive of the newly established South West Strategic Health Authority. The letter was written on behalf of, and with the agreement of, clinical leaders within the PCTs, including Dr Vickers. The letter said that change in the current structures of care in Wiltshire was essential but that the political will to change had been lacking in the past. Those writing the letter had been fully involved in the Pathways for Change consultation:

> "[W]e do strongly submit that change really is needed in Wiltshire. In particular, we are concerned that the number of hospital beds currently operated by the PCT absorbs finance and staff that could be more appropriately deployed in community health provision. We are concerned that further delays in necessary restructuring will lead to the disengagement of clinicians who have publicly supported the need for change.

> We are aware of some strident voices in favour of maintaining our very traditional hospital-based services, and are concerned that the real needs of our patients locally may be overlooked. We have been pleased by the positive responses from our staff about the modernisation programme described in Pathways for Change, and we would request your support in taking forward this important modernisation programme."

49. At a meeting of the PCT Professional Executive Committee on 12th September 2006 it was reported that the previous Avon Gloucestershire and Wiltshire Strategic Health Authority had supported the Pathways for Change process. It was thought that the new South West Strategic Health Authority would do likewise. There was a meeting of the Professional Executive Committee of the PCT on 9th January 2006. It considered the report which would be presented to the PCT Board later that month. It recognised that more work was to be done, but supported the report and the PCT's proposals.

The PCT's proposals (January 2007)

50. On 30th January 2007, the PCT's Director of Planning and Partnerships, Nicholas Gillard, submitted a paper entitled "Proposals for the reform of community services in Wiltshire" to a meeting of the PCT Board. It recommended the adoption of a scheme which was loosely based on the third of the three options in the consultation document, Taking the next step. The document identified as part of its vision delivering care much closer to people's homes and giving people greater choice over where and how they received NHS care. This meant more staff working in community teams and primary care, and fewer in community hospitals. Eleven neighbourhood teams of nurses and therapists, providing 24 hour care, were foreshadowed. They would support people to stay healthy so they would not need to go into hospital. There was to be a 24 hour neighbourhood team providing round the clock care to patients in their homes. The document proposed the upgrading of three community hospitals, which "along with Marlborough (Savernake Community Hospital) will provide modern appropriate facilities". Savernake was to have 24 general medical beds and was described as being a community hospital, which was to be improved. Paragraph 4.1 of the paper said this:

> "4.1 The current range of community health services in Wiltshire does not fit with the ambitions we have for modern NHS healthcare. There now exists an exciting opportunity to fundamentally change services for the better and in line with the Government's vision for the future of community health care set out in: Our health, our care, our say which relies less on inpatient hospital care and more on working with patients at home, elsewhere in the community or within primary care."

The document said that there would be two Minor Injuries Units, at Chippenham and Trowbridge. This new service aimed to provide "a balance between maintaining local access while providing sufficient concentration of resources to ensure high quality services." Access to local clinics would not be reduced by the proposals and improved community hospitals would continue to provide local outpatient clinics.

51. The appendices to the paper offered the PCT board further detail. Thus the neighbourhood teams were to be part of the reconfiguration, "to provide targeted care to local people who would otherwise need to travel to hospital to receive treatment." The service outcomes for neighbourhood teams included a shift to geographically based models of care at home. Neighbourhood teams would work to keep patients out of community hospitals by providing care in the community, in patients' homes or residential and nursing homes. Eleven neighbourhood teams would operate across Wiltshire, with teams operating overnight out of hours services. A streamlined model of care would replace existing models (community hospitals, intermediate care, community rehabilitation teams, rapid response, day hospitals and district nursing). There was a description of the service outcomes and service improvements and benefits which would be enjoyed by the community hospitals, including that at Savernake. The community hospitals would be places where a wide range of health and social care services could work together to provide integrated services to the local community.

52. As for the Minor Injuries Units, the service outcomes included patients and ambulances knowing which were available, and improved quality by concentrating skill on fewer sites. Reference was made to the Alberti report. A chart in the appendices for Marlborough and Savernake indicated that "ambulatory services would remain at Savernake including the clinical assessment centre." There would be a 24 hour neighbourhood team to create community hospital services delivered in people's own homes, wherever possible. Existing ambulatory services would continue, apart from the Minor Injuries Unit.

53. Under the heading "Finances", one factor mentioned in the PCT board paper was: "Reprovision of day hospital services through neighbourhood teams". Significant workforce implications were also mentioned, with the relocation, redeployment and the redirection of services.

> "The overall requirement for the general medical inpatient staff establishment will be reduced under the proposals, and staff who are displaced by the reconfiguration will have the opportunity to consider inpatient work in one of the three community hospitals or community based opportunities in neighbourhood teams through redeployment."

54. The paper also contained what were called "Town Stories", which "describe a story of reconfigured services in each of Wiltshire's major towns. The stories define the services available to the residents of each location along with the implications for the staff, quality of care and the building and facilities." The "Town Story" for Marlborough and Savernake stated that:

> "Ambulatory services will remain at Savernake including the clinical assessment centre as will provision of radiology and other diagnostic services. Other services being provided will include outpatient services and day therapy services. ...Existing ambulatory services continue apart from MIU"

PCT board endorses proposals (30 January 2007)

55. The PCT board considered the proposals at its meeting of 30 January 2007. The meeting had been postponed for a fortnight to enable a better consideration of the report and the consultation responses. Some 184 members of the public attended the board meeting. This was a new board since the Pathways for Change process had begun, because the two PCTs had merged on 1 October 2006. Only two of the eight non-executive board members had been on the previous PCT boards; 7 of the 16 PCT executives overlapped. Before the board meeting the chairman and chief executive had read all the responses received for the consultation in addition to the Red Bridge report. Partly that was because the proposals had become hotly contested. Moreover, each board member signed a statement that they had had an opportunity of reviewing the responses to the consultation, had taken all reasonable steps to avail themselves of the information and had assured themselves beyond the information presented at board meetings.

56. At the outset of the meeting the chairman explained that all board members had had access to all responses and that he had personally read them all. The chairman stated that in making any decision no directions from the government or the Strategic Health Authority had been received. In his presentation the Chief Executive said that despite the public impression that the proposals were a financial exercise, change was in any event demanded. Care had to be shifted from hospitals to local communities. The PCT's director of operations said that staff would be moved out of hospitals into community teams.

57. The Board then approved the reconfiguration of services set out in the report, including the eleven neighbourhood teams and the two Minor Injuries Units at Chippenham and Trowbridge. As regards the latter it had been explained to the Board that there was uncertainty among ambulance crews as to where existing Minor Injuries Units were open and the need to improve skills. With respect to this issue the Alberti Report was mentioned in one of the appendices to the Board papers.

"Reforming Community Services" implemented (January-December 2007)

58. The proposals set out in the January report became known as "Reforming Community Services". Implementation proceeded during most of 2007. Only certain aspects demand our attention.

59. Perhaps it is useful to step back a week to 24 January 2007, when there was a meeting between PCT executives and the League of Friends. The operation of the proposed Neighbourhood Teams was one matter addressed. Another issue raised was the proposed closure of the Minor Injuries Unit there. Some of the Friends, including Colonel Lefever, asked questions about this. In response the PCT chief executive said that minor injuries units were an indeterminate idea in most people's minds. It was necessary to make sure people used the services appropriately. The key was the complexity of the situation. There needed to be a sensible use of money and skills:

> "We are providing a service at Savernake MIU which could and should be provided in a GP surgery. A lot of activity at Savernake MIU is referred there by GP surgeries, work for which they are already being paid."

60. When in March 2007 Mr Boon, a resident of Marlborough, asked to see the responses to the consultation himself, so he could assess them, the PCT said it would involve the considerable task of removing personal information from each response, with resource implications. While not refusing outright, it asked why Mr Boon wished to undertake the exercise. There seems to have been no reply.

61. As part of the implementation process a staff consultation document was produced in April 2007, Reforming Community Services in Wiltshire. Under the heading "neighbourhood teams", it outlined that these would provide care and treatment for people in their homes, such as taking blood tests, changing dressings, making assessments, providing palliative care "and other provisions where the patient is better cared for locally than in a major hospital". The document acknowledged that working in a neighbourhood team in people's homes was likely to be different from the way in which staff were already working in hospitals or in community services. The changes at Savernake Community hospital were set out: the neighbourhood team would be established in July 2007 and the Minor Injuries Unit closed in September.

62. At a workshop for staff on 16 April 2007, the chart used the previous year in the consultation on Taking the next step was again presented, with arrows pointing from "current models" (including day hospitals) to neighbourhood teams. Following the meeting Margaret Manley, the sister at the Savernake Day Hospital, emailed managers at the PCT:

> "[V]ery good, informative day on Monday, but it has thrown up a lot of questions. Sally Sandcraft said that there is a separate review going on about day hospitals, but then we were told by Maddy that we would definitely be part of the neighbourhood team – we are a little confused as to where we will be as of July. Do you know when the result of this review will be known, as staff will need to know if the day hospital will exist in any shape or form before they have 1:1 consultations with HR to enable them (and me) to make decisions on our future?"

63. In late April 2007 Mrs Jean Ward, a nursing auxiliary at the Day Hospital, received what was a standard letter about her future employment. She was told that an implication of the changes was that more staff would work in community teams to provide care, fewer in a smaller number of community hospitals. The PCT therefore wished to "migrate" her.

64. Minutes of the Savernake Users' Group Meeting on 15th May 2007 record that the Day Hospital "will remain a separate unit from the NT [Neighbourhood Teams], but will be managed alongside them". Dr Tulloch, who chaired the group, took the minutes in shorthand and then prepared them formally. That reference in the minutes is now said by a PCT manager of adult community services not to be an accurate record of what was said at the meeting.

65. A staff meeting was held at Marlborough on 18 May 2007. In relation to the position on the Day Hospital at Savernake it was said that staff would be "migrating".

66. The Joint Consultation and Negotiation Committee ("JCNC") consists of PCT and trade union representatives. At the meeting of the JCNC on 24 May 2007, the

unconfirmed minutes record that there were a number of issues for the JCNC sub-group, including "the future of day hospitals". "With regard to day hospitals, the PCT were waiting for final specifications from the Commissioners". The PCT medical director of provider services said that a commissioning leads meeting was taking place the next day.

67. On 29th May 2007 Margaret Manley, the sister at the Savernake Day Hospital, emailed Dawn Hales, in the absence of Mr Gittings, the adult community services manager. Margaret Manley asked for clarification about the procedure for "closing down" the Day Hospital and also to confirm the date for closure: was it 29th June or was there a period of time to "wind down". Who would be informing the stakeholders i.e., GPs, transport, Dr Finch, the consultant who oversaw the Day Hospital? Does she, at this stage, inform current patients in writing of the intended closure date and the alternative input they could expect to receive? Finally, as there still seemed to be great confusion as to whether there would be an assessment centre at Savernake, would it be possible for someone from management to come and talk to the staff "as we are still receiving very conflicting messages." Dawn Hales replied, inter alia, that there would need to be a transition period of continuing with the current Day Hospital until the neighbourhood teams were in place.

> "Transition is essential [from] the now to then and it will not be a case of stop one day and start another scenario. The services for older people will not be stopping but over a period of time will be delivered via a different route some of which will be outpatient based other will be within their own home all of which should be as proactive as possible trying to encourage older people to seek help before crisis hits.
>
> …
>
> The commissioning specification intentions at present clearly indicate mainstreaming older peoples' services into core NT business. That will require care to be delivered in the environment most appropriate to patients and in the most cost and staff effective manner."

68. A PCT June 2007 newsletter, available to the public and on the website, said that community services were being brought "closer to you", to people's homes. Recruitment of the new neighbourhood teams was under way. Under the heading "Day Hospital changes" it was said that care and treatment would be arranged in a variety of settings including a person's own home, their GP surgery, a day care centre or club, or a community hospital. The accompanying photograph was of Chippenham hospital with the caption "Day Hospital services will move into the community." The section "Spotlight on Marlborough" contained this sentence: "The Day Hospital will be replaced by our Neighbourhood Team who will be able to provide services to people in their own homes."

69. The same message of treatment in the house, when possible, appeared in a document placed on the PCT intranet on 8 June 2007, "The Future Provision of Day Hospital Services". In particular, on the second page of that document, under the heading "Current Day Hospital Staff", the text read as follows:

> "Staff currently in the day hospitals and Falls clinic will migrate into the neighbourhood teams, ensuring that their skills and expertise are retained to maximum benefit of all service users. The staff will use their specialist skills to assist in the assessment of patients both in the home and within the clinic setting. Some staff will also form part of the multi-disciplinary teams supporting geriatrician out-patient sessions. Staff migrating to neighbourhood teams will receive appropriate education and training support."

70. Meanwhile the PCT was responding to letters about the changes and the processes. On 18th June the PCT Chief Executive sent a letter to Richard Benyon MP, the member for Newbury in the neighbouring county, about the Minor Injuries Unit at Savernake Hospital. There had been a considerable body of work, he told the MP, such as a review of urgent care cases, which included minor injuries. The continuation of the Savernake unit could not be justified because of insufficient activity and because those attending could visit their GP. Even if patients who currently attended the unit went to the main A&E at Great Western Hospital at Swindon, the PCT would save money. In July the PCT wrote to Mrs Compton. Among the matters mentioned was the minor injury services. In that context mention was made of the Alberti report.

71. A further meeting of the JCNC committee was held on 23 July 2007. The UNISON representative inquired what would happen to day hospitals and whether public consultation had been fulfilled. He was referred to the June 2007 newsletter, "stating that day hospitals would be closing from 30 June 2007". The PCT chief executive told the meeting that services were still being provided, although some were now being carried out at home rather than in hospital.

72. In July 2007 the PCT placed a number of questions and answers for staff on its web-site. Among some 40 questions were the following:

> I am a Band 2. Should I be team working?
>
> I have worked in a hospital setting for years, and I have no wish to move out in the community.
>
> I don't drive. How do you expect me to work in the community?
>
> I wanted to work in a team closer to where I live.
>
> Can the PCT provide a safe home working environment?
>
> I am a District Nurse and have been told I migrate to a Neighbourhood Team. I believe the jobs in a Neighbourhood Team are different to my existing community job.

To the question "I am disappointed that day hospital provision has not been discussed", the following answer was given:

> "Day hospital provision has been discussed all through the staff and public consultation processes and was a topic raised frequently at the staff briefings held last summer. The NT [neighbourhood team] will provide (in the "frail elderly", now "vulnerable older people", patient group) assessment and treatment for the group previously referred to day hospitals. The new model will deliver this service to all older people referred rather than only those who live near a day hospital."

73. The Minor Injuries Unit at Savernake Hospital closed on 30 September 2007. In December 2007 the neighbourhood teams, which had been only partially implemented on the intended date in July, were fully operational.

Post implementation (August 2007 -)

74. In December 2007 the PCT announced in a press release that its plans to return to financial balance by the end of March 2008 had been endorsed by the South West Strategic Health Authority. The PCT had greatly improved its financial position over the year. The PCT chief executive was quoted as saying: "It is absolutely essential that the NHS in Wiltshire returns to financial balance; like any organisation it is important that we live within our means."

75. The neighbourhood team for Marlborough consists of four district nurses, three senior physiotherapists, eleven Band 5 nurses, two Band 5 physiotherapists, eight rehabilitation support workers and one specializing in falls. The nurses see 45 patients a day: the therapists see 13 patients in the community and 24 on the wards. At the Day Hospital suite of rooms the PCT say that on Mondays there is a "Falls" clinic, providing intensive rehabilitation for patients who have injured themselves in a fall; on Tuesday afternoon a "care of the elderly clinic" run by a consultant geriatrician; on Wednesday morning a consultant-led multi-disciplinary clinic; and on Thursday, a further "Falls" clinic. Also taking place are "Falls" assessments, Parkinson's assessments, and balance assessments, 24 hour ECGs and consultant-provided injections such as cortisone. Mrs Compton disputes that some of this activity is taking place.

76. The two Minor Injuries Units in Wiltshire are at the Trowbridge Community Hospital, open 24 hours a day, 7 days a week; Chippenham Community Hospital, open 7 a.m. to 1 a.m. 7 days a week. Patients who might have previously sought treatment at the Minor Injuries Unit at Savernake Hospital are also to obtain treatment at the other locations, including the A&E department at Swindon. Patients who might have previously sought treatment there for minor illnesses are able to obtain treatment from their GPs

77. The PCT carried out a patient survey in November 2008 as to neighbourhood team provision. There were 225 completed questionnaires, 23 from patients treated by the team providing care around the area of Savernake Hospital. Of the 225 respondents, 84 percent said that the care was very good, and 14 percent said it was good. None said the care was poor. The survey also asked patients to compare services before and after the reconfiguration: 71 responded, and 80 percent said that there was a change for the better or no change.

78. A twelve month review of the Minor Injuries Unit service change was presented to the PCT board in December 2008. One aspect was a patient satisfaction survey carried out in the Trowbridge and Chippenham units in October 2008. Ninety-five percent of patients surveyed rated the services as very good, the remaining five percent as good.

79. The Friends of Savernake Hospital conducted a survey because they were not convinced that those previously treated at the Day Hospital had been asked in the PCT survey about how they felt. A variety of methods was used: a street survey, a web survey, a mail out, a town council survey and an approach to a dozen elderly persons who may have used the day hospital. There were a total of 556 responses. Of those who attended the Day Hospital at Savernake or cared for someone who did, almost all said they were not consulted about the closure and that they would prefer the choice of being able to use it rather than just being offered the services of the neighbourhood team. Almost all respondents thought that it was more difficult to access urgent treatment for minor injuries since the closure of the Savernake unit and that that unit should be reopened.

80. In January 2009 Wiltshire's neighbourhood teams were described over three pages in the Department of Health's report, Transforming Community Services and World Class Commissioning: Resource Pack for Commissioners of Community Services. The PCT points to beneficial effects of the neighbourhood teams such as the reduced attendance at A&E departments and a reduction in emergency admissions to hospital. It is fair to say that Mrs Compton disputes the benefits over the previous arrangements. The Healthcare Commission, the independent regulator of healthcare services, reviewed the provision of urgent and emergency care within the NHS in 2007/2008. Minor Injuries Units are one aspect of urgent care. The review focused upon how services were accessed, their effectiveness and integration and their management and commissioning. In its report of the review, published on 26 September 2008, the Commission placed Wiltshire PCT as one of the best performing, coming fifteenth out of 152 PCTs. Again, Mrs Compton disputes the benefits of closing the Savernake Minor Injuries Unit.

ISSUE 1: BIAS

81. The bias issue is common to both claims. It turns on the fact that Jane Britton, at the Strategic Health Authority, was the domestic partner of one of the directors of Red Bridge, which prepared the report on the consultation responses to the April 2006 document, Taking the next step. Mrs Compton contends that the involvement of Red Bridge in the consultation process leads to an appearance of bias, which vitiates the decisions.

The claimant's case

82. Mrs Compton's case is that the public needed to have confidence in the independence of the consultation process. They had been assured that the process of analysing the consultation replies would be conducted dispassionately. It was only much later that the public learnt of the connection between Red Bridge and the Strategic Health Authority. As Mrs Compton herself has expressed it, they then thought that the consultation was a sham. The local Member of Parliament, Rt Hon Michael Ancram MP QC has said that he was amazed when he learnt of the link. If he had known of it he would have objected most strongly to engaging Red Bridge because it gave the

impression of bias. If the matter had been known publicly there would have been an outcry "because it was patently clear to everyone involved that the process was being driven by the [Strategic Health Authority]". Cllr. Christopher Humphries, then leader of the Kennet District Council, has expressed similar views.

83. In legal terms Mrs Compton's case on bias is based constructed on a number of building blocks. First, it is said that the PCT and the Strategic Health Authority are closely linked organisations. In its Shaping the Future document in January 2006, the Strategic Health Authority emphasised that the priorities for the PCT must be "to implement the decisions taken as a result of Pathways for Change to improve provision and deliver financial balance …" It was also closely involved with the "Pathways for Change" consultation process, supporting the PCT's approach. It was also intimately involved in the PCT's financial arrangements, repeatedly putting pressure on the PCT regarding its budgeting and its financial predicament. Shaping the Future had said that the NHS in its area should find "new, more economical ways of working". None of this was surprising or objectionable, but it demonstrated that there was a real and substantial connection between the Strategic Health Authority and the PCT.

84. At the time of the decision of January 2007, nothing was known of the connection between the Strategic Health Authority and Red Bridge through Jane Britton. Ms Britton herself was involved on behalf of the Strategic Health Authority in the "Pathways for Change" process, representing it at the launch meeting in May 2005 and advising the PCT with regard to the "Pathways for Change" consultation process. The personal relationship between such a senior employee involved in "Pathways for Change", and the author of the report reviewing the public responses to the consultation process, gives rise to the appearance that the consultation process was tainted by bias. The decisions to close the Day Hospital and Minor Injuries Unit at Savernake Hospital were infected by that apparent bias and were unlawful.

85. Absence of actual bias is not the critical issue. The focus of the court's enquiry, it is submitted, must be on the impression that would be created in the mind of the fair minded and informed observer. Mrs Compton submits that the doctrine of apparent bias must permit consideration of whether the decision-maker's impartiality was or appeared to be tainted by one of the contributors to decision-making process. Still more is that true if the contributor performs any part of the decision-maker's function. The apparent bias here has two facets. First, there would be a real possibility of a fair minded and informed observer thinking that Red Bridge were biased because of their connection with the Strategic Health Authority. Second, there was a real possibility that such bias would have infected the views of the PCT. Among the factors identified in assessing what the fair-minded and informed observer would conclude in the present case, Mrs Compton points to Ms Britton's role in the PCT's consultation process; the fact that the PCT Board and Professional Executive Committee were not informed of the potential conflict of interest and accordingly could not assess the impartiality of their decision-making; the fact that the public were not informed of the connection and there was no public declaration of interest; and the importance of the report produced by Red Bridge to the decision-making process, the PCT having promised the public that there would be an independent assessment of their responses to the consultation process. In light of this there is more than a theoretical possibility of bias.

86. Finally, while Mrs Compton accepts that it is entirely legitimate for a public body in the defendant's position to make use of an independent organisation in assessing the public response to a consultation, that involved delegating the conscientious consideration of the product of the consultation to a third party. That delegation of function brought with it an obligation to ensure that the organisation chosen was untainted by bias or the appearance of bias in exactly the same way as the decision-maker itself must be free of bias. It could not be said that there was conscientious consideration of the consultation responses by the PCT board members. That the chairman and chief executive had read all the consultation responses meant, in effect, that other board members had not.

The law

87. The essence of the doctrine of apparent bias is that justice must be seen to be done. Both parties agree that the crucial question is whether the fair minded and informed observer, having considered the facts, would conclude there was a real possibility of bias: Porter v Magill [2001] UKHL 67; [2002] AC 357, [103], per Lord Hope. Friendship or close acquaintance is a factor which is capable of giving rise to a real possibility of bias: Locabail (UK) Ltd v Bayfield Properties Limited [2000] QB 451 at [25].

88. Recent authority has added flesh to the concept of the fair-minded and informed observer. That construct can be assumed to have access to all the facts that are capable of being known by members of the public generally: Gillies v Secretary of State for Work and Pensions [2006] UKHL2; [2006] 1WLR 781, [17], per Lord Hope. In Helow v Home Secretary [2008] UKHL 62; [2008] 1 WLR 2416, Lord Hope said that the fair minded and informed observer was not to be confused with the person who has brought the complaint. She had a measure of detachment. Assumptions that the complainer makes are not to be attributed to the fair minded and informed observer unless they could be justified objectively: at [2]. As to the attribute of being "informed", Lord Hope said that before the fair-minded and informed observer took a balanced approach to any information she was given,

> "she will take the trouble to inform herself on all matters that are relevant. She is the sort of person who takes the trouble to read the text of an article as well as the headlines. She is able to put whatever she has read or seen into its overall social, political or geographical context. She is fair-minded, so she will appreciate that the context forms an important part of the material which she must consider before passing judgment" (at[3]).

89. There was disagreement between the parties as to whether the actions of an advisor, to use that term, as opposed to the decision-making body itself, could give rise to an appearance of bias. R v Gough [1993] AC 646 was advanced on behalf of Mrs Compton to support the proposition that it could. That was a case where there was consideration of the advice given by a justices' clerk. For Mrs Compton it was said that if the bias of a justices' clerk could vitiate a decision of the justices, so too could that of an advisor like Red Bridge in this case. For the PCT it was said that justices' clerks are in a special position, because the justices are bound to follow their advice.

There is, however, no warrant for that proposition: see Stone's Justices' Manual, 2009, v.1, para 1-29.

90. The discussion in R v Gough demands closer analysis. In that case, Lord Goff (with whom the others agreed) said that in a case concerned with bias on the part of a justices' clerk, the court should go on to consider whether the clerk had been invited to give the justices advice and, if so, whether it should infer that there was a real danger of the clerk's bias having infected the views of the justices adversely to the applicant (at 670G). (In the light of Porter v Magill Lord Goff's "real danger" must be read as "real possibility"). In his concurring speech Lord Woolf said that no distinction arose in the application of the test because it was the clerk to the justices, rather than the justices themselves, who were alleged to be biased, since a clerk to the justices was part of the judicial process in the magistrates' court (at 671D).

91. In my view the principle is clear: the bias of advisers is capable of vitiating a decision when there is a real possibility that it has adversely infected the views of the decision-maker. That seems to me to turn on at least three considerations. First, there is the nature of the advice itself. Advice to my mind falls along a spectrum from the provision of information, which may or may not have a bearing on the ultimate decision, to a strong recommendation that a particular course be taken. Secondly, there is the matter to which the advice pertains. That may be tangential to the decision to be taken, or it may be an essential component without which no decision is possible. Thirdly, there is the relationship between the adviser and the decision-maker and whether it is so close that there is a real possibility that the bias of one will infect the other.

Analysis and conclusion on bias

92. Earlier I concluded that the fact that the relationship between Jane Britton of the Strategic Health Authority and Mr Tanner of Red Bridge was known to the PCT panel which recommended that Red Bridge be appointed. Red Bridge was selected at the conclusion of a normal process, where its tender was evaluated against criteria, including an interview, and Red Bridge performed best against them. Mr Tanner had the appropriate skills and experience for the task. The evidence of the Board members who read the individual responses in full found the report to provide an accurate analysis and summary of them, although the informed and fair minded observer would not know that.

93. However, I have no hesitation in expressing my view that the appointment of Red Bridge for the task was an error of judgment. Unimpressive, in my view, is the PCT's submission that it is no coincidence that the only individuals who claim there is an appearance of bias are vocal supporters of Mrs Compton's case. The views expressed by senior political leaders such as Rt Hon Michael Ancram MP QC and Cllr. Humphries cannot be so readily dismissed. The fact is that the consultation, as everyone knew, was highly contentious. The public do not make fine distinctions between different parts of the NHS, especially given the widespread perception that the consultation process was being driven by the financial shortfalls of the two PCTs in north Wiltshire. Moreover, it cannot be said that preparation of the Red Bridge report did not demand an exercise of judgment: it did, both in categorising the contents of responses and in other matters, such as choosing the quotations to accompany particular conclusions. Judgment was not excluded by the fact that the

report was analysis. Moreover, the PCT had highlighted that it would commission an independent report for the purpose of gathering together the responses in the consultation process.

94. Nonetheless, as a matter of legal analysis it is my view that the charge of apparent bias has not been made out in the circumstances of this case. That is because the fair minded and informed observer would know that the Red Bridge report summarised the responses made during the consultation and did not advise or make recommendations as to the decisions to be made by the PCT. The fair minded and informed and observer would have observed that the report included responses which were not supportive of the PCT and recorded resistance to proposals being made, for example to Option 1, which involved the complete closure of Savernake Hospital. The fair minded and informed observer would have heard the chairman and chief executive of the PCT had read all the responses to the consultation as well as the Red Bridge Report.

95. The fair minded and informed observer would also understand the true relationship between the Strategic Health Authority and the PCT: a Strategic Health Authority does not direct others to provide health services, its functions being limited to the support and performance management of the PCTs in its area, as provided in regulation 3(2) of the 2002 Regulations. The fair minded and informed observer would know that the involvement of the Strategic Health Authority in the consultation process was to advise on procedural requirements, not on substantive decision-making. In relation to the financial pressure which it is said the Strategic Health Authority placed on the PCT in order to control its decision-making, the fair minded and informed observer would know that the PCT was under a statutory obligation to balance its finances and that the Strategic Health Authority was simply applying that standard. Thus the fair minded and informed observer, as the law defines her, would not conclude that there was a real possibility of bias because of the connection between Red Bridge, the Strategic Health Authority and the PCT through Mr Tanner's and Ms Britton's domestic relationship.

96. Moreover, the doctrine of apparent bias could not apply, in my judgment, to the circumstances of this case because of the character of the Red Bridge report. As I have already said, although it was relevant to the decision which the PCT board took on 30 January 2007, the fair minded and informed observer would know that the report did not contain recommendations, explicit or implicit, as to the decision to be taken. The report was more in the character of information for use in the decision process. The report summarised responses to the consultation and, while that involved judgment, it was not part of the decision to be made. In a sense it was a tool which facilitated the taking of the decision, providing information for use in the decision-making, rather than being a clear pointer in the direction of what decision ought to be taken. The chairman and chief executive of the PCT had read all the consultation responses, and Board numbers had certified they were fully informed of what consultees had said. In all there was no apparent bias inflecting the PCT's decision-making process.

ISSUE 2: THE DAY HOSPITAL

97. Mrs Compton's case is that the Day Hospital at Savernake Hospital was closed and that the closure is unlawful because of a failure properly to consult. The PCT

responds that the Day Hospital remains open. The changes to its operation were subject to consultation and cannot be regarded as legally irrational. If that is wrong, and the PCT has closed the Day Hospital, Mrs Compton's case is that it would have been Wednesbury unreasonable, because it was not the decision which the PCT contends its board reached.

The claimant's case

98. Mrs Compton accepts that the PCT consulted on the introduction of neighbourhood teams in 2006. However, there was no suggestion either during the pre-consultation exercise, or during the consultation itself, that the Day Hospital would be closed. Indeed the Day Hospital was hardly mentioned during the consultation process. The consultation document, Taking the next step, makes no direct reference to it. The Day Hospital staff, including Mrs Compton herself, were not told at any time that the PCT was contemplating its closure. Colonel Lefever, Chairman of the Friends of Savernake Hospital, was unaware of any plans to close the Day Hospital, and it was only in May 2007 that he first heard of the proposed closure. The "Town Stories" in the paper which was approved by the PCT Board on 30th January 2007 indicated that ambulatory services would continue at the Savernake Hospital.

99. There was nothing in the documents to suggest that the PCT was proposing the closure of the Day Hospital or that the PCT Board decided to close it. On the contrary the clear inference was that it would remain open. That inference arises from the absence of any suggestion that it would be closed and secondly, from the inclusion as part of the PCT's future plans of a "clinical assessment centre" at Savernake, a reference which must be a reference to the Day Hospital. The PCT led staff, patients, practitioners and the public to believe that the Day Hospital would remain open, working alongside the neighbourhood teams. There was no consultation with patients, staff, GPs or the public on its closure. Indeed, the PCT now make the central feature of their defence the assertion that the Day Hospital remains open.

100. After the Board decision of the 30 January 2007, Mrs Compton's case is that the conduct of the PCT's officers served to reinforce the view that the intention at that time was to keep the Day Hospital open. Neighbourhood teams were portrayed as working alongside the Day Hospital. In a statement, a local GP, Dr Hook, says on behalf of his practice, that the closure was never properly consulted on and that they were never told it was going to close prior to the decision to close in May 2007. The expectation was that it would remain open and run in harmony with neighbourhood teams. Staff were led to believe that the Day Hospital would remain open. At the Savernake Users' Group meeting on the 15th May 2007, the minutes record the PCT's assistant director as stating that the Day Hospital would "remain a separate unit from the [Neighbourhood] Teams, but would be managed alongside them."

101. In principle it is unobjectionable as a matter of law that the PCT did not see the decisions of the board of 30th January 2007 as the last word on how services would be reconfigured and there remained some latitude available to them as to how this might be done. It is to be expected that the Board makes decisions of principle and staff are left to work out practical ways of bringing those decisions into effect. But that latitude cannot operate to avoid the common law and statutory duty to consult on changes of substance. If there were to be changes in the way health services were provided, or decisions were to be made which affected the operation of health

services, there was a duty to consult. The closure or running down of the Day Hospital constituted a significant change in the way services were provided and a decision to close the Day Hospital substantially affected the operation of health service for the people of Marlborough.

102. As regards the dispute over closure, Mrs Compton's case is that as a factual matter the Day Hospital has been closed. Closure was the language used in some of the communications from senior PCT officials. As a matter of fact the Day Hospital has been closed and the rooms are increasingly used for storage. In Mrs Compton's own graphic description it is as much as a redundant church still stands, and may be used for laudable purposes, but it is no longer a functioning church. The Day Hospital entrance is closed and the rooms are unused. The suggestion that there is now a clinical assessment centre at the Savernake Day Hospital is not borne out by the evidence of staff and patients.

103. Thus in Mrs Compton's case the PCT did not decide to close the Day Hospital on 30th January 2007. Closure was never part of the consultation. The PCT board endorsed proposals which provided for the Day Hospital to continue in being. Before late May 2007, the PCT represented to patients and staff that it would not close. But then the decision to close it was taken in or about late May 2007, and communicated later that month.

The law on consultation

104. The common law duty of consultation is well-established: consultation must be undertaken at a time when proposals are still at a formative stage; it must include sufficient reasons for particular proposals to allow those consulted to give intelligent consideration and an intelligent response; adequate time must be given for this purpose; and the product of consultation must be conscientiously taken into account when the ultimate decision is taken: R v Brent London Borough Council, ex parte Gunning (1985) 84 LGR 168; R v North and East Devon Health Authority, ex parte Coughlan [2001] QB 213, [108].

105. There is a statutory duty imposed on health authorities to consult on changes to the provision of health care services. That obligation is now contained in section 242 of the Health Service Act 2006. At the time, however, the relevant provision was section 11 of the Health and Social Care Act 2001 ("the 2001 Act"). The relevant parts were as follows:

> "(1) It is the duty of every body to which this section applies to make arrangements with a view to securing, as respects health services for which it is responsible, that persons to whom those services are being or may be provided are, directly or through representatives, involved in and consulted on—
>
> (a) the planning of the provision of those services,
>
> (b) the development and consideration of proposals for changes in the way those services are provided, and

(c) decisions to be made by that body affecting the operation of those services.

(2) This section applies to—

…

(b) Primary Care Trusts,

…"

106. In R (on the application of Fudge) v South West Strategic Health Authority [2007] EWCA Civ 803 Moses LJ said that the duty under section 11 was not to involve and consult but to make arrangements with the objective of securing involvement and consultation. The very use of different terms, involvement and consultation, only made sense if something less than consultation would be appropriate in certain circumstances. The two concepts of involvement and consultation reflected the different stages at which the obligation might be triggered. There was no warrant for construing section 11(1) as imposing an obligation to consult on each and every occasion one of the circumstances identified has occurred.

> "The arrangements which bodies responsible for health services must make must be designed both to secure public involvement and public consultation. Whether mere involvement or something more, namely consultation in the full Gunning sense, is required, will depend upon the circumstances identified in s. 11(1)(a)-(c)" (para 51).

Discussion

107. There was considerable debate at the hearing as to whether or not the Day Hospital at Savernake Hospital has closed. On reflection it seems to me that the way the issue was approached was mistaken. Mrs Compton's evidence persuaded me that the Day Hospital as a suite of rooms at the Savernake site has been, in substance, closed. The rooms formerly occupied for Day Hospital purposes are largely unused. The limited services now available there, for example the Falls clinics, are confined to a relatively small part of what once constituted the Day Hospital part of the Lavington building.

108. However, if the Day Hospital is regarded as a collection of health care services, it is in my judgment alive and well. Those services are delivered at the patient's home and elsewhere in the community and can be obtained, it would seem, that some of the same staff are still involved in providing them. In some circumstances patients might still be assessed at the Day Hospital's suite of rooms. But since Day Hospital services are largely offered in the community there is no great need for most rooms. In particular the dining room is no longer used for meals because the previous model of patients visiting the Day Hospital site for the day no longer obtains. Other rooms are not used as well, and the entrance is certainly closed, although access is provided on the other side of the Lavington building.

109. In considering the issue of consultation, it seems important to bear in mind that this was not a consultation solely about Savernake Day Hospital but about services across

the whole PCT area. Nonetheless, it is clear that the notion of providing Day Hospital type services more in the community and home, and less in hospitals, was at the forefront of the PCT proposals from early in the "Pathways for Change" process. That the public wanted to be treated in their homes was a finding of the stakeholder assemblies in mid 2005. There was also the fact that Wiltshire had no community nursing out of hours. The analysis of the reasons for admission to hospital demonstrated that the majority of patients could be treated at home. As a result of these factors the idea of neighbourhood teams was conceived.

110. The PCT consultation document, in April 2006, Taking the Next Step, made explicit that the consultation aimed to outline a new way of providing NHS services, more in the community and the home, less in hospitals. Neighbourhood teams were described, to provide more healthcare and services in patients' homes, the teams to include nurses, therapists, rehabilitation staff and community matrons. For the elderly this was said to be important since, with the right support, they could live independently in their own home, rather than being admitted to hospital or care homes.

111. Once the consultation was under way, the message was reinforced. As described earlier the presentation to staff at the consultation meeting in Marlborough on 26 April 2006 highlighted the objectives of caring for more people in different ways, and in different settings, offering 24 hour access to nursing care and increasing support to people who wished to be treated at home. That could be achieved, it was said, by the introduction of neighbourhood teams to provide more healthcare in people's home. It will be recalled that the staff were told that neighbourhood teams would provide urgent, managed, frail elderly and palliative care. "A number of nurses in the community hospitals will move into the community", it was said. At the second staff meeting in Marlborough on 29 June 2006 there was the slide: current models, including day hospitals, with the arrow to neighbourhood teams. Similarly, at the Marlborough public consultations the existing arrangements, including day hospitals, were described and the proposed neighbourhood teams outlined.

112. As regards the PCT decision after the consultation, it will be recalled that the Paper which went to the PCT Board on 30 January 2007 referred to more staff being in community teams and in primary care, and fewer in a smaller number of improved community hospitals. There was reference to changing services with less inpatient hospital care and more working with patients at home, elsewhere in the community or within primary care. The plans for neighbourhood teams were set out. Among the service outcomes for neighbourhood teams mentioned were keeping patients out of community hospitals by providing care in the community, patient's homes or residential and nursing homes. It will be recalled that under the finance heading there was mention of: "Reprovision of day hospital services through neighbourhood teams." Staff implications mentioned included redeployment. The minutes of the PCT Board meeting at which the proposals were approved included the explanation that neighbourhood teams would involve moving staff out from hospitals and putting them into community teams.

113. Once the decision was made to introduce neighbourhood teams work began on its implementation. In the late April letters to staff such as Mrs Jean Ward, who worked at the Day Hospital, the PCT's intention to "migrate" them to community based working was clear. That was confirmed in later documents such as the June

newsletter and the intranet message of 8 June: "Staff currently working in the day hospitals and falls clinics will migrate into the neighbourhood teams …"

114. In the light of this background it is clear to me that the decision about the future of Day Hospital services was a decision reached after the consultation which Parliament requires. In the words of section 11, the PCT made arrangements to secure involvement in and consultation on the planning of the provision of the Day Hospital services, the development and consideration of proposals for changes in the way the Day Hospital services were provided, and decisions affecting the operation of Day Hospital services. The proposed introduction of neighbourhood teams was a key aspect of the proposals upon which there was consultation. It was clear that the services offered by neighbourhood teams would generally be at home, rather than in hospital. Staff would be expected to "migrate", to use the jargon later invoked. This message was so strong that in my view it completely swamped anything which could be taken as a qualification or contradiction, such as the references in the Marlborough "Town Story" in the Board paper of 30 January to a continuation of ambulatory services at Savernake.

115. Moreover, in my view, on the 30th January 2007 the PCT expressly decided that services previously provided at places such as a Day Hospital would be provided by neighbourhood teams in a variety of settings, predominantly in the community. The precise design of how this was to be implemented came later. Perhaps unsurprisingly there was some uncertainty among staff and in the community about what the changes meant. But in my judgment the decision had clearly been made on 30 January and none of the work towards implementation of that decision amounted to a fresh decision or a change in substance from the original decision. Thus the rationality challenge also fails.

ISSUE 3: THE MINOR INJURIES UNIT

116. All three options in the "Pathways for Change" consultation paper envisaged the closure of the Savernake Minor Injuries Unit. The PCT asserts that it was closed on clinical and financial grounds. Mrs Compton's case is that there was no clinical support for the closure and that the decision was purely financial and unreasonable. The clinical reasons the PCT advances in these proceedings for the closure were not the true reasons. In any event the financial case put forward by the PCT for the closure of the Savernake Minor Injuries Unit is flawed. Mrs Compton also submits that the PCT failed to have proper regard in the decision on closure to the report by Professor Sir George Alberti, "Emergency Access: Clinical Case for Change".

The claimant's case

117. Mrs Compton contends that there is a significant body of evidence to the effect that there is no clinical basis for closing the Savernake Minor Injuries Unit. She has provided witness statements from patients, staff members and local clinicians to show that there was no clinical justification for the closure, and that in fact it has had an adverse effect on patients. For example, the nurse, Jane Galbraith, who formerly ran the Minor Injuries Unit, states that she and her colleagues could find no evidence of anyone who supported the closure and that the ideas they put forward were simply ignored. She sets out the structure and qualities of the unit and the significant impact upon the population, including children and the elderly, of the closure. She argues

that the PCT had no real understanding of what the Savernake Minor Injuries Unit did. Indeed Mrs Compton contends that the reasons for the closure were not those now given by the PCT, and that in truth the Unit was closed for financial reasons. Since the true reasons for closure are not those now relied on by the PCT, the decision should be quashed.

118. On Mrs Compton's case the PCT's evidence as to the clinical basis for closure of the Savernake Minor Injuries Unit is evidence from just one GP, Dr Jakeman, who did not work there. He states that the clinical reasons for closing the unit were that the staff at the Unit were at risk of losing their clinical skills as a result of the low number of patients that they were treating; that Minor Injuries Unit staff were spread too thinly throughout Wiltshire so the types of injuries which could be treated depended on which member of staff was on duty on which day; that the ambulance service were unsure which unit could treat specific patients on any given day; and that there was confusion over the opening times of the Minor Injuries Units throughout Wiltshire, since they were not uniform.

119. On Mrs Compton's case these so called clinical grounds for closing the Savernake Minor Injuries Unit do not stand scrutiny. Thus there is no evidence that the staff at Savernake Minor Injuries Unit were de-skilled or that the PCT ever assessed this before proposing the closure. Further, there is no empirical evidence as to the problems alleged to have been encountered by the ambulance service or about public confusion. An alleged lack of sufficient staff is a financial, not a clinical, justification for closing the Unit. Mrs Compton observes as to a desire for uniform opening times that the Minor Injuries Units now being run by the PCT, at Chippenham and Trowbridge, do not have the same opening times. The absence of clinical reasons is evident, says Mrs Compton, in the paper put to the Board on 30th January 2007.

120. The true reason for the closure was given, on Mrs Compton's case, in the letters to Dr and Mrs Rosedale and to Mr Richard Benyon MP, both referred to earlier. Those letters are striking as they do not mention the clinical grounds for closure relied on by the PCT in Dr Jakeman's witness statement. In both letters the point is made that the Savernake Minor Injuries Unit was providing services which could be provided by GPs and for which the GPs were already being paid under their contract with the PCT.

121. In any event, Mrs Compton submits that the financial case advanced by the PCT for the closure of the Savernake Minor Injuries Unit is flawed and such as to make the closure decision reviewable. There is no before-and-after closure budget, no financial projections, no service level agreements, and no management accounts. There is no evidence from the PCT's own finance director or its accountants and no explanation of costings, past or present, which make up the purported annual cost. Jane Galbraith's statement undermines the basis of the PCT's statistics for unit attendances by showing that the PCT in advancing its statistics is not comparing like with like. Mr de Saxe, a respected accountant, has demonstrated well founded gaps in the PCTs' methodology, including the inclusion of certain indirect costs which ought to be excluded insofar as they would continue after closure. Mr de Saxe also notes that the use of a national A&E cost comparator is inappropriate and that a cost for the A&E unit at Swindon should be used.

122. Finally, Mrs Compton contends that the PCT did not take the Alberti report into consideration as a relevant consideration. It encouraged NHS bodies such as the PCT to increase the provision of facilities such as Minor Injuries Units. The PCT had no or insufficient regard to the Alberti report when making its decision to close the Savernake Minor Injuries Unit and provides no, or no sufficient, explanation of its decision in this regard. The PCT's own position on this issue is confused because in its response to Mrs Compton's letter of claim in August 2007 it stated that there "was no reliance on Sir George Alberti's report in relation to the closure decision." It now states that it had regard to the report. In fact, it should have had regard to the report as a highly material consideration. Had it done so, it would have been obliged to give it substantial weight. At the very least, the PCT ought to have explained why it was not following the guidance contained in that report.

Discussion

123. In the April 2006 consultation document, Taking the Next Step, the PCT proposed concentrating all Minor Injuries Unit activity onto two sites, so that it would be able to offer a more comprehensive Minor Injuries Unit service, treating a wider range of conditions. Mention was made of a dispersed expertise under the existing arrangements. Finance was referred to, in particular that services provided from a number of sites meant that management and running costs were high.

124. It will be recalled that the paper prepared for the PCT Board on 30 January 2007 referred to the proposed changes, with two comprehensive minor injury and illness units and the commissioning of enhanced primary care-led minor injuries and illness services. The new model for minor injuries units was aimed at providing a balance between maintaining local access while providing sufficient concentration of resources to ensure high quality services. The service would form one part of a new integrated model of urgent care.

125. Earlier in the judgment the minutes of the PCT Board meeting from 30 January 2007 were mentioned. There the chief executive is recorded as refuting the public impression that the proposals were in general a financial exercise. (That is underlined because the option the Board adopted that day was not the least expensive). In introducing the proposals for Minor Injuries Units, the approach of the Alberti Report was specifically outlined. The Board was told that the seven Minor Injuries Units within Wiltshire had different opening hours and accessibility and there was therefore a lack of clarity in respect of running all services. The difference in the services they provided and the hours they were open was highlighted, as were the difficulties the Ambulance Service had because of the uncertainty of being accepted. The point was made that it appeared to be far better to have a small number of more reliable and more comprehensive Minor Injuries Units to avoid people going to A&E. The Board was also told that a number of the present Minor Injuries Units were being staffed by using more senior nurses and bank staff to fill gaps. In an appendix to the Board papers a question was raised at concerns over Minor Injuries Unit provision for the East of Kennet District residents. The response to this was that the PCT was to undertake a strategic review of its urgent and emergency care provision, with an intention of developing a new strategy for urgent care provision. That was to consider, inter alia, the Alberti Report.

126. On the basis of this and other material referred to earlier in the judgment, it seems clear to me that there was a mix of reasons, clinical, operational and financial, for the decision to close the Minor Injuries Unit at Savernake Hospital. It was one of a number of decisions which the PCT took on 30 January 2007 to reconfigure its services. This mix of reasons was contained in the consultation document, Taking the Next Step, and in the board paper considered on 30 January 2006. The minutes of that meeting record that the Board considered these various reasons. I fail to see how it can be said that the PCT is now advancing reasons not used as justification previously. Some of the reasons were clinical, in a broad sense of that term. As far as the clinical case is concerned I note as well that the Professional Executive Committee, a committee of clinicians, had endorsed the January board paper shortly before the PCT board itself considered it. The criticism of Dr Jakeman as a mere GP is unjustified, when he is the Medical Director of the PCT.

127. As for the financial critique Mrs Compton now advances, it seems to me to be a temptation to enter on a merits review. In any event I note the PCT's response, including the point that NHS accounting standards differ from those used in the private sector. Given the financial arguments the PCT now adduces, it is impossible for me to conclude that the PCT's financial case was flawed on public law grounds. The Alberti report, which identified the desirable format of urgent care services, was published in early December 2006, just before the PCT board made its decision on Minor Injuries Units. The Alberti report was mentioned both in the report which went to the 30 January board meeting and at the meeting itself. Insofar as the report was relevant to the PCT's decision it was taken into account at that stage. The question of the weight to be attached to it was a matter for the PCT.

REMEDY

128. Both parties accepted that there was a discretion whether to grant relief. For Mrs Compton it was said that the starting point for me must be that a claimant who succeeds in establishing the unlawfulness of administrative action is entitled to a remedial order: R (on the application of Edwards) v Environment Agency [2008] UKHL 22, [2008] 1 WLR 1587, [63], per Lord Hoffmann. A passage from de Smith was cited to the effect that because a public authority may have to spend money correcting the consequences of its own unlawful action is not of itself a ground for the refusal of the grant of relief: De Smith's Judicial Review (6th Edition, 2007), para 18-058. As I pointed out in argument the authority supporting that proposition, advanced by the distinguished editors of de Smith, is thin. There is a considerable body of authority that the court may refuse relief where the grant of a remedy would be detrimental to good administration and adversely affect the rights of third parties: e.g. R (Fudge) v South West Strategic Health Authority [2007] EWCA Civ 803.

129. Mrs Compton contends that reinstatement of the facilities would produce savings. On the other hand the PCT submits that the reconfigured arrangements, including Neighbourhood Teams, are working well, for patients living near to Savernake Hospital and across Wiltshire. Moreover, it would not be financially or practically possible to reinstate the facilities, submits the PCT, quite apart from the issue of principle that an order to do this with the Day Hospital would amount to an unwanted degree of interference in the operational decision-making of a public body, which owes obligations to all those in Wiltshire.

130. Given my decision that the PCT has not acted unlawfully, there is no need to explore these arguments further. In any event, both sides in their closing submissions requested a further hearing for me to consider relief should I have allowed the claims for judicial review and been minded to quash the decisions regarding the Day Hospital and the Minor Injuries Unit, or to order reinstatement of the former.

CONCLUSION

131. The Day Hospital and Minor Injuries Unit at the Savernake Hospital in Marlborough were popular and well-respected local facilities. That is evident from the degree of support which Mrs Compton, the claimant in this case, has won for her campaign. During the hearing I was impressed with the attendance each day of a considerable number of her backers. It must have been especially galling when shortly after the facilities at the Savernake Hospital had been refurbished the decisions regarding the Day Hospital and Minor Injuries Unit were taken. The rooms used by the Day Hospital stand largely idle and the Minor Injuries Unit has been closed. That public concern must have been compounded when it was discovered that the firm which had analysed the responses to the PCT consultation preceding these changes was connected to the Strategic Health Authority through the domestic relationship between a director and the latter's associate director of patient and public involvement. The reaction of the local Member of Parliament, Rt Hon Michael Ancram MP, QC, and the then leader of the district Council, Cllr Humphries, is unsurprising. I have expressed my view that the decision to engage Red Bridge constituted an error of judgment.

132. The issues for my decision, however, are of a strictly legal character. The larger merits of Mrs Compton's case against the PCT decisions to reconfigure services at Savernake Hospital are not for me. In legal terms the challenge that the decisions were flawed for apparent bias because of Red Bridge's involvement cannot succeed. That is because the law requires that the standpoint be that of the fair minded and informed observer. Because of the knowledge which the law assumes that legal construct to have, it is my judgment that she would not think that there was a real possibility of bias in the circumstances. Moreover, the existence of a real possibility of bias must be of the decision-maker or someone closely associated with the decision in the way I have described in the judgment. That was not the case here.

133. Consultation in relation to both decisions had to meet the standards laid down in section 11 of the Health and Social Care Act 2001. In my view the consultation on the April 2006 PCT document Taking the Next Step met those standards. Moreover, the decisions on the neighbourhood teams, with its implications for the Day Hospital, and to close the Minor Injuries Unit, were not flawed for the public law reasons advanced on Mrs Compton's behalf. Thus as a matter of law I have concluded that the PCT's decisions in respect of both the Day Hospital and the Minor Injuries Unit at Savernake Hospital were properly made and are not susceptible of review whether on the grounds of bias, inadequacy of consultation, or irrationality.