Neutral Citation Number: [2022] EWHC 384 (Admin)

Case No: CO-1752-2021

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 23/02/2022

Before:

MRS JUSTICE HILL

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Between:

ANJNA KHURANA	**Claimant**
- and –	
(1) NORTH CENTRAL LONDON CLINICAL COMMISSIONING GROUP (2) THE NATIONAL HEALTH SERVICE COMMISSIONING BOARD	**Defendants**
-and-	
(1) AT MEDICS LTD (2) OPEROSE HEALTH LTD	**Interested Parties**

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Adam Straw QC and **Leon Glenister** (instructed by Leigh Day) for the **Claimant**
Fenella Morris QC and **Jennifer Thelen** (instructed by Hill Dickinson) for the **Defendants**
Susanna Rickard (instructed by Mills & Reeve) for the **Interested Parties**

Hearing dates: 1 and 2 February 2022

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Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

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Covid-19 Protocol: this judgment was handed down by the judge remotely by circulation to the parties' representatives by email and release to Bailii. The date and time of hand-down is 10.30am on 23rd February 2022

Mrs Justice Hill:

Introduction

1. This is a claim for judicial review of a decision by the North Central London CCG (NCL) on 13 January 2021 to authorise a change in the control of the holding company of AT Medics Ltd. AT Medics Ltd has been commissioned by NCL to provide primary care services through GP practices in north central London.

2. The Claimant is a patient at one of the relevant GP practices. She is supported in her claim by Keep Our NHS Public (KONP). KONP is a non-party political organisation campaigning against privatisation and underfunding of the NHS.

3. The claim, based on four grounds, was issued on 17 May 2021. Permission was refused on the papers. The Claimant did not renew the application for permission in relation to the fourth ground. On 12 October 2021, after an oral hearing, permission was granted on the other three grounds by Richard Hermer QC sitting as a Deputy High Court judge.

4. The Claimant's grounds are, in summary, that (1) NCL misdirected itself in various respects as to the approach it should take to the decision and therefore excluded from its consideration important information; (2) NCL failed to obtain any information about the financial stability of the companies to whom it was proposed control be transferred; and (3) NCL failed to adequately consult or otherwise involve patients and other stakeholders in the decision to authorise the change in control.

5. The Defendants resist the claim on the basis that (1) there was no misdirection as alleged and the Claimant has pointed to no material which NCL irrationally excluded from its decision-making; (2) NCL relied on an adequate financial due diligence exercise in reaching its decision; and (3) there was sufficient involvement of the public in the decision-making process, whether viewed against the requirements of policy or the common law. The Defendants also argue that if any of the grounds are found to have merit, relief should not be granted, on the basis of section 31(2A) of the Senior Courts Act 1981 and/or the court's general discretion to decline relief. The Claimant submits that there is no basis to refuse her relief.

6. At the hearing the Claimant was represented by Adam Straw QC and Leon Glenister, the Defendants by Fenella Morris QC and Jennifer Thelen and the Interested Persons by Susanna Rickard. Ms Rickard addressed certain factual matters in writing, but otherwise aligned herself with the legal submissions made by Ms Morris. I was greatly assisted by the written and oral submissions from counsel and by their agreement of a list of issues.

7. Professor Sue Richards, a member of Islington KONP and the KONP national executive committee, provided witness evidence in support of the Claimant's claim. The Claimant also relied on her own witness evidence and that from Anna Dews (her solicitor at Leigh Day).

8. The Defendants and Interested Parties relied on witness statements from Paul Sinden (NCL's Chief Operating Officer), Ian Bretman (Lay Member of NCL's Governing Body), Allan Ruan (Head of Digital at NHS North East London Commissioning Support Unit, which provides hosting and technical support for NCL's website),

Richard Parker (solicitor at Hill Dickinson LLP) and Elizabeth Perry (Interim Chief Executive Officer for Operose Health Ltd (OHL) and Operose Health Group Ltd (OHGL)).

The factual background

The parties

9. The Claimant has been a patient at Hanley Primary Care Centre since 2015. She is a local councillor for the area in which the practice is situated.

10. The Second Defendant, known as NHS England, delegates powers to Clinical Commissioning Groups (CCGs) throughout England.

11. The First Defendant, NCL, is the CCG for north central London.

12. AT Medics Ltd contracts with CCGs to provide primary care services in and around London. It does so through 37 GP practices across 49 sites, serving around 375,000 patients. It has been a provider of primary care services since 2004. It is a for-profit legal entity, as is usually the case for those entities which contract for the provision of GP services.

13. AT Medics Ltd holds eight Alternative Provider Medical Services (APMS) contracts with NCL, providing primary care to around 57,000 patients in north central London through a series of GP practices, one of which is Hanley Primary Care Centre.

14. AT Medics Ltd is wholly owned by AT Medics Holdings LLP. Until 10 February 2021 AT Medics Holdings LLP was wholly owned by six GP directors and their spouses.

15. After that date, as a result of the decision under challenge dated 13 January 2021, AT Medics Holdings LLP became controlled by OHL. OHL is directly owned and controlled by MH Services International (UK) Ltd. This is ultimately controlled by a US based company, Centene Corporation (Centene) via two further holding companies.

16. OHL is one company within OHGL, which is an established provider of NHS community and GP services with over 7 years' experience in the field.

17. Ms Perry's evidence was that OHL has complete autonomy over its strategy and annual business objectives. Its business functions are separate from those of Centene. Centene has provided working capital to OHL and OHGL as is commonly the case with holding companies, but "has, and continues to have, no influence and/or involvement in the day to day operation of AT Medics. Day to day decisions about the management and delivery of primary care under the APMS contracts held by AT Medics Limited are made by the executive team at AT Medics Limited".

18. The Claimant remained concerned about the level of control Centene has over OHL, pointing to the fact that the directors of OHL are Ms Perry, Centene's President and Chief Operating Officer, its Senior Vice President and its Vice President.

AMPS contracts

19. The APMS Directions 2020 (as amended) set out mandatory provider conditions and contractual terms for APMS contracts. The contracts are in a standard form drawn up by NHS England.

20. The contracts are very prescriptive. They establish the essential medical services a general practice must provide to its patients. They set the relevant quality standards for premises and workforce and the requirements for inspection and oversight. They outline the key policies relating to issues such as indemnity, complaints, insurance, clinical governance and termination of the contract. A provider cannot change the terms of the contract or how patients access services under it without the commissioner's written and signed agreement.

21. A key feature of APMS contracts is that they are time limited, meaning that they must be put out to public procurement regularly. Commissioners have a range of "levers" to monitor the services provided under APMS contracts. These include various Key Performance Indicators (KPIs), the CCG's ability to trigger a full performance review of a practice and the CCG's right to decide not to extend contracts once their terms expire.

22. The parties to APMS contracts are not required to include a clause in the contract relating to a change in control in respect of a provider. However, the parties in this case chose to include such a clause, which is in standard form, as follows:

> "**54 Sub-contracting and Change of Control** …
>
> 54.3 Save in respect of a public limited company listed on an internationally recognised exchange the Contractor shall not undergo a Change of Control without the prior authorisation of the Commissioner and subject to such conditions as the Commissioner may impose..."

NCL's Primary Care Commissioning Committee (PCCC)

23. The decision under challenge in this case was made by NCL's PCCC. This is a committee of NCL's Governing Body. It exercises the primary care commissioning functions delegated to NCL by the Second Defendant.

24. PCCC meetings take place bi-monthly or as otherwise agreed by the Committee. The dates of PCCC meetings are set at the start of each year and listed on its website within NCL's website. The agenda and papers for the following meeting are made available a week before each meeting.

25. The PCCC's Terms of Reference (ToR) include the following relevant features:

> <u>Paragraph 4.2</u>: The PCCC comprises the following voting members: (i) a Governing Body clinician; (ii) the Governing Body Registered Nurse; (iii) an independent GP; (iv) three Governing Body Lay Members; (v) the Chief Operating Officer; (vi) the Director of Quality and Chief Nurse; and (vii) a director of finance.
>
> <u>Paragraphs 5.2-5.2</u>: The following shall be invited to PCCC meetings as standing (non-voting) attendees: (i) up to two community Members; (ii)

Primary Care Contracting and Commissioning Team representative(s); (iii) a Public Health representative from a Health and Wellbeing Board; (iv) Healthwatch representative(s); (v) representative(s) from the London-wide Local Medical Committee and (vi) CCG Borough Directorate representative(s).

Paragraph 15.1: PCCC meetings shall be held in public unless the Committee resolves to exclude the public from a meeting. Meetings held in public are referred to as 'Meeting Part 1' and those held in private referred to as 'Meeting Part 2'.

Paragraph 15.2: Attendees, observers and the public can be excluded from all or part of the meeting for a range of reasons. These include that the matter being discussed is commercially sensitive or confidential, for "other special reason stated in the resolution and arising from the nature of that business or of the proceedings", for "any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time" or "to allow the meeting to proceed without interruption, disruption and/or general disturbance".

Paragraph 16.1: The PCCC may "receive questions from the public at its absolute discretion in line with the CCG's protocol for public questions which is available on the CCG's website".

Paragraph 16.2: The PCCC may "receive, at its absolute discretion, Deputations from members of the public or interested parties to make the Committee aware of a particular concern or concerns they have".

Preparations for the proposed change in control

26. By letter dated 15 November 2020, AT Medics Ltd wrote to all 13 London CCGs with whom it contracted requesting authorisation for a change in control. The letter proposed that ownership of AT Medics Holdings LLP would transfer to OHL on or around 7 December 2020. The letter indicated that the current directors of AT Medics Ltd would remain actively involved in the organisation, which would continue to provide the services under the contracts. It was said that there were no intentions to change the personnel involved in providing the services or the service delivery. An organogram appended to the letter made clear that OHL's parent company was MH Services International (UK) Ltd. It did not illustrate the corporate structures "above" that level and so did not mention Centene.

27. A due diligence exercise was coordinated across all 13 CCGs.

28. Hill Dickinson LLP obtained what are described as "full insolvency reports" on OHL, OHGL, MH Services International (UK) Ltd and MH Services International Holdings (UK) Ltd.

29. On 1 December 2020 certain assurances were sought from AT Medics Ltd. These assurances were provided by letter dated 3 December 2020. A further query was raised, and this led to a supplementary response dated 4 December 2020.

30. The 3 December 2020 assurances letter confirmed that (i) the proposal was to the effect that OHL would take the majority interest in AT Medics Holdings LLP and MH Services International (UK) Ltd would hold the second minority interest; (ii) the ultimate beneficial owner of OHL's holding companies is Centene; (iii) neither OHL nor any group companies would be disqualified from holding an APMS contract by virtue of sections 5(1)(b) and 5(2) of the APMS Directions 2020; (iv) there were no CQC enforcement actions within OHL that would impact on AT Medics Ltd and/or its delivery of services under the APMS contract; and (v) the current AT Medics Ltd Board of Directors would join the Operose Health Executive Team and there were no planned staffing or management changes at AT Medics Ltd at operational level. Further assurances were given on data protection and security issues.

31. The supplementary response dated 4 December 2020 confirmed that OHL was not aware of any ongoing or potential disputes, litigation or regulatory findings, orders or decisions relevant to OHL or any group company which may impact on AT Medics Ltd and/or its delivery or services under the APMS contract, nor had it been notified of any of these things.

32. The proposed change in control was due to be discussed at the PCCC meeting on 17 December 2020.

The agenda and papers for Part 1 of the 17 December 2020 PCCC meeting

33. On 10 December 2020, NCL published the agenda for Part 1 of the 17 December 2020 meeting on its website, listing as an item for decision 'AT Medics – Change of Control Request'. This item directed readers to page 94 of the supporting material, published on the same day. Page 94 was the start of a background report on the change of control request prepared by Vanessa Piper (NCL's Assistant Director of Primary Care).

34. As this was the key public document about the proposal it is necessary to consider it in a little detail. The background report comprised a 1.5-page overview and then 2 further pages. Its contents can be summarised as follows:

> Page 1: This page provided a summary of the report. It referenced the due diligence that had been carried out across the affected London CCGs. It included a recommendation that approval be given to the proposed change of control. The report noted that the Certificate of Good Standing had not yet been received from Companies House and asked that if this had still not been received at the time of the meeting, approval be given conditional on its late receipt by Chair's action.
>
> Page 2: Of relevance on this page is that the report noted under 'Identified Risks and Risk Management Actions', "Financial standing of the company related to the change [sic] control]". It was said that this risk had been mitigated by the solicitors carrying out a "financial standing company search". Under 'Engagement' the report said: "There will be no service or staff change. AT Medics Ltd the current provider will continue to operate the 8 APMS contracts in Camden, Islington and Haringey".

Page 3: This provided further detail on the background to the proposal, including reference to the new proposed ownership of AT Medics Holdings LLP. No mention was made of Centene.

Pages 3-4: Under the heading ‘Due Diligence’ the report explained that “Given the potential financial and service provision risk which might arise as a result of e.g. any failure in one of the companies involved or as a result of significant changes to management of staffing of the practices run by AT Medics Ltd, commissioners agreed it was essential to carry out due diligence in respect of the proposals and to seek various assurances”. The assurances given by AT Medics Ltd confirming that it would continue to be responsible for providing primary care services, that there would be no change to the personnel involved and that the directors of AT Medics Ltd would remain actively involved in the organisation were set out.

Page 4: The report stated that “The solicitors also carried out searches on financial stability and Good Standing to provide further assurance to commissioners in respect of Operose Health Ltd; Operose Health Group; MH Services International and MH Services International Holdings. Following the search, no concerns arose as a result of these searches and the responses to the questions asked of AT Medics Ltd which were judged to provide assurance as to the financial and organisational stability of the companies involved”. It concluded with further details of the pan-London process, noting that for those CCGs that were not meeting in December, a request for Chair’s action would be made and “the Part 1 paper and minutes shared in the next meeting in public for transparency”.

The agenda and papers for Part 2 of the 17 December 2020 PCCC meeting

35. A separate agenda for Part 2 of the 17 December 2020 meeting was produced, again including ‘AT Medics – Change of Control Request’ as an item for decision.

36. An expanded background report was prepared for the Part 2 meeting. This included further detail of the legal advice that had led to the assurances process, including the supplementary response dated 4 December 2020. It made clear that the financial reports obtained by the solicitors were available to the PCCC if required. This paper included as appendices a group structure organogram (which I assume to be identical to the organogram appended to the 15 November 2020 letter) and the “assessment letter response” (which I understand should read “assurance letter response” and therefore relate to the 3 December 2020 letter and 4 December 2020 supplementary response).

37. On 14 December 2020 a “pre-meet” for members of the Part 2 PCCC was held, specifically to discuss the proposed change in control, because it was recognised that the issue was relatively complex and potentially controversial.

38. On 16 December 2020, an additional Part 2 report was prepared addressing issues raised by the PCCC members, including at the pre-meet, for consideration at the Part 2 meeting on 17 December 2020. This report noted at the outset that “the remit of the PCCC with contentious decisions is to take into consideration the likelihood of success from the risk of legal challenge from a provider who puts in a claim”. The report noted

that "[i]f there are no adverse findings with the due diligence PCCC members and commissioners would have to set out a strong case to oppose the change control." It indicated that "[t]he CCG's case to oppose is weakened, because at present due diligence checks carried out have not identified any adverse findings". The report reminded the PCCC of other contentious decisions it had taken, summarised the mitigation factors against any risks from the change in control, provided further detail of the corporate structure behind the change in control, gave an overview of why the proposal did not involve a contract novation and made some proposals for the establishment of future procurements, linked to any conditions the PCCC may want to insert into the recommendation.

The format of Part 1 of the 17 December 2020 PCCC meeting

39. Under normal circumstances members of the public were able to observe the Part 1 meetings of the PCCC in person. That said, the PCCC's website stressed that "…although [PCCC] meetings are held in public, they are not 'public meetings'": members of the public were able to listen to the proceedings and where submitted questions relating to the agenda could be answered, PCCC members would respond. Further questions asked during the meeting would be managed at the Chair's discretion in the time available.

40. The PCCC had moved to holding its meetings virtually, using MS Teams, at the start of the Covid 19 pandemic, in the early part of 2020. It was anticipated that the 17 December 2020 meeting would also be held virtually. At that time Covid rates were rising at an alarming rate, and the vaccination programme was only just commencing.

41. However, Mr Bretman's evidence was that during 2020, technical issues relating to the use of MS Teams limited the facility for the public to observe meetings directly. Members of the public were only able to follow the meetings after the event, by listening to an audio recording which was published on the PCCC's website shortly after the meeting. At the start of the meeting, the PCCC would pass a resolution to exclude the public on public health grounds, in accordance with the Public Bodies (Admission to Meetings) Act 1960 (as referred to in the PCCC's ToR: see above). This process had apparently been in place since the start of the pandemic without complaint.

42. I found the evidence on this issue a little hard to follow. The minutes from the 17 December 2020 meeting suggested that the Governing Body meetings were held fully "live" (i.e. with members of the public observing in real time) and so it was not immediately apparent to me why the same process could not be used for PCCC meetings. Further, Mr Bretman's evidence that a technical solution to allow members of the public to observe the meeting in real time was in place for the PCCC meeting on 18 February 2021 did not seem borne out by the transcript and minutes of that meeting. These documents again recorded the exclusion of the general public. They suggested an anticipation that by April 2021 PCCC meetings would be held on MS Teams Live, but I do not know whether that happened.

43. Be that as it may, Mr Ruan's evidence shows that as at 10 December 2020 the PCCC's website described the revised procedure to be used at PCCC meetings. The website indicated that "Questions relating to the meeting must be submitted before the meeting" and provided an email address and timescale for doing so (by 10 am on a Monday, for

a PCCC meeting on a Thursday). It showed where the link to the audio recording could be obtained.

44. This background also explains why the agenda for the 17 December 2020 meeting referred at section 1.9 to ‘Questions from the public relating to items on the agenda received prior to the meeting’ [my emphasis].

Part 2 of the 17 December 2020 meeting

45. Mr Sinden explained that Part 2 of the 17 December 2020 meeting took place before Part 1, and that several members of the PCCC including Mr Bretman had done their own research on publicly available material about OHL and Centene. The minutes reflect that the due diligence review was considered in Part 2 as it involved commercial in confidence information. Reference was again made to the assurances received.

46. The Part 2 meeting requested future reports on contract delivery and performance for contracts held by AT Medics Ltd, and a post-meeting action was set for Ms Piper to alert the PCCC to “any material changes in the performance on contracts held by AT Medics’ post the change in control”.

47. The Part 2 meeting recommended approval of the change of control request to the Part 1 meeting “on the basis of the successful due diligence process, subject to final confirmation on due diligence from Companies House”.

Part 1 of the 17 December 2020 meeting

48. At the outset of the Part 1 meeting, the PCCC passed a resolution to exclude members of the public as described above.

49. The minutes of the Part 1 meeting record that no questions from the public had been received prior to the meeting (section 1.9).

50. The change in control request was discussed. An overview of the due diligence process was given. It was reported that the process “to date had not raised any concerns and the consequent need to place conditions on the change in control”. Reference was made to the fact that no contract breaches had been identified other than one contract with some prescribing concerns which were being addressed. The Part 1 meeting was told of the action that had been set to alert the PCCC to any adverse or positive change in performance as they occurred.

51. The Part 1 meeting approved the change in control request, subject to no concerns being identified in the financial standing searches that were outstanding with Companies House.

21 December 2020-17 February 2021

52. On 21 December 2020 the relevant Companies House certificates were received.

53. On 13 January 2021 NCL sent its signed authorisation for the change in control to AT Medics Ltd. This is the decision under challenge.

54. On 10 February 2021 the change in control was implemented and the ownership of AT Medics Holdings LLP transferred from the six GPs and their spouses to OHL.

55. On 11 February 2021 NCL published the draft minutes of Part 1 of the 17 December 2020 meeting on its website, within the papers for the next PCCC meeting on 18 February 2021. The minutes included written confirmation of the decision as to change in control. They noted that OHL was a UK subsidiary of Centene.

56. On the same day the replacement of the six GPs as directors of AT Medics Holdings Ltd with the OHL personnel was announced on the Companies House website.

57. A period of what is described by the Claimant as “serious public disquiet” followed. The disquiet related primarily to concerns about the new companies and the role of the six GPs, as well as an alleged lack of transparency and poor decision-making by the PCCC. In respect of the new companies, the concerns were that although a due diligence process had been carried out, the PCCC had not investigated specific concerns about the suitability of Centene to hold the controlling interest in AT Medics Ltd. These related to fines and litigation it had faced in the USA arising from its management of ‘Obamacare’ and state Medicaid contracts and reports that it had closed GP surgeries in the UK. There was also a concern that the PCCC had not sufficiently considered the financial standing of the new companies. In respect of the six GPs, they had resigned as statutory directors of AT Medics Ltd, and there was a concern that this was contrary to NCL’s expectation.

58. The lead councillor cabinet members for health in each of the five London boroughs affected (the five health leads) described the decision as “a matter of huge public concern” which had “caused anger and risked trust”. Various other councillors, assembly members, mayors and members of Camden’s Patient Participation Group expressed similar views. 55,000 members of the public signed a petition indicating concerns and 76 MPs tabled an Early Day Motion on the issue.

18 February 2021

59. On 18 February 2021 nine written questions from the five health leads and members of the public were published by NCL, together with NCL’s responses, in a 15-page document. This summarised the process that had been followed to authorise the change in control, confirmed that the AT Medics Ltd directors would remain as executive leads in the company and explained that the PCCC had focused on the impact of the change of the control on the performance of the provider, and the way that would be monitored going forward.

60. The PCCC met on this day, again by MS Teams. A deputation of four of the five health leads attended Part 1 of the meeting. Reference was made to the nine questions document. Sue James spoke on behalf of the five health leads and expressed their concerns about the transfer of ownership and the involvement of Centene, the adequacy of the due diligence process, the resignation of the AT Medics Ltd directors apparently contrary to the assurances given and the lack of public engagement and consultation sought by the PCCC before making its decision.

61. The deputation asked the PCCC to revoke the agreement to the change of control. The PCCC explained the process and reasoning behind the decision. The minutes record

that "CCGS are required to consent to...requests [for change of control] unless there are specific grounds that the change of control would impact on the performance of the contract, especially with regard to patient experience. A due diligence process is followed to provide assurance in this regard". The PCCC reiterated that the due diligence process had not raised any concerns. It was explained that former directors of AT Medics Ltd remained in senior leadership roles, with operational responsibility for delivering the APMS contracts. It was said that "Services delivered to, and access for, patients would not change as a result of the change of control, as there was no change to the contract or commissioned services".

62. The PCCC did not accede to the deputation's request. However, an action was set to add the five health leads to the circulation list for PCCC papers in future.

Events after 18 February 2021

63. On 19 March 2021 the change in control issue was discussed at the North Central London Joint Health Overview and Scrutiny Committee. The NCL representative acknowledged that "…in hindsight…it would have been better to proactively inform elected members" about such issues. A similar acknowledgement was given at the meeting of the London Borough of Camden's Health and Adult Social Care Scrutiny Committee on 7 April 2021. As set out above, the PCCC had already set an action to implement this.

64. On 7 April 2021, a written question about the process that had been put to the Department of Health and Social Care was answered in Parliament, to the effect that:

> "…there was no legal or contractual basis for the CCG to reject the transfer as it will not lead to any significant change in service provision. The contract owner remains AT Medics Ltd and the change on control of the holding company to [OHL] does not affect service provision in any way. No consultation involving local authorities and patient representatives was undertaken as this is only required when there is a significant change in service provision".

65. Since the change in control, there have been no issues in respect of AT Medics Ltd's contracts that have warranted referral to the PCCC to consider any contractual action. Two of their contracts were due to expire in July 2021, alongside two others held by another provider in Enfield. A full strategic and performance review was carried out on the four contracts. Following this the PCCC approved a one-year extension of each. The rationale was to seek continued improvement in performance in certain areas as measured by the Key Performance Indicators (KPIs) specified in the contracts. However, these were assessed across three financial years and so predating the change in control. A process of quarterly reviews of achievement against the KPIs has resumed. In respect of the AT Medics Ltd contracts that are due to expire in 2022 a decision will be taken by the PCCC to consider a further extension or to allow the natural expiry of the contract and procurement of a new one.

The legal framework

66. Under section 83(1) of the National Health Service Act 2006 (the 2006 Act) NHS England has statutory responsibility for commissioning primary medical services in

England. Under section 83(2), it may "make such arrangements for the provision of primary medical services as it considers appropriate; and it may, in particular, make contractual arrangements with any person". This is the source of the power to enter into APMS contracts.

67. Under section 13Z(2)(b) of the 2006 Act, NHS England may arrange for any function to be exercised by a CCG. Pursuant to this power, NHS England has arranged that its functions under section 83 in relation to services north central London shall be exercised by NCL.

68. In exercising their statutory functions, including those under section 83, NHS England and the CCG are subject to a series of "high level" duties under the 2006 Act. The duties on NHS England, which the Claimant argues are delegated to a CCG such as NCL, are set out in section 13 of the 2006 Act. They include a duty to exercise functions effectively, efficiently and economically (section 13D) and a duty to exercise functions with a view to securing continuous improvement in the quality of services provided to individuals (section 13E). The same duties are placed specifically on CCGs by sections 14Q and 14R.

69. Parliament intended CCGs to enjoy a broad discretion when choosing how to commission primary medical services: *R (Hutchinson) v Secretary of State for Health and Social Care* [2018] EWHC 1698 (Admin), 21 CCL Rep 446, per Green J (as he then was), at [94].

70. In *R (A and others) v South Kent Coastal CCG and others* [2020] EWHC 372 (Admin) at [75] Farbey J observed that the number of different duties in the 2006 Act relate to a "wide range of factors, reflecting the complexity of decision-making in an advanced healthcare system such as the NHS". This meant that the decision in issue in *A* (relating to the commissioning of hospital services, but relied on by the Defendants here), was "multi-factorial, involving the allocation of limited resources between competing needs". She continued, "[t]he 2006 Act duties engage socio-economic interests and do not all pull in the same direction. In balancing the competing factors, the 2006 Act clearly involves the exercise of substantial discretion, judgment or assessment (*R (Pharmaceutical Services Negotiating Committee & another) v Secretary of State for Health* [2018] EWCA Civ 1925, [2019] PTSR 885, para 81)."

71. The 2006 Act sets out certain duties of public involvement and consultation which I consider in the context of Ground 3 below.

The Claimant's grounds

72. The Claimant advanced three grounds of judicial review, although there is a certain amount of overlap between the first two grounds. I summarise them in the way in which they were argued by counsel and following the agreed list of issues.

Ground 1: Misdirection

73. The Claimant's case on Ground 1 was that NCL had misdirected itself in three separate respects.

Issue (1): Did NCL unlawfully preclude itself from taking into account relevant circumstances?

The parties' submissions

74. Mr Straw QC argued that NCL had a broad discretion as to whether to authorise the change in control: this was clear from the general principle in *Hutchinson* at [94] and the fact that clause 54.3 of the contract did not limit the discretion in any way. NCL should have exercised this broad discretion with regard to its various statutory duties, including those requiring it to exercise its functions effectively, efficiently and economically (sections 13D and 14Q).

75. He submitted that instead of this broad approach, NCL wrongly limited the information it would take into account to that information obtained in the due diligence process. By limiting itself in this way, NCL fettered its discretion and precluded itself from taking into account relevant circumstances. This was contrary to the principles set out in *R v SSHD, ex p Venables* [1998] AC 407 at 496H and 497B to the effect that a person on whom a discretionary power is conferred "cannot fetter the future exercise of his discretion by committing himself now as to the way in which he will exercise his power in the future" and "[i]f…an inflexible and invariable policy is adopted both the policy and the decisions taken pursuant to it will be unlawful". NCL's approach was an arbitrary one, for no good reason.

76. The relevance of this misdirection was that while the due diligence process had provided information about bankruptcy or insolvency of the new companies, it had not considered (i) the serious concerns relating to Centene's suitability; and (ii) the financial standing of the new companies. These were relevant circumstances which NCL did not take into account.

77. Had NCL applied the right approach, the Claimant contends that it would have rationally considered (i) the risk that the new companies would overcharge NCL, or would fail to perform contractual obligations, in light of the similar allegations to this effect made against Centene subsidiaries in the past; (ii) the risk that OHL would become insolvent, leading AT Medics Ltd to be unable to perform its contractual obligations; (iii) the risk that OHL's precarious financial situation would lead it to be unable to perform all of its contractual obligations; (iv) the risk that it would seek to divest itself of unprofitable contracts as it had done previously. Consideration of these risks might have led to consent not being given to the proposed change in control.

78. Ms Morris QC for the Defendants agreed that NCL was exercising a broad discretion but submitted that this did not mean it had 'carte blanche'. The question before it was a relatively narrow one. It had to act rationally and could only refuse authorisation to the change in control for a rational reason. It was for NCL as the decision-maker, and not the court, to decide what was relevant, subject only to a *Wednesbury* review (*R (Khatun and others) v Newham London Borough Council* [2005] QB 37 at [35]).

79. She submitted that a chronological and fair reading of the key contemporaneous decision-making documents showed that NCL had not in fact misdirected itself in the manner alleged. As well as the due diligence results, NCL had considered the assurances. These were a critical part of the process, as they related to possible changes in staffing and service provision, data protection, disqualification and litigation.

Overall, NCL had rightly focussed on the "true character" of the question before it, namely what consequences might reasonably be foreseen, in the sense of the risks to performance of the contracts, as a result of a change in control. It had not unlawfully excluded consideration of any particular factor.

80. This ground was, at most, a *Tameside* challenge. As to this, *R (Plantagenet Alliance Ltd) v Secretary of State for Justice and others* [2015] 3 All ER 261 at [139] confirms that:

> "[t]he test for a *Tameside* duty is one of rationality, not of process. The *Tameside* test can be formulated as follows: Could a rational decision-maker, in this statutory context, take this decision, without considering particular facts or factors. And if the decision-maker was unaware of the particular fact or factor at the time, could he or she nevertheless take this decision without taking reasonable steps to inform him or herself about it".

81. Ms Morris argued that the Claimant could not meet this test in relation to the Centene information: (i) Centene is "six steps removed" from AT Medics Ltd and, like OHL, has no influence in the daily running of AT Medics Ltd; (ii) the penalties and lawsuits in the US arose in an entirely different healthcare and regulatory system and 74% of the fines were incurred by subsidiaries before they were acquired by Centene; (iii) publicly available material suggests that Centene's financial position is strong, it has been named as one of Fortune World's Most Admired Companies and it continues to operate successfully in the US healthcare market, receiving government contracts; (iv) the contractual scheme would prevent the new companies from overcharging the CCG or failing to perform their contractual obligations; and (v) pursuant to the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013/500, Regulation 3(2), NCL was not permitted to discriminate between for-profit and other providers.

82. To the extent that this was in reality a *Tameside* challenge focussed on the failure to obtain information about the financial standing of the new companies, this is addressed by Ground 2. I consider it in that context, as the advocates did in their submissions.

Analysis and conclusion

83. On balance I consider that Ms Morris's submissions on the meaning of the contemporaneous documents are well-founded.

84. Mr Straw's submissions that NCL had unlawfully limited itself to considering the due diligence material were founded primarily on three passages in the documentation.

85. *First*, he relied on the passage in the minutes of the Part 2 meeting on 17 December 2020 which indicated that "Committee scrutiny was limited to the due diligence process…rather than any broader context about the nature of the change in control and parent organisation (Centene)". This was one bullet point in a list, which appeared to be a summary of the concerns that had been raised at the pre-meet and the further information given to the Part 2 meeting. It also has to be seen in the context of the document itself, which was the minutes of the Part 2 meeting. By definition this was focussing on the due diligence aspect of the exercise because consideration of the

commercial in confidence material that underpinned it was the specific role of the Part 2 meeting.

86. *Second*, Mr Straw relied on extracts from the 18 February 2021 minutes to the effect that "CCG's are required to consent to such requests unless there are specific grounds that the change of control would impact on the performance of the contract. A due diligence process is followed to provide assurance in this regard…. Due diligence checks are carried out by and with the advice of an independent solicitor. No concerns were raised…during the due diligence process…NCL…. therefore…gave consent" [his emphasis]. These passages are taken from a summary of an ex post facto explanation of the decision-making process given by Mr Bretman. I agree with Ms Morris that care therefore needs to be taken in placing too much weight upon them. However, they do not in my view indicate that NCL was only considering the due diligence material. At various points in the documents "due diligence" appears to be a shorthand for the entire process, including the obtaining of the assurances, and that seems to be the case here: the references Mr Bretman made in this document to the "due diligence" about patient data, staffing and management changes can only be a reference to the assurances.

87. *Third*, he drew support from paragraph 28 of Mr Bretman's witness statement to the effect that "it was my understanding that the PCCC was not being asked to exercise judgement on Centene but to focus on the providers of the APMS contracts in the UK". He argued that this was consistent with the minutes of the Part 2 meeting on 17 December 2020 referred to above. In my view he is correct that Mr Bretman's statement indicates that the PCCC was not conducting a full review of the wider context, including all the details about Centene, but Ms Morris does not aver that they did, or needed, to do so. I do not consider that this passage in Mr Bretman's statement supports the proposition that the PCCC was only focussed on the due diligence material.

88. In *R (A and others)* at [78]-[79] Farbey J reiterated that the supervisory nature of the court's jurisdiction in judicial review, rather than its consideration of the merits of executive action, should not be undermined by "invitations to the court to cherry-pick evidence or to interpret the Defendants' decision-making…documents like a statute". In my view Mr Straw's reliance on these passages to generate the misdirection alleged amounts to such an invitation to "cherry-pick".

89. Rather, I agree with Ms Morris that when the totality of the decision-making documents are considered, they do not show that NCL misdirected itself as alleged. It did not focus solely on the due diligence process but also considered the assurances given, which were an important element of the process. As well as the assurances, the PCCC also had regard to whether any contract breaches had been identified and the measures it could take to receive notice of any adverse changes in future performance as they occurred. Accordingly, I do not accept that NCL misdirected itself by fettering its discretion in the way alleged.

90. Mr Straw did not put his case on this issue on a *Tameside* basis. However, to the extent that this was, in reality, a *Tameside* challenge focussed on the failure to obtain further information about Centene. Applying *R (Plantagenet Alliance Ltd)* at [139], it is not sufficient to say that NCL could rationally have taken more information about Centene into account: it is necessary for the Claimant to show that it was irrational for NCL not to have done so.

91. I recognise the strength of feelings about Centene from the Claimant's evidence and submissions. However, I do not consider that she can meet the threshold of showing that NCL acted irrationally by not obtaining more information about it. NCL was entitled to determine that its overall approach should be focussed on the impact on service provision of the change in control and it did so. In that context, it had received assurances about the limited impact of the new corporate structure on service provision, especially given the prescriptive nature of the contracts (including provisions as to charging, thus mitigating the risk of overarching). It was aware of the ongoing operational role of the six GPs (irrespective of their resignation of statutory directorships). It was also conscious of the levers that can be used to address performance issues (albeit never eliminating them entirely). In those circumstances, and bearing in mind the totality of the information the PCCC had obtained, including the due diligence process, the assurances and the Companies House material, I do not consider that NCL acted irrationally in a *Tameside* sense with respect to further Centene information.

Issue (2): Did NCL misdirect itself as to the legal test?

92. Mr Straw submitted that NCL further erred by considering that it was required to consent unless the due diligence showed the change in control would impact on contract performance. NCL's broad discretion should not have been approached on the basis that there was a presumption against exercising it, contrary to the principle summarised in *R v Chief Immigration Office ex parte Quaquah* [2000] HRLR 325 at 334.

93. Ms Morris argued that NCL did not approach the decision with an improper presumption. It was not saying "all things being equal, the decision should be refused" - rather, it was highlighting the need for a good reason to refuse before that course could be taken. It was properly focussed on the narrow question before it, and the PCCC rightly recognised that if it were to refuse the request, it would have to be for a reason which was linked to the impact of the change of control request, rather than any generalised perception about the nature of the parent company.

94. Again, I consider that Ms Morris' submissions about the proper reading of the contemporaneous documents are sound.

95. Mr Straw's submission in support of the alleged presumption was drawn from the same part of Mr Bretman's ex post facto explanation of the decision-making at the 18 February 2021 meeting, to the effect that "CCG's are required to consent to such requests unless there are specific grounds that the change of control would impact on the performance of the contract".

96. Looked at in the context of all of the contemporaneous documents, I do not consider that this phrase indicates that NCL operated a presumption against giving the authorisation, as was the situation in *Quaquah*. In particular, the minutes of the Part 1 and Part 2 meetings on 17 December 2020 do not reflect such a presumption being operated.

97. Rather, I consider that the summary of Mr Bretman's explanation indicates that as part of its approach, the PCCC was rightly recognising that it could only refuse consent for a good reason specifically linked with the change of control request.

Issue (3): Did NCL unlawfully take an unbalanced approach?

98. Mr Straw argued that NCL took a one-sided approach, by giving substantial weight to the risk of a legal challenge from the provider seeking the change in control, but by giving no weight to the risk of a legal challenge from someone opposed to the change. This partial exercise of power was unlawful as it was contrary to the principles set out in *R (Hussain) v SSHD* [2012] EWHC 1952 (Admin) at [46] to the effect that "all persons in a similar position should be treated similarly" and "[a]ny discretionary public law power 'must not be exercised arbitrarily or with partiality as between individuals or classes affected by it'".

99. Ms Morris argued that there was nothing wrong in NCL recognising the risk of a legal challenge from a provider as this may have had a negative impact on services to patients.

100. Mr Straw is right to highlight that the contemporaneous documents refer more than once to the risk of a challenge from the provider and does not refer to the risk of a challenge from someone opposed to the change in control. He does not dispute that the PCCC was entitled to take into account the risk of legal challenge from a provider. His sole argument is that the PCCC erred by failing to take into account the risk of a legal challenge from someone opposed to the change.

101. I consider that, stepping back, and looking at all of the contemporaneous decision-making documents, Ms Morris is right to assert that the PCCC did not place undue emphasis on this factor or allow it to distort the overall process. The overall tenor of the documents is that in having regard to this factor, the PCCC was simply trying to make its decision on a correct and lawful basis, with regard to its ongoing relationship with the provider.

102. It could perhaps be said that consideration of the risk of legal challenge from one party implicitly involves consideration of the risk of challenge from the opposing party: as Mr Bretman said "[a] decision to refuse is subject to all the same legal requirements as a decision to approve – in both cases relevant considerations must be taken into account, and irrelevant considerations must not".

103. Accordingly, in my view the PCCC did not unlawfully exclude from its consideration the risk of a challenge from a party opposed to the change in control.

104. For these reasons I consider that the answer to Issues (1), (2) and (3) is 'No'. Accordingly, I do not consider that NCL misdirected itself in any of the ways alleged in Ground 1.

Ground 2: Failure to inquire into/take into account information about the financial stability of the new companies generally

105. The parties agree that this ground distils into a single issue as below.

Issue (4): Did NCL unlawfully fail to inquire into the financial stability of the new companies?

106. Mr Straw argued that the PCCC had decided that it was essential to conduct inquiries into the potential bankruptcy and financial standing of the new companies because of "the potential financial and service provision risk which might arise as a result of e.g. any failure in one of the companies involved", but did not do so. He submitted that the due diligence exercise only looked at bankruptcy issues and the PCCC failed to obtain information about the financial standing of the new companies. This was unreasonable and a breach of the *Tameside* duty because such information was plainly relevant to the duties under the 2006 Act. No reasonable PCCC could have acted in this way, so the *Plantagenet Alliance* test is met.

107. In *R v Camden London Borough Council, ex p H* [1996] ELR 360 at 377G, the Court of Appeal held that having decided what factual issue or issues they had to resolve, and what inquiries they could reasonably make in order to resolve them, school governors and the local education authority had to make sure that the inquiries proposed were reasonably thorough. Mr Straw submits that NCL erred in a similar way here.

108. Ms Morris argued that the inquiries carried out by the PCCC were plainly capable of identifying any material concerns as to the financial viability of the acquiring company, OHL and its parent companies. Bankruptcy and insolvency were the key issues, and these were the focus of the due diligence exercise.

109. It is clear that the PCCC determined that it needed information about the "financial standing" of the new companies. This is referred to in the background report for the Part 1 meeting and in various other parts of the documentation, although I have also seen a reference to information on "financial stability" being sought.

110. At various points in the Claimant's submissions the phrase used was "financial suitability" or "financial situation". To the extent that these phrases are wider than "financial standing" or "financial stability", the contemporaneous documents do not suggest that this is what the PCCC determined it needed.

111. All of the contemporaneous documents suggest that the PCCC did obtain what it had anticipated it was going to obtain. There is nothing to suggest that it considered that key information was missing.

112. Overall I accept Ms Morris's submissions that it was not irrational for NCL to rely on the due diligence reports (which focussed on bankruptcy and insolvency), the assurances process and the Companies House material to provide the material it considered it needed on financial standing, and to have drawn sufficient reassurance from it. In my view, it was not irrational in a *Tameside* sense for NCL to have gone no further, given the nature of the decision before it and the results of the inquiries it had undertaken in the process.

113. Accordingly, I do not consider that NCL erred in the way alleged in Ground 2.

Ground 3: Failure to consult or involve

114. This ground generates several sub-issues which I address in turn.

Issue (5): Did NCL unlawfully depart from paragraph 8.1 of NHSE Guidance 'Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England'?

The statutory duty under section 14Z2

115. Section 13Q (2) of the 2006 Act sets out a statutory duty of public involvement and consultation by NHS England. Section 14Z2 of the 2006 Act imposes similar obligations on CCGs. It provides as follows:

> "(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").
>
> (2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways) –
>
> (a) in the planning of the commissioning arrangements by the group,
>
> (b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and
>
> (c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.
>
> (3) The clinical commissioning group must include in its constitution –
>
> (a) a description of the arrangements made by it under subsection (2), and
>
> (b) a statement of the principles which it will follow in implementing those arrangements.
>
> (4) The Board may publish guidance for clinical commissioning groups on the discharge of their functions under this section.
>
> (5) A clinical commissioning group must have regard to any guidance published by the Board under subsection (4).
>
> (6) The reference in subsection (2)(b) to the delivery of services is a reference to their delivery at the point when they are received by users".

116. Ms Morris emphasised that the duty on a CCG under section 14Z2 is to "make arrangements" to "secure" the "involvement" of those to whom services are being or may be provided are involved. The wording of the section makes clear that the involvement can be by a range of methods, including consultation and the provision of

information (see *R (Glatter) v NHS Herts Valley CCG* [2021] EWHC 12 (Admin) at [70]).

117. Linden J considered the similarly worded duty under section 242 of the 2006 Act in *R (Dawson)* v *United Lincolnshire Hospitals* [2021] EWHC 928 (Admin); [2021] PTSR 1474. He held that (i) the section 242 duty may be discharged by "standing machinery for service user involvement in the form of established procedures, channels of communication, user groups and committees etc", or by "arrangements for service user involvement in relation to a particular planning process, proposal and/or decision" [99]; (ii) the arrangements may secure involvement "directly by service users…or through representatives" [99]; (iii) the relevant body must secure the opportunity for service users to have involvement (whether or not they choose to avail themselves of that opportunity) [107]; and "[s]elf-evidently the opportunity must be meaningful" [107]. The parties appeared agreed that these broad principles can be read across to the section 14Z2 duty.

The parties' submissions

118. Ms Straw expressly invited the court not to determine that the statutory duty arose on the facts of this case. Ms Morris described this as a 'curiosity' of the Claimant's case, given her concerns about the impact of the change in control on service provision. In my view Mr Straw's position was an implicit, and sensible, acceptance that on the evidence available to the PCCC at the time of the decision-making process, there was no evidence that the proposed change in control would have an impact on the manner in which the services were to be delivered, so as to trigger the duty under sections 14Z2(2)(b) or (c).

119. Instead, Mr Straw founded his argument on Ground 3 on the applicable statutory guidance, '*Patient and public participation in commissioning health and care: Statutory guidance for clinical commissioning groups and NHS England*'. Paragraph 8.1 of this guidance indicates that in circumstances where the statutory duty does not apply, CCGs "should still consider and make a judgment about whether some form of public involvement, or staff/stakeholder engagement, would be beneficial. This is particularly important where there is likely to be significant public interest, where a promise to consult has been made, or a precedent to do so has been sent...". He relied on the "significant public interest" part of this paragraph.

120. Mr Straw argued that the contemporaneous documents made clear that once NCL had decided that there was no change in service provision, such that consultation, involvement or engagement was not required as a matter of statutory duty, it did not give the matter further thought. It failed to consider whether, given the public interest in the change in control issue, some form of involvement or engagement should occur. This was a departure from the statutory guidance, without good reason, and so was unlawful: *R (Lumba) v SSHD* [2012] 1 AC 245 at [26]. He referred to Appendix B of the guidance which was a template for CCGs to use to determine whether there was a need for patient and public participation in a particular commissioning activity and if so how to plan for it. There was no evidence NCL had completed this document in the process of considering the change in control issue.

121. Ms Morris argued that although the statutory duty was not engaged, the processes NCL have in place for PCCC decision-making meet its requirements: (i) there is patient and

public representation at the PCCC; (ii) the agenda for PCCC meetings is published a week in advance; (iii) alongside the agenda the public are told that they may ask questions or make deputations about the intended decisions; and (iv) there is provision for public involvement in meetings. As to (i), Ms Morris pointed to the fact that the PCCC includes the Lay Members and representatives from Healthwatch (a statutory body established to gather and promote the views of health and social care service users), the community, the local Health and Wellbeing Board, the London-wide Local Medical Committee, independent and local GPs and other clinicians. She submitted that given the arrangements that were in place, there was no need for NCL to consider whether further means of involvement were needed for this particular decision or any other.

122. In any event, she argued that the PCCC had considered whether further involvement was needed, as was clear from the passage in the background report for the 17 December 2020 Part 1 meeting under 'Engagement', where the report said: "There will be no service or staff change. AT Medics Ltd the current provider will continue to operate the 8 APMS contracts in Camden, Islington and Haringey". This phrase was repeated in the expanded background paper for the Part 2 meeting.

Analysis and conclusion

123. In my view Mr Straw is right to read the contemporaneous documents as he does.

124. I share his view that the entry under 'Engagement' in the background report for the Part 1 meeting (and later repeated) most likely reflects consideration of whether the statutory duty applied: this much seems apparent from the reference to there being "no service or staff change". In other words, this report was saying that as there was to be no impact on services, the statutory duty did not apply.

125. It seems to me a stretched interpretation to read this reference as a determination that the statutory duty did not apply and then consideration of, and a judgment about, whether some further form of involvement or engagement would be beneficial, as per the guidance. Had this been what NCL was doing in this report one would expect the report to refer to the guidance or at least its wording and, perhaps, completion of an Appendix B template. My conclusion on this issue is reinforced by the terms of the 7 April 2021 Parliamentary answer, namely "No consultation involving local authorities and patient representatives was undertaken as this is only required when there is a significant change in service provision". Again, this reads as a reference back to the statutory duty only and does not imply consideration of the guidance.

126. I therefore accept Mr Straw's submission that there is no clear evidence that NCL specifically applied the guidance to consider whether, notwithstanding the statutory duty not applying, some involvement or engagement would be beneficial.

127. However, as will become apparent from my analysis of Issues (6) and (7), I consider that NCL complied with any duty to secure involvement or engagement that arose and so such departure from the guidance as there was has had no material impact.

Issue (6): Whether, and if so to what extent, a duty to consult or otherwise involve the public arose (by policy and/or common law)?

The parties' submissions

128. Although this issue has been formulated by the parties with reference to 'policy' what is being referred to is the statutory guidance considered above.

129. Mr Straw argued that if NCL had considered the guidance, given the agreed substantial public interest in the decision, the only conclusion it could have reached was one to the effect that some involvement or engagement was required.

130. Further or alternatively, he argued that NCL was subject to a duty to consult or involve because these steps were required by common law fairness and transparency. He drew support for this proposition from *R (Moseley & Stirling) v Haringey LBC* [2014] 1 WLR 347 at [23], [24] and [44], *R (Howard League) v Lord Chancellor* [2017] 4 WLR 92 at [39, *R (Article 39) v Secretary of State for Education* [2021] PTSR 696 at [84]-[86], *R (Dewson) v United Lincolnshire Hospitals* [2021] PTSR 1474 at [112]-[113] and *R (Good Law Project) v Secretary of State for Health* [2021] EWHC 345 (Admin) at [140]. He also cited NCL's *Patient and Public Engagement Strategy 2020-22* at [1] and the NHS Constitution, principles 4 and 7, both of which emphasise the role of patients in decision-making and the need for accountability and transparency.

131. By either of these routes, Mr Straw submitted that at the very least, NCL was required to consult the five health leads as the key elected representatives of the 57,000 patients. He relied on the later acknowledgments by NCL that this process would be adopted in future.

132. As to whether a duty to consult or involve arose outside of the statutory duty, Ms Morris submitted that a duty to engage in a full consultation would be disproportionate having regard to the impact of the decision on services and the duty of the CCG to perform its functions efficiently and effectively. The fact that the CCG was in the midst of a pandemic was also relevant to what fairness required. Any duty inferred by this route could only be a duty to involve the public in decision-making and to secure wider public involvement, to the extent that NCL did.

Analysis and conclusion

133. I consider that if the guidance, or the general common law requirements of fairness and transparency, required there to be a level of involvement or engagement in the change of control decision, the extent of that duty cannot sensibly be formulated any more widely than the statutory duty that would have applied if service delivery was in issue. This much can be inferred from the nature of the statutory duty Parliament has chosen to impose in circumstances when service delivery is in issue. *A fortiori*, it seems to me, a wider duty cannot be imposed when service delivery is not in issue.

134. On that basis, any duty here would be, at most, one to make arrangements to secure the meaningful involvement of service users, which could be met through established processes and through representatives rather than through the public directly (*Dawson* at [99] and [107]).

135. As to the extent of any such duty, in *Dawson* at [110] Linden J agreed with NHS guidance from 2008 to the effect that "Involvement can be viewed as a continuum with

different levels. The level of involvement should be matched to the circumstances and context in which it is to be used". He continued:

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

136. As to where on the continuum any duty lay here, I agree with Ms Morris that a duty of full consultation would be disproportionate in this context, and bearing in mind the nature of the decision in issue, for the reasons she gave.

137. I am prepared to accept for the sake of argument that the public interest in this decision did require NCL to ensure that there was an appropriate level of involvement or engagement that fell short of a full consultation. In fact, I did not understand NCL to disagree with this proposition.

Issue (7): Did NCL fail to comply with any such duty?

The parties' submissions

138. If there was a duty to consult or involve, Mr Straw argued that NCL failed to discharge it adequately because, in summary, (i) the information available ahead of the 17 December 2020 meeting was very limited; (ii)the presence of certain independent attendees at Part 1 of the meeting was not an adequate substitute for consultation or engagement; and (iii)there was an inadequate opportunity for involvement in the meeting as it was held in private.

139. Ms Morris contended that NCL had complied with any such duty given the established processes set out at paragraph 119 above. These general processes went further than page 12 of the guidance suggested in respect of involving the public in governance. She accepted that it was less than ideal than the usual process for the meeting on 17 December 2020 could not be followed for technical reasons. However she argued that the lack of real time attendance by members of the public was mitigated by the facts that members of the public were able to ask questions before the meeting by published methods, and the audio recording of the meeting was published the following day. She suggested that questions could be asked by email during the meeting (although this option was not mentioned on NCL's website on 10 December 2020 or in the agenda for the 17 December 2020 meeting, and I am doubtful as to how effective a route that would be given that members of the public could not follow the meeting as it was taking place).

Analysis and conclusion

140. Overall, I do not consider that NCL failed to comply with any such duty of involvement or engagement for the following reasons.

141. *First*, NCL had made arrangements to secure the involvement of patients and the public in the PCCC's decision-making apparatus.

142. There were arrangements for three Lay Members to vote on the PCCC. NCL therefore fully complied with page 12 of the guidance which required that two Lay Members should be appointed but recommended a third.

143. There were also arrangements for representatives from Healthwatch, Public Health officials from the local Health and Wellbeing Board and community representatives to attend PCCC meetings. The statutory functions of Healthwatch organisations specifically include providing the NHS with the views of service users on their needs for and experiences of health services, on the standard of provision of health services and on whether or how the standard could or should be improved (see section 45A(5) of the Health and Social Care Act 2008). Moreover, the websites for the Enfield and Camden Healthwatch organisations (both of which were represented at the 17 December 2020 meeting) emphasised their role in ensuring a patient voice. The section 45A(5) functions can surely extend to the sort of decision in issue here, given the stated concern that the change in control might impact on the delivery of health services. I therefore disagree with the Claimant's submissions that it was not Healthwatch's remit to become involved in this sort of issue.

144. The Part 1 papers are not confidential. Committee members and attendees can share and discuss them with external stakeholders as part of their preparation for the meeting. This enables them to convey the views of those stakeholders if they feel they should do so. Mr Bretman explained that in the past this process has been effective in enabling attendees to raise matters of wider concern and for members of the public to take the opportunity to submit questions. This means that the Healthwatch and Public Health officials attending the meeting could have obtained views on upcoming business from their peers in other boroughs or from within their own organisations (therefore including the five health leads) and conveyed them at the meeting.

145. There had also been a specific Part 2 pre-meet to enable the change in control issue to be discussed further ahead of the PCCC meeting.

146. *Second*, NCL had made arrangements for the involvement of the wider public in the decision-making process.

147. I do not accept that NCL had given insufficient notice to the public of the proposed decision. Any member of the public with a particular interest in GP services in north central London would know, from established and publicised processes, when the PCCC meetings were going to take place and when the documentation would be published in advance. The agenda and supporting paperwork for the 17 December 2020 meeting were published a week in advance, in accordance with those processes.

148. They agenda and paperwork was not inaccessible as alleged. The agenda was a three-page document which included only seven 'Items for Decision' at section 3. Under the side-heading 'Haringey, Camden & Islington', the agenda listed the following: 'AT Medics – Change of Control Request'. The agenda then referenced page 94 of the supporting material as relevant to this topic. Any member of the public with a particular interest in GP services in Haringey, Camden and Islington could therefore see what the issue was and easily identify the supporting report. Moreover, those who have

complained of a lack of notice of the proposed decision did so having obtained information about it through precisely the same means (i.e. publication of the minutes of the meeting on NCL's website).

149. The four-page background paper which began at page 94 of the supporting material gave almost all of the details of the proposal that were included in the first Part 2 paper.

150. *Third*, NCL clearly could have chosen to give specific notice of the proposed change in control to the five health leads. However, those five health leads could still have had a meaningful involvement through liaison with those embedded in the PCCC's decision-making process or in the same way that a member of the public would have done. They could also have sought to attend the meeting as a deputation, as they did at the 18 February 2021 meeting.

151. The fact that NCL has acknowledged that in future it will give the five health leads early notice of issues to be discussed at the PCCC is, in my view, caught by the principle summarised in *Keep the Horton General v Oxfordshire Clinical Commissioning Group and others* [2019] EWCA Civ 646 at [18]. This states: "…to be lawful, a consultation must be fair, but fairness does not require perfection. A challenge will not necessarily succeed simply by pointing out ways in which the consultation could have been better, unless the failure to proceed in this way has led to real unfairness". In other words, I consider that while early notice to the five health leads may well have made the involvement or engagement process here better, the fact that it did not occur has not led to real unfairness.

152. *Fourth*, bearing in mind the totality of the arrangements made, as set out above, I do not consider that the inability of members of the public to observe the 17 December 2020 PCCC meeting "live" led to such real unfairness that NCL breached any duty to involve or engage. As set out above, arrangements had been made for the public to be involved in the PCCC's decision-making apparatus. Members of the public had had adequate notice of the issue to be discussed and the background information about it. There was an established and published process by which members of the public could ask written questions in advance of, and potentially during, the meeting. They were also able to follow the decision-making shortly after the event, by accessing the audio recording. Again, I consider that *Keep the Horton General v Oxfordshire Clinical Commissioning Group and others* [2019] EWCA Civ 646 at [18] applies.

153. *Fifth*, the fact that the various arrangements summarised above did not in fact lead to members of the public or the five health leads being more involved in the decision-making process is not determinative: what is important is that they had a meaningful opportunity to do so (*Dawson* at [107]) which in my view they did.

154. For these reasons I consider that NCL has not acted unlawfully as alleged in Ground 3.

Relief

155. For the reasons set out above I dismiss this claim on its merits. To that extent the issue of relief is academic. However, I set out here my findings on relief as it was the subject of full argument by the parties.

Issue (8): Is it highly likely that the outcome would not have been substantially different had the conduct complained of not occurred?

156. Section 31(2A) of the Senior Courts Act 1981 provides that the High Court must refuse to grant relief on an application for judicial review and may not make an award of damages on such an application, if it appears "highly likely that the outcome for the applicant would not have been substantially different if the conduct complained of had not occurred".

157. Ms Morris argued that (i) the question presented to the PCCC was a narrow and not multi-faceted one; (ii) when, on 18 February 2021, the PCCC was asked to revoke the authorisation by the five health leads, it declined to do so; (iii) Mr Bretman's evidence is that he had reviewed the further financial information provided and concluded that the decision would not have been substantially different; (iv) even if the financial information provided had been taken into account by the PCCC, it could not in reality have given rise to the type of risks alleged by the Claimant, given the narrow question before the PCCC; and (v) no substantial concerns have arisen over the last year since the change in control and any concerns have been addressed through the contractual process.

158. Mr Straw denied that there was any basis for granting relief. He submitted that the test in section 31(2A) was not met: the "highly likely" threshold is a high one and courts should be cautious about straying into the "forbidden territory" of assessing the merits. The failings here should be considered cumulatively (*R (KE) v Bristol CC* [2018] EWHC 2103 (Admin). Taken together, the failings were serious, and it could not be said that if they had not occurred, it is still highly likely that the authorisation would have been given. The assessment of what was "highly likely" should be based on the material available at the time of the initial decision and not post-decision speculation by an individual decision-maker (*R (Logan) v Havering London Borough Council* [2016] PTSR 603 at [55]).

159. On balance I consider that even allowing for the caveats rightly identified by Mr Straw, Ms Morris's arguments on this issue have force.

160. Since the decision was taken by NCL, further information was provided about Centene and the other new companies. A deputation on behalf of all five health leads was made to the next PCCC meeting which raised the key issues at the heart of this claim. The decision was not reversed. Since then, Mr Bretman has reviewed further financial material and explained why in his view the change in control would still be authorised.

161. This evidence leads me to conclude that even if NCL directed itself to approach the authorisation issue more broadly than it did and looked at further material about Centene and further financial material (thus not conducting itself in the ways that were criticised in Grounds 1 and 2) and had facilitated more engagement with the health leads in particular (thus not conducting itself in the way that was criticised in Ground 3), it is highly likely that the change in control would still have been authorised, such that the outcome for the Claimant would not have been substantially different.

Issue (9): If so, should the requirements in section 31(2A) be disregarded because of the exceptional public interest?

162. Mr Straw argued that even if the terms of section 31(2A) of the Senior Courts Act 1981 are satisfied, the requirements should be disregarded because of the wider public importance of the claim under section 13(2B): all 13 CCGs made the same decision as NCL, so some 375,000 patients are affected, the issues it raises are legally novel and other similar cases are likely to follow in the future as this type of change within the NHS becomes more common.

163. Ms Morris argued that there is no basis to disregard the requirements of section 31(2A): a high standard of care continues to be provided under the contracts, no service provision issues have arisen and the public interest therefore lies in not ordering relief that could potentially disrupt these arrangements which are currently working well. The Claimant's suggestion as to terminating and re-tendering the contracts would put service provision at risk (for the reasons explored further under Issue (10) below), which is said to be the very result she wishes to avoid.

164. Again, I prefer Ms Morris's submissions on this issue.

165. Accordingly, even if I had upheld the claim on its merits I would have considered myself required to deny the Claimant relief by application of section 31(2A).

Issue (10): Whether, in all of the circumstances, some or all of the relief sought should be refused?

166. Mr Bretman's evidence was that revoking the authorisation and undertaking a fresh procurement exercise to retender the contracts would potentially undermine the practices. He said that the impacts would be "at best worrying for patients and possibly disruptive to their care". He indicated that the CCG only takes these steps when there are serious concerns about quality and safety which is not the case here.

167. Mr Sinden explained that "the ability to mobilise the 8 contracts…concurrently would be unprecedented and set in the context of, and constrained by, appointments offered in general practice being above Pre-Covid-19 pandemic levels and the pressure that practices in North Central London are operating under currently".

168. Ms Perry's evidence was that reversing integration of AT Medics Ltd and OHL would be:

> "uneconomical, at odds with our strategy and a complex, time-consuming exercise. The reassignment of employees and the reestablishment of 2 separate business would run the risk not only of destabilising the management of primary care services provision at the Hanley Road surgery (or any of the other 35 surgeries and additional branch sites served by AT Medics Limited with a combined patient list size of 470,000), but also at the additional 21 Operose Health Group APMS and GMS surgeries across the rest of the country. Seeking to "undo" the change of control could therefore cause the very situation that the Claimant states she is concerned about in her evidence and seeks to avoid through her challenge – a risk to patient care and a deterioration in service and quality provided to patients".

169. For these reasons, Ms Morris argued that termination of the contracts as a result of relief being granted would inevitably be hugely disruptive to third parties (namely patients and AT Medics Ltd), and put service provision at risk, the very result the Claimant wishes to avoid.

170. Mr Straw submitted that a quashing order or declaration would not necessarily cause prejudice: NCL would not be required to terminate the contracts, but such an order would be a relevant factor in whether or not NCL exercised its discretion to terminate the contracts with notice and re-tender during the notice period.

171. In my view, the evidence as to the adverse impact on third parties, principally patients, by the grant of an order quashing the change in control was compelling. Ms Morris's submissions are well-founded and would have been a further reason for refusing this form of relief. However, I would not have declined to grant a declaration under this ground alone as that would not seem to have the same direct impact on third parties.

Conclusion

172. For the reasons set out above I dismiss the claim on its merits. However, if I had upheld the claim on its merits, I would have denied the Claimant any relief by application of section 31(2A) of the Senior Courts Act 1981. The court's general discretion with respect to relief would have been a further basis for declining the quashing order sought.