IN THE SUPREME COURT OF JUDICATURE QBCOF 1999/0110/4
IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE QUEEN'S BENCH DIVISION (Crown Office List)
(MR JUSTICE HIDDEN)

Royal Courts of Justice
Strand
London WC2

Friday 16 July 1999

B e f o r e:

THE MASTER OF THE ROLLS
(LORD WOOLF)
LORD JUSTICE MUMMERY
LORD JUSTICE SEDLEY

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IN THE MATTER OF AN APPLICATION FOR JUDICIAL REVIEW

R E G I N A

\- v -

NORTH AND EAST DEVON HEALTH AUTHORITY **Respondent**
EX PARTE PAMELA COUGHLAN **Applicant**

and

SECRETARY OF STATE FOR HEALTH **Intervenor**

and

ROYAL COLLEGE OF NURSING **Intervenor**

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(Transcript of the Handed Down Judgment of
Smith Bernal Reporting Limited, 180 Fleet Street,
London EC4A 2HD
Tel: 0171 421 4040
Official Shorthand Writers to the Court)

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MR R GORDON QC with MR T WARD and MISS J RICHARDS (Instructed by Messrs T V Edwards, London, E1 4TP) appeared on behalf of the Appellant.
MR N PLEMING QC and MR S KOVATS (Instructed by the Treasury Solicitor, London, SW1H 9JS) appeared on behalf of the Secretary of State.
MR T GOUDIE and MISS S WARD (Instructed by Messrs Bevan Ashford, Bristol, BS1 4TT) appeared on behalf of the Respondent
MR P HAVERS and MR K STERN (Instructed by the Royal College of Nursing Legal Dept, London, W1M OAB) appeared on behalf of the Royal College of Nursing.

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J U D G M E N T
(As approved by the Court)

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Friday 16 July 1999

JUDGMENT

LORD WOOLF, MR: This is a judgment of the Court to which all the members of the Court have contributed.

INTRODUCTION

1. The critical issue in this appeal is whether nursing care for a chronically ill patient may lawfully be provided by a local authority as a social service (in which case the patient pays according to means) or whether it is required by law to be provided free of charge as part of the National Health Service ("NHS"). If local authority provision is lawful, a number of further important questions arise: as to the propriety of the process by which eligibility for long term health care on the NHS, instead of as a social service, is determined; as to the effect of an assurance given by the Exeter Health Authority, the predecessor of the appellant, the North and East Devon Health Authority ("Health Authority") to the respondent to this appeal (the applicant for judicial review), Miss Coughlan, that she should have a home for life at Mardon House, a NHS facility; and as to the process by which Miss Coughlan has been assigned to local authority care.

2. Normally where a person is assigned to local authority care she will, subject to a means test, be liable to meet the cost of that care. For reasons to which we will come, Miss Coughlan will not in any event be called upon to pay for her care; but, in hearing her claim, which he decided in her favour, Hidden J. did not consider

that this made the issues and, in particular, the critical issue academic. Now that all issues have been decided in her favour both the Health Authority and (on this appeal) the Secretary of State for Health plainly have a proper interest in challenging the judgment.

3. Miss Coughlan was grievously injured in a road traffic accident in 1971. She is tetraplegic; doubly incontinent, requiring regular catheterisation; partially paralysed in the respiratory tract, with consequent difficulty in breathing; and subject not only to the attendant problems of immobility but to recurrent headaches caused by an associated neurological condition. In 1993 she and seven comparably disabled patients were moved with their agreement from Newcourt Hospital, which it was desired to close, to a purpose-built facility, Mardon House. It is a decision of the Health Authority made on 7 October 1998 to close Mardon House which is the immediate cause of the present litigation.

The Judgment

4. In a reserved judgment delivered on 10 December 1998 Hidden J. reached the following conclusions.

> (a) Miss Coughlan and the other patients had been given a clear promise that Mardon House would be their home for life, and the Health Authority had established no such overriding public interest as justified it in breaking the promise.
>
> (b) The process by which the decision to close Mardon

House was arrived at was flawed by a want of proper assessment of Miss Coughlan, by a bias in favour of closure in the materials laid before the Health Authority, and because no alternative placement for Miss Coughlan had been identified.

The bias was in part due to a consultation process which was vitiated by pre-judgment, non-disclosure of materials and inadequate time for response.

(d) In law, all nursing care was the sole responsibility of the NHS acting through the Health Authority. It was therefore not open to the Health Authority to transfer the responsibility for long-term general nursing care of a patient such as Miss Coughlan to the social services department of the local authority.

(e) The eligibility criteria adopted and applied by the Health Authority for long-term health care were correspondingly flawed.

Hidden J. accordingly granted an order of certiorari quashing the closure decision.

Intervention on the Appeal: Secretary of State and Royal College of Nursing

5. Upon the Health Authority's appeal two further parties have sought to be heard. For reasons mentioned above, the Secretary of State for Health applied and was given leave to be heard. It is appropriate that he should be treated for all purposes as a party. He was represented by Mr Nigel Pleming QC. Thereafter the Royal

College of Nursing ("the Royal College") applied to be heard and was given leave to put in a written submission on two issues of particular concern to it: whether nursing care is required to be provided free of charge in nursing homes, as it is in the patients' own home and in hospitals; and whether the distinction made by the Health Authority between specialist and general nursing care is contrary to law. We have taken into account that written submission and the evidence in support of it, as well as the Secretary of State's response to it. We have briefly heard Mr. Philip Havers QC on behalf of the Royal College. Its intervention has been of assistance, but it has rightly not sought to do more than intervene for a limited purpose.

Nursing Care for Miss Coughlan at Mardon House

6. From the time of her accident until the events with which this appeal is concerned, Miss Coughlan's care, which has always included, but has not been confined to, nursing care, was accepted as the responsibility of the NHS acting through the Exeter Health Authority and, more recently, the Health Authority. The Health Authority does not dispute that Miss Coughlan and her fellow long-term patients accepted the move from Newcourt Hospital to Mardon House in 1993 on the basis of a clear promise that Mardon House would be their home for life. Although both Mr. James Goudie QC for the Health Authority and Mr. Richard Gordon QC for Miss Coughlan have based their arguments upon a clear promise to this effect, it will be necessary later in this judgment to look at its precise terms because Mr. Gordon contends that when it took the closure decision the Health Authority was presented with a diluted version of the promise.

7. For the first year the John Grooms charity was engaged to run Mardon House, which was leased to the charity and registered as a nursing home under the Registered Homes Act 1984. By the summer of 1994, however, this arrangement had failed and the premises reverted to the local NHS Trust. Section 21(3) of the Registered Homes Act 1984 excludes NHS hospitals from registration as nursing homes. By section 128(1) of the National Health Service Act 1977 ("the Health Act") a "hospital" includes any institution for the reception and treatment of persons suffering from illness, so that Mardon House could no longer be registered as a nursing home, albeit this was the description which most nearly fitted it.

8. Mardon House, although purpose-built for the long-term disabled, had other health service functions as a rehabilitation – or "reablement" – unit. For reasons which we do not have to analyse, the Health Authority by 1995 was having to consider whether the reablement service could realistically be kept at Mardon House. This in turn threw up the question whether, if the reablement service were to go, Mardon House could be maintained as a home for younger chronically disabled patients together with some alternative health service use or uses.

NHS Changes: Legislation, Policy and Guidelines

9. Alongside these difficulties of health service provision changes were taking place in health service policy. On 1 April 1993 the National Health Service and Community Care Act 1990 came into force. Among the purposes set out in the long title were "to make further

provision about health authorities and other bodies constituted in accordance with the [Health Act], to provide for the establishment of National Health Service Trusts; …. to make further provision concerning the provision of accommodation and other welfare services by local authorities …". Mr. Gordon's initial charge that this legislation was mistakenly taken by the NHS to permit long-term nursing care to be handed over to local authorities has been defused by Mr. Pleming's acceptance, adopted by Mr. Goudie, that no material change was introduced by the Act of 1990 and that all the material powers are to be found in the Health Act, the successor to the originating National Health Service Act 1946. It will be necessary to consider in detail the history and significance of those statutory provisions which adjust the relationship between NHS and local authority provision for persons who are ill.

10. The coming into force of the Act of 1990 was accompanied by a guideline document, HSG (92) 50, issued by the NHS Management Executive to District Health Authorities. It is captioned "Local Authority Contracts for Residential and Nursing Home Care: NHS Related Aspects" and begins:

> "This guidance sets out District Health Authority and Local Authority responsibilities, from April 1993, for funding community health services for residents of residential care and nursing homes who have been placed in those homes by local authorities."

The guidance drew a distinction between "specialist" nursing services, which were to continue to be provided by the NHS, and "general nursing care", which the guidance proposed should be for

the local authority to purchase. It said:

> "Full implementation of the White Paper "Caring for People" will mean that local authorities will have responsibilities for purchasing nursing home care for the great majority of people who need it and who require to be publicly supported. When, after April 1993, a local authority places a person in a nursing home after joint HA/LA assessment, the local authority is responsible for purchasing services to meet the general nursing care needs of that person, including the cost of incontinence services (eg laundry) and those incontinence and nursing supplies which are not available on NHS prescription. Health authorities will be responsible for purchasing, within the resources available and in line with their priorities, physiotherapy, chiropody and speech and language therapy, with the appropriate equipment, and the provision of ***specialist*** nursing advice, eg continence advice and stoma care, for those people placed in nursing homes by local authorities with the consent of a DHA. Health authorities can opt to purchase these services through directly managed units, NHS Trusts, or other providers including the nursing home concerned. Health Authorities continue to have the power to enter into a contractual arrangement with a nursing home where a patient's need is primarily for health care. Such placements must be fully funded by the health authority."

11. In March 1993 the Secretary of State gave approvals and directions under section 21(1) of the National Assistance Act 1948 ("the Care Act") – to which we will come – directing local authorities to make arrangements to provide residential accommodation for persons who were unable through illness to take care of themselves, and to enable such people to obtain nursing attention so long as this did not impinge upon statutory NHS provision.

12. In 1995 further guidance was issued by the Secretary of State for Health, directed both to NHS bodies and to local authorities (HSG (95) 8; LAC (95) 5)). It sought to delineate in further detail the appropriate division of responsibility between the NHS and local

authorities for those in need of continuing health care. It made clear that access to specialist medical and nursing services should be available and provided at the expense of the NHS for those persons who were no longer eligible for in patient care. It called on health authorities to develop and publish policies and eligibility criteria for the purchase of continuing health care as from April 1996.

13. The Health Authority published policies and eligibility criteria in conjunction with its twin Devon Health Authority and Devon Social Services. The published document builds upon the distinction made in the 1992 guidelines between specialist and general nursing care, setting out a definition of specialist nursing which Mr. Gordon and Mr. Havers have submitted is idiosyncratic. It relates specialisation not to qualification but to employment, and it lists as examples of specialist nursing continence care, stoma, diabetic, paediatric, palliative, tissue viability and breast care. It distinguishes these from what it calls core nursing: the work of district nurses, health visitors, practice nurses, community psychiatric nurses, community mental handicap nurses and midwives. Of those areas identified as specialist, none are recognised as such by the United Kingdom Central Council for Nursing. Those listed as non-specialist are arguably all examples of specialist nursing. It is not for us to resolve this difference of approach, but it is relevant to note that the notion of specialist nursing, introduced by way of policy guidance and not by statute, is, on any view, elusive. As to nursing home care the document says:

> "Many people regard care in a Nursing Home as health care, and therefore the purchasing responsibility of the NHS. However, under the NHS and Community Care Act, Social Services were

given a new responsibility for purchasing Nursing Home beds. As with the previous arrangement through the Department of Social Security this is subject to a means test. The regulations governing this are laid down nationally. It is anticipated that the majority of placements in Nursing Homes in Devon will continue to be made through Social Services.

Under the terms of the government's guidance it is open to Health Authorities to purchase care from Nursing Homes as NHS Continuing Care (although they do not have to do so if they can meet these responsibilities in other ways ie through contracting for hospital beds). Patients eligible for NHS purchased nursing home care would need to meet the criteria for in-patient care. The care required would be at a higher level than that normally provided by Nursing Homes.

Health and Social Services purchasers are working together to describe more clearly Social Services "normal" expectations of Nursing Homes and how an NHS purchased placement would differ from this.

NHS in-patient care is free at the point of need but Social Services are obliged by law to charge for care; this is decided by Parliament. The question of charging cannot be taken into account in these eligibility criteria nor in decisions on care for individuals, since these are based on Consultants' clinical judgements."

The policy statement goes on to say:

"The National Health Service Executive recommend that the following services are to be regarded as standard, ie. not specialist, in nursing homes: general physical and mental nursing care, artificial feeding, continuous oxygen therapy, wound care, pain control, administration of drugs and medication, catheter care, bladder wash-outs, suction, tracheotomy care, tissue viability."

14. In spite of counsel's best endeavours it has proved impossible to locate the source of the recommendation upon which this passage of the policy is expressly based. Their best guess – that it is HSG (92) 50 – is insufficient because only the broad division between general and specialist nursing care is to be found there. Those instructing Mr. Goudie have been able to tell us that from their recollection some

recommendations were conveyed in meetings convened by the South West Regional Office of the National Health Service Executive. Mr. Pleming has been able to ascertain nothing about these meetings from the departmental end, and neither party has been able to produce a single memorandum or note relating to them. In this situation, which in the experience of the court is unusual, we will take the policy at face value and infer that the allocation of functions is not the work of the Health Authority alone but derives from central NHS guidance.

Closure of Mardon House

15. In the first months of 1996 a review was instituted by the Health Authority of the options for the placement and care of Miss Coughlan and her two fellow patients. It was based upon the eligibility criteria for NHS care and concluded that Miss Coughlan did not meet these. (Nor, it was considered, did her fellow patient Ross Bentley, who was immobile, unable to communicate, and doubly incontinent.) In January 1998, a week after Devon County Council had assessed Mardon House as "ideally suited" to Miss Coughlan's physical and psychological needs, the Health Authority issued a consultation paper which set out five options, of which its Board approved the fifth, which involved the closure of Mardon House. In April 1998, after public consultation, the Health Authority approved Option 5. Option 5 did not include an alternative placement for Miss Coughlan or her fellow-patients, but the Health Authority was satisfied that one would be found.

16. Following the grant of leave by Laws J. on 3 June 1998 the Health Authority agreed to rescind its decision and to go out again to consultation. A new consultation paper was issued on 2 September 1998.

Through her solicitors Miss Coughlan responded to it. It took time to reach those representing other Mardon House residents, but they responded by 22 September, two days before the consultation period ended. Meanwhile the Health Authority had bespoken and received a report from Dr. Clark which was not disclosed as part of the consultation process. It supported the closure proposal. Accordingly, on 7 October 1998 the Health Authority took a fresh decision to withdraw services from Mardon House, which would inevitably result in its closure. The consultation process, which has been the subject of a discrete head of challenge, will be examined in more detail later in this judgment. The Form 86A was amended accordingly and the proceedings, for which leave had already been granted, continued.

Grounds of Challenge

17. Miss Coughlan's case that the decision to close Mardon House is flawed is put on a number of different grounds by Mr Gordon QC. Any one of those grounds, if established, is sufficient to render the decision unlawful. We shall deal with the points in the following order:

A. Nursing as Health Care and as Social Care (Paras 18 – 32)
B. Eligibility Criteria (Paras 33 – 50)
C. The Promise of a Home for Life (Paras 51 – 90)
D. Human Rights (Paras 91 – 94)
E. Assessment and Placement (Paras 95 – 108)
F. Consultation (Paras 109 – 118)

A. NURSING AS "HEALTH CARE" AND AS "SOCIAL CARE"

18. Before Hidden J., the question of the legality of nursing care being provided by a local authority was not the primary issue raised by Mr Gordon on behalf of Miss Coughlan. The decision of the judge has made it the

most important issue on this appeal. As to this issue the judge said:

> "I accept Mr Gordon's submissions on the question of nursing care that nothing in either NHSCCA or in HSG (95) 8 altered the statutory responsibilities of Health Authorities to provide health services including nursing care. As a result both general and specialist nursing care remain the *sole responsibility* of the Health Authorities. Thus the Respondent Authority was clearly wrong in law in assuming that the law had changed and that it was no longer entitled or empowered to provide or arrange long term general nursing care in an NHS setting and/or that there had been a transfer to Social Services Department of such responsibility as a result of "new legislation". Those assumptions were wholly misconceived and led to the Authority taking account of irrelevant matters. .... [emphasis added] ..... I conclude that nursing is "health care" and can never be "social care" and that ..... HSG (95) 8 did not make any change to any NHS responsibility for health care services including nursing".

19. If the judge's decision is right on this issue, his decision will have significant adverse financial consequences for the Secretary for State and the Health Authority. In addition it will mean that the policy of the Secretary of State as to the provision of nursing care, which has existed for a number of years, has been unlawful. It will, on the other hand, improve the position of those in a similar situation to that of Miss Coughlan. If the judge is right, those who receive nursing care while residing in the community in a nursing or similar home provided by a local authority will be entitled to have that care provided free of charge. This would be the same position as would apply if they were living in their own homes. If the judge is wrong, it means that the nursing services will have to be paid for, unless the financial resources of the person concerned have been nearly exhausted. In these circumstances it is not surprising that a substantial proportion of the argument on this appeal has been devoted to this issue.

20. The answer to this issue depends on the correct interpretation of three sections: sections 1 and 3 of the Health Act and section 21 of Part III of the Care Act. The language of the sections today can be readily traced back to the original legislation which founded the welfare state after the last war. Their legislative history reflects the changes in the manner in which health and care services have been provided since that time. We have, therefore, had the legislative history of the three sections explained to us in depth. (The Health Act is a descendant of the National Health Act 1946. The Care Act has been substantially amended since 1948). In the end, however, this issue has to be determined by construing the provisions in their current form.

In examining the language of the sections it is desirable to start with the Health Act because, as the Care Act makes clear, the Health Act is the dominant act. This dominance is consistent with the long standing role of local authorities under Part III of the Care Act of only being required to provide assistance for those in need who have no other way of obtaining that assistance. In that sense, assistance under the Care Act is provided as a last resort.

The Health Act

22. The Health Act is a consolidating Act. Section 1(1) places upon the Secretary of State a duty to continue to promote a comprehensive health service. It sets out the target which the Secretary of State should seek to achieve in the following terms:

"1(1) It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement –

(a) in the physical and mental health of the people of those countries, and

(b) in the prevention, diagnosis and treatment of illness,

and for that purpose to provide or secure the effective provision of services in accordance with this Act.

It will be noted that Section 1(1) does not place a duty on the Secretary of State to provide a comprehensive health service. His duty is "to continue to promote" such a service. In addition the services which he is required to provide have to be provided "in accordance with this Act".

Section 1(2) makes clear that those services are in general to be provided free. Section 1(2) provides:

"The services so provided shall be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, whenever passed".

Moving to section 3, it is only necessary to refer to section 3(1). That sub-section states :

"It is the Secretary of State's duty to provide throughout England and Wales, to such extent as he considers necessary to meet all reasonable requirements –

(a) hospital accommodation ;

(b) other accommodation for the purpose of any service provided under this Act;

(c) medical, dental, nursing and ambulance services;

(d) such other facilities for the care of expectant and nursing mothers and young children as he considered are appropriate as part of the health service;

(e) such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service;

(f) such other services as are required for the diagnosis and treatment of illness."

23. It will be observed that the Secretary of State's section 3 duty is subject to two different qualifications. First of all there is the initial qualification that his obligation is limited to providing the services identified to the extent that he considers that they are necessary to meet all reasonable requirements. In addition, in the case of the facilities referred to in (d) and (e), there is a qualification in that he has to consider whether they are appropriate to be provided "as part of the health service". We are not concerned here with this second qualification since nursing services would come under section 3(1)(c).

24. The first qualification placed on the duty contained in section 3 makes it clear that there is scope for the Secretary of State to exercise a degree of judgment as to the circumstances in which he will provide the services, including nursing services referred to in the section. He does not automatically have to meet all nursing requirements. In certain circumstances he can exercise his judgment and legitimately decline to provide nursing services. He need not provide nursing services if he does not consider they are reasonably required or necessary to meet a reasonable requirement.

25. When exercising his judgment he has to bear in mind the comprehensive

service which he is under a duty to promote as set out in section 1. However, as long as he pays due regard to that duty, the fact that the service will not be comprehensive does not mean that he is necessarily contravening either section 1 or section 3. The truth is that, while he has the duty to continue to promote a comprehensive free health service and he must never, in making a decision under section 3, disregard that duty, a comprehensive health service may never, for human, financial and other resource reasons, be achievable. Recent history has demonstrated that the pace of developments as to what is possible by way of medical treatment, coupled with the ever increasing expectations of the public, mean that the resources of the NHS are and are likely to continue, at least in the foreseeable future, to be insufficient to meet demand.

26. In exercising his judgment the Secretary of State is entitled to take into account the resources available to him and the demands on those resources. In *R v Secretary of State for Social Services and Ors ex parte Hincks*[1980] 1 BMLR 93 the Court of Appeal held that section 3(1) of the Health Act does not impose an absolute duty to provide the specified services. The Secretary of State is entitled to have regard to the resources made available to him under current government economic policy.

The Care Act

27. To ascertain whether local authorities can provide any nursing services as part of their care services pursuant to their Part III responsibilities it is now necessary to turn to the third of the trio of sections, namely section 21 of the Care Act. The section provides:

"(1) [Subject to and in accordance with the provisions of this

Part of the Act, a local authority may with the approval of the Secretary of State, and to such extent as he may direct shall, make arrangements for providing] –

(a) residential accommodation for persons [aged eighteen or over] who by reason of age, [illness, disability] or any other circumstances are in need of care and attention which is not otherwise available to them; [and

(aa) residential accommodation for expectant and nursing mothers who are in need of care and attention which is not otherwise available to them.]

(2) In [making any such arrangements] a local authority shall have regard to the welfare of all persons for whom accommodation is provided, and in particular to the need for providing accommodation of different descriptions suited to different descriptions of such persons as are mentioned in the last foregoing subsection.

(5) References in this Act to accommodation provided under this Part thereof shall be construed as references to accommodation provided in accordance with this and the five next following sections, and as including references to board and other services, amenities and requisites provided in connection with the accommodation except where in the opinion of the authority managing the premises their provision is unnecessary.

(7) Without prejudice to the generality of the foregoing provisions of this section, a local authority may –

(a) ....

[(b) make arrangements for the provision on the premises in which accommodation is being provided of such other services as appear to the local authority to be required.]

(8) Nothing in this section shall authorise or require a local authority to make any provision authorised or required to be made (whether by that or by any other authority) by or under any enactment not contained in this Part of this Act [or authorised or required to be provided under the National Health Service Act 1977.]”

(The passages in square brackets indicate amendments).

The following points should be noted in relation to section 21.

(a) The requirements for approval and directions by the Secretary of State in section 21(1) give the Secretary of State considerable control over both what and how services are provided by local authorities under Part III. (The necessary directions were given in 1993 in an appendix to guidance issued by the Secretary of State in 17 March 1993.)

(b) Under section 21 the primary service provided is accommodation. But the express reference to age, illness and disability as being among the characteristics of the person who is seeking accommodation, which amount to a qualification for the grant of the accommodation, indicate that in many cases there is likely to be a need for nursing services as part of the care provided.

(c) The words in section 21(5), "board and other services" are readily capable of being construed as including nursing services and there appears to be no reason why they should not be so construed. If there were any doubt as to this, it would be removed by the reference in section 26(1B) to "residential accommodation where nursing care is provided".

(d) The nursing services would, however, as section 21(5) requires, have to be "provided in connection with the accommodation".

So far the language of three sections creates no particular difficulty as long as it is subjected to detailed analysis. Section 21(8) remains to be considered. It provides the key to this issue. How are the words "or authorised or required to be provided under" the Health Act to be applied?

28. Each word is of significance. The powers of the local authority are not excluded *by* the existence of a power in the Health Act to provide the service, but they are excluded where the provision is authorised or required to be made *under* the Health Act. The position is different in the case of "any other enactment", where it is sufficient if there is an authority or requirement to be made *by or under* the enactment.

29. The references in s.21 to the Health Act were added by the National Health Service and Community Care Act 1990. The amendment was made in part by section 42 of Part III of that Act. Part III introduced the new arrangements for community care. The same section also added the provision which is now section 26 (1B) of the Care Act to which we have already

referred. It was clearly contemplated that services which could be provided might include nursing services. Section 21(8) was added to by s.66 and para 5(3) of Schedule 9, entitled "Minor and Consequential Amendments". The section should not be regarded as preventing a local authority from providing any health services. The subsection's prohibitive effect is limited to those health services which, in fact, have been authorised or required to be provided under the Health Act. Such health services would not therefore include services which the Secretary of State legitimately decided under section 3(1) of the Health Act it was not necessary for the NHS to provide. It would have been remarkable if a minor and consequential amendment of s.21(8) of the Care Act had had the effect, as Mr Goudie contended, of reducing the Secretary of State's important public obligations under the Health Act. The true effect is to emphasise that Care Act provision, which is secondary to Health Act provision, may nevertheless include nursing care which properly falls outside the NHS.

Conclusion

30. The result of the detailed examination of the three sections can be summarised as follows:

(a) The Secretary of State can exclude some nursing services from the services provided by the NHS. Such services can then be provided as a social or care service rather than as a health service.

(b) The nursing services which can be so provided as part of the care services are limited to those which can legitimately be regarded as being provided in connection with accommodation which is being provided to the classes of persons referred to in section 21 of the Care Act who are in need of care and attention; in other words as part of a social services care package.

(c) The fact that the nursing services are to be provided as part of social services care and will have to be paid for by the person

concerned, unless that person's resources mean that he or she will be exempt from having to pay for those services, does not prohibit the Secretary of State from deciding not to provide those services. The nursing services are part of the social services and are subject to the same regime for payment as other social services. Mr Gordon submitted that this is unfair. He pointed out that if a person receives comparable nursing care in a hospital or in a community setting, such as his or her home, it is free. The Royal Commission on Long Term Care, in its report, With Respect to Old Age, (March 1999 chapter 6 pages 62 et seq. Cm 4192-1) not surprisingly agrees with this assessment and makes recommendations to improve the situation. However, as long as the nursing care services are capable of being properly classified as part of the social services' responsibilities, then, under the present legislation, that unfairness is part of the statutory scheme.

(d) The fact that some nursing services can be properly regarded as part of social services' care, to be provided by the local authority, does not mean that all nursing services provided to those in the care of the local authority can be treated in this way. The scale and type of nursing required in an individual case may mean that it would not be appropriate to regard all or part of the nursing as being part of "the package of care" which can be provided by a local authority. There can be no precise legal line drawn between those nursing services which are and those which are not capable of being treated as included in such a package of care services.

(e) The distinction between those services which can and cannot be so provided is one of degree which in a borderline case will depend on a careful appraisal of the facts of the individual case. However, as a very general indication as to where the line is to be drawn, it can be said that if the nursing services are (i) merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide to the category of persons to whom section 21 refers and (ii) of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide, then they can be provided under section 21. It will be appreciated that the first part of the test is focusing on the overall quantity of the services and the second part on the quality of the services provided.

(f) The fact that care services are provided on a means tested contribution basis does not prevent the Secretary of State declining to provide the nursing part of those services on the NHS. However, he can only decline if he has formed a judgment which is tenable that consistent with his long term general duty to continue to promote a comprehensive free health service that it is not necessary to provide the services. He cannot decline simply because social services will fill the gap.

31. It follows that we do not accept the judge's conclusion that all nursing care must be the sole responsibility of the NHS and has to be

provided by the Health Authority. Whether it can be provided by the local authority has to be determined on an assessment of the circumstances of the individual concerned. The Secretary of State accepts that, where the primary need is a health need, then the responsibility is that of the NHS, even when the individual has been placed in a home by a local authority. The difficulty is identifying the cases which are *required* to be placed into that category on their facts in order to comply with the statutory provisions. Here the needs of Miss Coughlan and her fellow occupants were primarily health needs for which the Health Authority is as a matter of law responsible, for reasons which we will now explain.

B. ELIGIBILITY CRITERIA

32. Mr Pleming, on behalf of the Secretary of the State, submitted that since the inception of the NHS there has been a broad division between specialist medical services, which are always the NHS's responsibility, and general care services, which can be the responsibility of local authorities. A reflection of this distinction was to be found in section 21(7) of the Care Act prior to its amendment. The section excluded from the services which could be provided by local authorities "specialist services or services of a kind normally provided only on admission to a hospital ...." He also contended that there can be an overlap between the categories of services which can be provided by the NHS and local authorities and that therefore a method needs to exist to determine an individual's eligibility for NHS services for which there would be no charge. The selected method is a combination of guidance by the Secretary of State, to be implemented by health authorities and local authorities, and eligibility criteria drawn up by health authorities in accordance with that guidance. The next issue which has to be determined is whether

the guidance and eligibility criteria which have been adopted and applied by the twin Health Authorities and Devon Social Services were flawed. The eligibility criteria could be flawed because they reflected guidance of the Secretary of State, which itself was flawed or they could be flawed because the Health Authorities, in laying down the eligibility criteria, misunderstood, misapplied or failed to follow that guidance.

33. We have already referred to the documents that contained the formal guidance, namely HSG (92) 50 and HSG (95) 8. Those documents could not and, as the judge accepted, did not alter the legal responsibilities of the NHS under the Health Act. They did, however, reflect a change of policy in relation to those who needed long-term care. Although the policy change is not directly relevant to the outcome of this appeal, it probably explains how the legal problems to be resolved by this case arose and some of the confusion on the part of the Health Authority as to its responsibilities.

34. At the request of this Court, Mr Pleming, on behalf of the Secretary of State, prepared a helpful note as to how the present policy in relation to long-term care evolved. In general there has been a shift from in-patient hospital care to community provision. This has coincided with advances in the way health and social services treatment and care are provided. Community care can offer improvements in terms of the quality of life it provides over long term residence in institutions, such as hospitals. We also recognise that, because of that improvement, the scale of health care which is needed may be reduced. However, subject to this, the fact that a patient is being treated in one setting rather then another will not affect their health care needs.

35. In keeping with this change of approach an announcement was made in the House of Commons on 12 July 1989 indicating that the aim of the policy would be to enable people to live as full and independent a life as is possible in the community for so long as they wished to do so. This statement was considered to be in accord with the report by Sir Roy Griffiths in 1988, "Community Care: Agenda for Action". The report accepted the distinction between health and social care and did not alter what should be the responsibility of the NHS for health care. It was, however, intended that local authorities should normally assume responsibility for the care element of public support for people in private and voluntary residential care and nursing homes. A text of the statement was issued under cover of circular HN (89) 18/LASSL (89) 6. Paragraph 25 of the statement confirmed:

> "Community care is no longer primarily about providing an alternative to long-stay hospital care. The vast majority of people needing care have never been, nor expect to be in such institutions. The policy aim is to now strike the right balance between home and day care on the one hand, and residential and nursing home care on the other, while reserving hospital care for those whose needs truly cannot be met elsewhere. The changes we propose will for the first time ensure that all public monies are devoted to the primary objective of supporting people at home whenever possible."

36. The policy was developed and implemented by a White Paper, "Caring for People, Community Care in the Next Decade and Beyond" (Cm. 849, November 1989) and the National Health Service and Community Care Act 1990 which was brought into force in April 1993. The Act was accompanied by policy guidance "Caring for People: Community Care in the Next Decade and Beyond". Again it was not intended to alter the

responsibilities of the NHS. So far as funding was concerned, the change which occurred in April 1993 is that, whereas previously funding for residential nursing home care had been met by central social security funding, after April 1993 this became the direct responsibility of the local authorities. This was intended to induce a more responsible approach on the part of local authorities as to how the resources were deployed.

37. It is accepted, however, that the NHS continued to be responsible for (a) funding placements for nursing home residents requiring continuing in-patient care and (b) meeting the specialist health care needs of residents of nursing homes for whom the local authority was generally responsible. As we will see, the category (a) responsibility is of significance. It involves the recognition that there will be residents of nursing homes who, while they do not require in patient care in hospital, do need NHS care in the community.

38. As a result of a report by the Health Service Commissioner in 1994, it was accepted by the then Secretary of State and the Chief Executive of the Health Service that the Health Service had withdrawn too far from its responsibilities in relation to continuing health care. This was followed by the issue of the guidance circular HSG (95) 8/LAC (95) 5 which was intended to address the concerns which had been expressed in the Commissioner's report. This was followed by further guidance on 26 September 1995 provided in Circular HSG (95) 45. The annex to that circular states in para 4.1:

> "....In respect of people being discharged from long stay institutions, the NHS is responsible for negotiating

> arrangements with local authorities, including any appropriate transfer of resources which assist the local authority meeting the care needs of such people and of their successors who may otherwise have entered the institution.....”

It is stated in paragraph 5.1 that Health Authorities are also responsible for the purchase and provision of:

> "(ii) specialist or intensive medical or nursing support for people in nursing homes .....” (emphasis added)

39. We have no difficulty with the Secretary of State adopting a policy of treatment in the community where in-patient treatment in a hospital is not required. In determining what health services are to be provided by the NHS, the Secretary of State may take into account what services are and can be lawfully provided by local authorities as care provision. However, the question remains as to whether the correct boundary has been identified between what is the proper responsibility of the NHS and what is the proper responsibility of local authorities.

40. The Secretary of State does not suggest that the NHS need not fund those health services which would not be an appropriate part of the package of care which a local authority can provide under s.21. We recognise that what services can be appropriately treated as responsibilities of a local authority under section 21 may evolve with the changing standards of society. It is always going to be difficult to identify the limits of those services. In the case of the circulars published by the Secretary of State, despite Mr Gordon’s submissions on behalf of Miss Coughlan to the contrary, we do not find that they

improperly place any responsibilities on local authorities or remove any responsibilities of health authorities. In fact both the judge and Mr Gordon accepted that these circulars had made no change to the responsibilities for health care of the NHS.

41. What Mr Gordon particularly complained of was the distinction which the circulars adopted between general and specialist nursing care. We have already indicated why a dividing line based on this distinction can be described as idiosyncratic. Certainly the expressions should not be regarded as giving anything more than the most general indication of what is and is not health care which the NHS should provide. The distinction between general and special or specialist services does provide a degree of non technical guidance as to the services which, because of their nature or quality, should be regarded in any particular case as being more likely to be the responsibility of the NHS. Where the issue is whether the services should be treated as the responsibility of the NHS, not because of their nature or quality, but because of their quantity or the continuity with which they are provided, the distinction between general and specialist services is of less assistance. The distinction certainly does not provide an exhaustive test. The distinction does not necessarily cater for the situation where the demands for nursing attention are continuous and intense. In that situation the patient may not require in-patient care in a hospital under the new policy, but the nursing care which is necessary may still exceed that which can be properly provided as a part of social services care provision. We read circular HSG (95) 8 as recognising that there can be such cases (see paragraph 21). But the shortcoming of the circular is that

it associates such cases only with in-patient treatment and does not make clear whether the in-patient treatment to which it refers has to be in a hospital. What the circulars do not contain are clear statements that the fact that a case does not qualify for in-patient treatment in a hospital does not mean that the person concerned should not be a NHS responsibility. The importance of there being clear statements as to this arise because of the increased emphasis being placed on care in the community. This could result in it being assumed that, because patients who would previously have been treated as in-patients in hospital no longer qualify for such treatment, they are automatically disqualified from receiving care on the NHS. This is not what is permitted.

42. On this aspect of the case, two things are clear. First, the fact that the resident at a nursing home does not require in-patient treatment in a hospital does not mean that his or her care should not be the responsibility of the NHS. Secondly, as the judge points out, at one time the Health Authority was totally confused as to what the proper division of responsibility between the Health Authority and the local authorities was. Dr Gillian Morgan, the Chief Executive of the Health Authority, in her first affidavit accepts that this was the position. In paragraph 39 of her first affidavit she apologises for the confusion which she and other officers of the authority were under and appear to have caused by their statements. This could be the result of the shortcomings of the circulars.

43. The fact that there is this background of possible confusion makes it important that any eligibility criteria should be drawn up with

particular care. They need to identify at least two categories of persons who, although receiving nursing care while in a nursing home, are still entitled to receive the care at the expense of the NHS. First, there are those who, because of the scale of their health needs, should be regarded as wholly the responsibility of a health authority. Secondly, there are those whose nursing services in general can be regarded as being the responsibility of the local authority, but whose additional requirements are the responsibility of the NHS.

44. As to the second of those two categories, in her affidavit Dr Morgan states:

> "Nursing Homes do not generally divide their charges between accommodation and care. In my view, it would be very difficult if not impossible to distinguish between the elements of nursing care and what otherwise might be called social care – for example help with eating or washing. The difficulty is particularly acute in the context of work carried out by nursing auxiliaries or other carers under the supervision of qualified nurses. This will generally parallel the equivalent arrangements in NHS hospitals where care is delivered by a range of individuals including nursing auxiliaries and others who are not professional nurses. I therefore seriously doubt whether a coherent and consistent division could be maintained between what is a nursing task and what is a carer's task if it were proposed that there should be a different funding regime for the two types of care."

45. We are not in a position to comment on the correctness of this view of Dr Morgan. However if she is correct, then the position can be remedied by the Health Service taking responsibility for the whole cost. Either a proper division needs to be drawn (we are not saying that it has to be exact) or the Health Service has to take the whole responsibility. The local authority cannot meet the costs of services

which are not its responsibility because of the terms of section 21 (8) of the 1948 Act.

46. Mr Gordon contended that it would be absurd for those who do not meet the Health Authority's eligibility criteria for in-patient care not to be entitled to "general" nursing care services free if they are entitled to "specialist" health care services free. As we have already indicated, there are clearly grounds for saying that for there to be a different regime with regard to payment dependent upon the location where a person is receiving nursing services is unfair, but, that point apart, if a portion of nursing care can still be provided as a service for which the local authority is responsible, then we do not see anything improper in those services being charged for under the local authority regime. Other services for which the NHS is responsible can still be provided on health service terms.

47. It is Criterion 1 of the Eligibility Criteria of the twin Health Authorities and Social Services which is relevant to the issues in this case. It commences by recognising in extremely guarded terms that patients will be eligible for continuing health care "possibly exceptionally in nursing home settings". This follows an introduction which indicates that usually the need for on-site care from doctors (ie not nurses) is a reliable test for eligibility. There are also examples given of "the characteristics which are likely to apply" in cases for which the NHS has a continuing responsibility and they are extreme cases. Core nursing is given the definition which we have already cited. This indicates that nursing is not specialist nursing not because of what nursing services are rendered but because of the

title of the nurse, such as district nurses or midwives, who provides the care. This is followed by the statement said to be that of the NHS Executive already quoted.

48. It is for the Health Authority to decide what should be the eligibility criteria in its area in the co-operative framework envisaged by the circulars. In doing so it can take account of conditions in its area. We do not accept the argument that there cannot be variations between the services provided by the NHS in different areas. However the eligibility criteria cannot place a responsibility on the local authority which goes beyond the terms of section 21. This is what these criteria do. Cases where the health care element goes far beyond what the section permits were being placed upon the local authority as a result of the rigorous limits placed on what services can be considered to be NHS care services. That this is the position is confirmed by the result of the assessment of Miss Coughlan and her fellow occupants. Their disabilities are of a scale which are beyond the scope of local authority services.

49. The relevance of our upholding Miss Coughlan's complaint as to the eligibility criteria is that this could be a factor contributing to the decision to close Mardon House due to lack of support. She argued that, if the proper approach had been adopted as to who qualifies for NHS care, there would not have been this lack of support. Mardon House was an imaginatively conceived NHS facility in part for those who were unfortunate enough to have a similar degree of disability to Miss Coughlan. We agree that the closure decision is called into question by the erroneous view of the Health Authority as to its general

legal obligations towards patients, such as Miss Coughlan.

We turn next to its specific legal obligations owed to her personally.

C. THE PROMISE OF A HOME FOR LIFE

50. The Health Authority appeals on the ground that the judge wrongly held that it had failed to establish that there was an overriding public interest which entitled it to break the "home for life" promise. In particular, the judge erred in concluding that the Health Authority had applied the wrong legal test in deciding whether the promise could or should be broken and that it had wrongly diluted the promise and treated it as merely a promise to provide care. It contends that it applied the correct legal test and that the promise had, in the decision making process, been plainly and accurately expressed and given appropriate prominence.

51. It is also contended that the judge failed to address the overwhelming evidence on the urgent need to remedy the deficiencies of the reablement service and of the serious and acute risks to the reablement service if the status quo at Mardon House were maintained. If he had addressed that issue he would and should have concluded that the Health Authority was entitled to decide that such consideration pointed inexorably to the closure decision

52. It has been common ground throughout these proceedings that in public law the Health Authority could break its promise to Miss Coughlan that Mardon House would be her home for life if, and only if, an overriding public interest required it. Both Mr. Goudie and Mr. Gordon adopted the position that, while the initial judgment on this question

has to be made by the Health Authority, it can be impugned if improperly reached. We consider that it is for the court to decide in an arguable case whether such a judgment, albeit properly arrived at, strikes a proper balance between the public and the private interest.

The Facts

53. In order to determine this issue it is necessary to set out the facts in more detail than we have so far. They are as follows:

(a) From the date of her tragic accident in 1971 until 1993 Miss Coughlan lived in and received nursing care in Newcourt Hospital for the chronically sick and disabled. It was a large old house with communal wards. It was considered unacceptable for modern care. A decision was taken to discharge the residents "to a setting which would be more clinically and socially appropriate".

(b) On 15 March 1993 Miss Coughlan moved to Mardon House along with other patients and the majority of the staff from Newcourt. Mardon House was a purpose built NHS facility costing £1.5m. It was designed to house young, long term, severely disabled, residential patients. It had been proposed as early as 1989 as a replacement for Newcourt. There were 20 beds. There were 17 purpose built, individual flatlets each designed to have a bedroom, sitting room, inter-connecting bathroom and a designated kitchenette area. They were individually tailored for the needs of those moving into them. The residents of Newcourt had been involved in discussions about the nature and design of the building and its services. They chose their flatlets and the decor. Intensive reablement services and respite care were

also to be provided there. There was a mix of residential/nursing home care and active acute treatment.

(c) The Newcourt patients were persuaded to move to Mardon House by representations on behalf of the Health Authority that it was more appropriate to their needs. The patients relied on an express assurance or promise that they could live there "for as long as they chose". Nursing care was to be provided for them in Mardon House. It was the "new Newcourt".

(d) Mardon House was let by the Exeter & District Community Health Service NHS Trust to a charity, the John Grooms Association, and it was registered as a nursing home. John Grooms withdrew in June 1994, as they felt that the evolving service was so heavily weighted in favour of acute clinical work that the unit would be unregistrable under the terms of the Registered Homes Act 1984. It ceased to be a registered nursing home and became the responsibility of the NHS Trust. It reverted to being solely a NHS facility. No new long term patients were admitted from mid-1994.

(e) On 7 October 1998 the decision was taken by the Health Authority to withdraw services from Mardon House and to close the facility. It was minuted in these terms-

> "Option 11 - Move reablement to Heavitree Hospital, Exeter Community Trust to sell Mardon House and the residents to move to nursing/residential homes/community care settings.
>
> The Authority unanimously voted to support this option."

Three patients, all ex-Newcourt including Miss Coughlan are left living

there. They are all chronically sick and disabled and are considered by the Health Authority to require "generalist nursing care."

(f) The decision was preceded by a Consultation Paper (DHA 98/109) dated 25 August 1998 on the options for the future of services for people with physical disability currently provided at Mardon House. Section 2.0 of the paper deals with "PROMISE TO THE RESIDENTS" as follows-

> "2.1 When Mardon House opened in 1993 several of the residents expressed their desire to stay at Newcourt Hospital. Verbal assurances were given by senior officers of the former Exeter Health Authority and the Exeter Community Unit that Mardon House would be expected to be the residents "home for life."
>
> 2.2 In June 1994, the General Manager of the former Exeter Health Authority wrote to the residents for whom Exeter and North Devon Health Authority were responsible [two of the current three residents] assuring them that he would ask the Exeter Community Trust to ensure that Mardon House would be their permanent home, for as long as they wished to remain there.
>
> 2.3 The Authority needs to give due recognition and weight to this promise in taking any decisions about the future configuration of services.
>
> 2.4 The Authority has previously recognised this commitment and accepted continuing responsibility for funding the residents' care."

The Section headed "CONSIDERATIONS" identifies this as one of the issues to be discussed-

> "the Authority needs to consider carefully the "promise for life" given to residents, its implications and whether this outweighs any considerations for the acute service. Is an ongoing commitment to fund care ie, to maintain the residents in continuing NHS funded continuing care fair or appropriate?"

(g) The Consultation Paper and a further paper, "Responses from the Consultation" (DHA 98/127) were placed before the Health Authority at the meeting on 7 October 1998. There was included a "Response by the Residents". In the section "DECISION MAKING PROCESS" 3.1 states that:

> "The starting point is the promise to the residents that Mardon House would be a home for life".

The "CONCLUSIONS" section 5.0 states that :

> "The Health Authority has to decide, in the light of all available evidence, either to support the Exeter Community Trust in running a residential home which may not be viable, or to assist the residents to move whilst "in breach of the original promises" or to move alternative NHS services into Mardon House with a less than satisfactory outcome both financially and from the point of clinical compatibility."

Various options were then set out in section 6.0, including retaining the status quo at Mardon House (Option 1) and Option 11, which was eventually taken.

On this issue the ground of review relied on was that the Health Authority had acted unlawfully:

> "...in breaking the recent and unequivocal promise given by it that the Applicant and other patients could live there for as long as they chose".

The Judgment

54. It is also helpful to set out the views of the judge on this issue.

The judge regarded as "the proper starting point" the question of what effect did the "promise for life" have in law. He held that it was a clear promise to Miss Coughlan and the other patients that Mardon House would be a permanent home for them; that a decision to break it, if unfair, would be equivalent to a breach of contract; that a public authority could reasonably resile from such a promise where the overriding public interest demanded it; and that the Health Authority had failed to discharge the burden of establishing that there were "compelling circumstances" amounting to an overreaching public interest. The Health Authority had concluded that, in its scale of priorities, reablement came higher than Miss Coughlan and her fellow patients. The "promise for life " was a relevant consideration . The judge concluded as follows :

> "Consideration of the promise had to start with a proper understanding of the promise. It was a promise to provide care at Mardon House but the respondent wrongly treated it as merely a promise to provide care. That meant that the Authority's attitude to the place where care was to be provided was flawed from the start."

Legitimate Expectation – The Court's Role

55. In considering the correctness of this part of the judge's decision it is necessary to begin by examining the court's role where what is in issue is a promise as to how it would behave in the future made by a public body when exercising a statutory function. In the past it would have been argued that the promise was to be ignored since it could not have any effect on how the public body exercised its judgment in what it thought was the public interest. Today such an argument would have no prospect of success, as Mr Goudie and Mr.

Gordon accept.

56. What is still the subject of some controversy is the court's role when a member of the public, as a result of a promise or other conduct, has a legitimate expectation that he will be treated in one way and the public body wishes to treat him or her in a different way. Here the starting point has to be to ask what in the circumstances the member of the public could legitimately expect. In the words of Lord Scarman in *Re Findlay [1985] 1AC 318* at p338, "But what was their *legitimate* expectation?" Where there is a dispute as to this, the dispute has to be determined by the court, as happened in *Findlay*. This can involve a detailed examination of the precise terms of the promise or representation made, the circumstances in which the promise was made and the nature of the statutory or other discretion.

57. There are at least three possible outcomes. (a) The court may decide that the public authority is only required to bear in mind its previous policy or other representation, giving it the weight it thinks right, but no more, before deciding whether to change course. Here the court is confined to reviewing the decision on Wednesbury grounds. This has been held to be the effect of changes of policy in cases involving the early release of prisoners (see *Re Findlay* [1985] AC 318; *R v Home Secretary ex parte Hargreaves* [1997] 1 WLR 906. (b) On the other hand the court may decide that the promise or practice induces a legitimate expectation of, for example, being consulted before a particular decision is taken. Here it is uncontentious that the court itself will require the opportunity for consultation to be given unless there is an overriding reason to resile from it (see *A-G*

for Hong Kong v Ng Yuen Shiu [1983] 2 AC 629) in which case the court will itself judge the adequacy of the reason advanced for the change of policy, taking into account what fairness requires. (c) Where the court considers that a lawful promise or practice has induced a legitimate expectation of a benefit which is substantive, not simply procedural, authority now establishes that here too the court will in a proper case decide whether to frustrate the expectation is so unfair that to take a new and different course will amount to an abuse of power. Here, once the legitimacy of the expectation is established, the court will have the task of weighing the requirements of fairness against any overriding interest relied upon for the change of policy.

58. The court having decided which of the categories is appropriate, the court's role in the case of the second and third categories is different from that in the first. In the case of the first, the court is restricted to reviewing the decision on conventional grounds. The test will be rationality and whether the public body has given proper weight to the implications of not fulfilling the promise. In the case of the second category the court's task is the conventional one of determining whether the decision was procedurally fair. In the case of the third, the court has when necessary to determine whether there is a sufficient overriding interest to justify a departure from what has been previously promised.

59. In many cases the difficult task will be to decide into which category the decision should be allotted. In what is still a developing field of law, attention will have to be given to what it is in the first category of case which limits the applicant's legitimate

expectation (in Lord Scarman's words in *Re Findlay*) to an expectation that whatever policy is in force at the time will be applied to him. As to the second and third categories, the difficulty of segregating the procedural from the substantive is illustrated by the line of cases arising out of decisions of justices not to commit a defendant to the Crown Court for sentence, or assurances given to a defendant by the court: here to resile from such a decision or assurance may involve the breach of legitimate expectation (See *R v Reilly* [1985] 1 Cr. App.R (5) 273,276; *R v Southampton Magistrates Court* [1994] Cr. App.R (5) 778, 781-2).

No attempt is made in those cases, rightly in our view, to draw the distinction. Nevertheless, most cases of an enforceable expectation of a substantive benefit (the third category) are likely in the nature of things to be cases where the expectation is confined to one person or a few people, giving the promise or representation the character of a contract. We recognise that the courts' role in relation to the third category is still controversial; but, as we hope to show, it is now clarified by authority.

60. We consider that Mr Goudie and Mr Gordon are correct, as was the judge, in regarding the facts of this case as coming into the third category. (Even if this were not correct because of the nature of the promise, and even if the case fell within the second category, the Health Authority in exercising its discretion and in due course the court would have to take into account that only an overriding public interest would justify resiling from the promise.) Our reasons are as follows. First, the importance of what was promised to Miss

Coughlan, (as we will explain later, this is a matter underlined by the Human Rights Act 1998); second, the fact that promise was limited to a few individuals, and the fact that the consequences to the Health Authority of requiring it to honour its promise are likely to be financial only.

The Authorities

61. Whether to frustrate a legitimate expectation can amount to an abuse of power is the question which was posed by the House of Lords in *R. v. IRC, ex parte Preston* [1985] AC 835 and addressed more recently by this court in *R v. IRC, ex parte Unilever Plc* [1996] STC 681. In each case it was in relation to a decision by a public authority (the Crown) to resile from a representation about how it would treat a member of the public (the taxpayer). It cannot be suggested that special principles of public law apply to the Inland Revenue or to taxpayers. Yet this is an area of law which has been a site of recent controversy, because while Preston has been followed in tax cases, using the vocabulary of abuse of power, in other fields of public law analogous challenges, couched in the language of legitimate expectation, have not all been approached in the same way.

62. There has never been any question that the propriety of a breach by a public authority of a legitimate expectation of the second category, of a procedural benefit – typically a promise of being heard or consulted – is a matter for full review by the court. The court has, in other words, to examine the relevant circumstances and to decide for itself whether what happened was fair. This is of a piece with the historic jurisdiction of the courts over issues of procedural

justice. But in relation to a legitimate expectation of a substantive benefit (such as a promise of a home for life) doubt has been cast upon whether the same standard of review applies. Instead it is suggested that the proper standard is the so-called Wednesbury standard which is applied to the generality of executive decisions. This touches the intrinsic quality of the decision, as opposed to the means by which it has been reached, only where the decision is irrational or (per Lord Diplock in *CCSU v. Minister for the Civil Service* [1985] AC 374, 410) immoral.

63. This is not a live issue in the common law of the European Union, where a uniform standard of full review for fairness is well established (see J. Schwarze, *European Administrative Law*, English language ed., 1992, pp. 1134-5 and the ECJ cases reviewed in *R. v. MAFF, ex parte Hamble (Offshore) Fisheries Ltd* [1996] 2 All ER 714 at 726-8). It is however, something on which the Human Rights Act 1998, when it comes into force, may have a bearing.

64. It is axiomatic that a public authority which derives its existence and its powers from statute cannot validly act outside those powers. This is the familiar ultra vires doctrine adopted by public law from company law (*Colman v. Eastern Counties Railway Co. Ltd*. (1846) 16 L.J.Ch. 73). Since such powers will ordinarily include anything fairly incidental to the express remit, a statutory body may lawfully adopt and follow policies (*British Oxygen v. Ministry of Technology* [1971] AC 610) and enter into formal undertakings. But since it cannot abdicate its general remit, not only must it remain free to change policy; its undertakings are correspondingly open to modification or

abandonment. The recurrent question is when and where and how the courts are to intervene to protect the public from unwarranted harm in this process. The problem can readily be seen to go wider than the exercise of statutory powers. It may equally arise in relation to the exercise of the prerogative power, which at least since the decision in *R. v. Criminal Injuries Compensation Board, ex parte Lain* [1967] 2 QB 864 has been subject to judicial review, and in relation to private monopoly powers (*R. v. Panel on Take-overs and Mergers, ex parte Datafin* [1987] QB 875).

65. The court's task in all these cases is not to impede executive activity but to reconcile its continuing need to initiate or respond to change with the legitimate interests or expectations of citizens or strangers who have relied, and have been justified in relying, on a current policy or an extant promise. The critical question is by what standard the court is to resolve such conflicts. It is when one examines the implications for a case like the present of the proposition that so long as the decision-making process has been lawful, the court's only ground of intervention is the intrinsic rationality of the decision, that the problem becomes apparent. Rationality, as it has developed in modern public law, has two faces: one is the barely known decision which simply defies comprehension; the other is a decision which can be seen to have proceeded by flawed logic (though this can often be equally well allocated to the intrusion of an irrelevant factor). The present decision may well pass a rationality test; the Health Authority knew of the promise and its seriousness; it was aware of its new policies and the reasons for them; it knew that one had to yield, and it made a choice which, whatever else can be said of

it, may not easily be challenged as irrational. As Lord Diplock said in *Secretary of State for Education and Science v. Tameside MBC*:

> "The very concept of administrative discretion involves a right to choose between more than one possible course of action upon which there is room for reasonable people to hold differing opinions as to which is to be preferred."

But to limit the court's power of supervision to this is to exclude from consideration another aspect of the decision which is equally the concern of the law.

66. In the ordinary case there is no space for intervention on grounds of abuse of power once a rational decision directed to a proper purpose has been reached by lawful process. The present class of case is visibly different. It involves not one but two lawful exercises of power (the promise and the policy change) by the same public authority, with consequences for individuals trapped between the two. The policy decision may well, and often does, make as many exceptions as are proper and feasible to protect individual expectations. The departmental decision in *Hamble Fisheries* is a good example. If it does not, as in the *Unilever* case, the court is there to ensure that the power to make and alter policy has not been abused by unfairly frustrating legitimate individual expectations. In such a situation a bare rationality test would constitute the public authority judge in its own cause, for a decision to prioritise a policy change over legitimate expectations will almost always be rational from where the authority stands, even if objectively it is arbitrary or unfair. It is in response to this dilemma that two distinct but related

approaches have developed in the modern cases.

67. One approach is to ask not whether the decision is ultra vires in the restricted *Wednesbury* sense but whether, for example through unfairness or arbitrariness, it amounts to an abuse of power. The leading case on the existence of this principle is *Preston*. It concerned an allegation, not in the event made out, that the Inland Revenue Commissioners had gone back impermissibly on their promise not to re-investigate certain aspects of an individual taxpayer's affairs. Lord Scarman, expressing his agreement with the single fully reasoned speech (that of Lord Templeman) advanced a number of important general propositions. First, he said:

> "...I must make clear my view that the principle of fairness has an important place in the law of judicial review, and that in an appropriate case it is a ground on which the court can intervene to quash a decision made by a public officer or authority in purported exercise of a power conferred by law."

Second, Lord Scarman reiterated, citing the decision of the House in the *National Federation of Self-Employed* case [1982] AC 617, that a claim for judicial review may arise where the Commissioners have failed to discharge their statutory duty to an individual or "have abused their powers or acted outside them". Third, that "unfairness in the purported exercise of a power can be such that it is an abuse or excess of the power".

68. It is evident from these passages and from Lord Scarman's further explanation of them that, in his view at least, it is unimportant

whether the unfairness is analytically within or beyond the power conferred by law: on either view public law today reaches it. The same approach was taken by Lord Templeman:

> "Judicial review is available where a decision-making authority exceeds its powers, commits an error of law, commits a breach of natural justice, reaches a decision which no reasonable tribunal could have reached or abuses its powers."

69. Abuses of power may take many forms. One, not considered in the *Wednesbury* case (even though it was arguably what the case was about), was the use of a power for a collateral purpose. Another, as cases like *Preston* now make clear, is reneging without adequate justification, by an otherwise lawful decision, on a lawful promise or practice adopted towards a limited number of individuals. There is no suggestion in *Preston* or elsewhere that the final arbiter of justification, rationality apart, is the decision-maker rather than the court. Lord Templeman at 864-6 reviewed the law in extenso, including the classic decisions in *Laker Airways v Department of Trade* [1977] QB 643; *Padfield v Minister of Agric*ulture [1968] AC 997; *Congreve v Home Office* [1976] WB 629 and *HTV v Price Commission* [1976] ICR 170 ("It is a commonplace of modern law that such bodies must act fairly … and that the courts have power to redress unfairness": Scarman LJ at 189.)

He reached this conclusion :

> "In principle I see no reason why the taxpayer should not be entitled to judicial review of a decision taken by the commissioners if that decision is unfair to the taxpayer

> because the conduct of the commissioners is equivalent to a breach of contract or a breach of representation. Such a decision falls within the ambit of an abuse of power for which in the present case judicial review is the sole remedy and an appropriate remedy. There may be cases in which conduct which savours of breach of contract or breach of representation does not constitute an abuse of power; there may be circumstances in which the court in its discretion might not grant relief by judicial review notwithstanding conduct which savours of breach of contract or breach of representation. In the present case, however, I consider that the taxpayer is entitled to relief by way of judicial review for "unfairness" amounting to abuse of power if the commissioners have been guilty of conduct equivalent to a breach of contract or breach of representation on their part."

The entire passage, too long to set out here, merits close attention. It may be observed that Lord Templeman's final formulation, taken by itself, would allow no room for a test of overriding public interest. This, it is clear, is because of the facts then before the House. In a case such as the present the question posed in the **HTV** case remains live.

70. This approach, in our view, embraces all the principles of public law which we have been considering. It recognises the primacy of the public authority both in administration and in policy development but it insists, where these functions come into tension, upon the adjudicative role of the court to ensure fairness to the individual. It does not overlook the passage in the speech of Lord Browne-Wilkinson in *R. v. Hull University Visitor ex parte Page* [1993] AC 682, 701, that the basis of the "fundamental principle … that the courts will intervene to ensure that the powers of public decision-making bodies are exercised lawfully" is the *Wednesbury* limit on the exercise of powers; but it follows the authority not only of

Preston but of Lord Scarman's speech in *Nottinghamshire County Council v. Secretary of State for the Environment* [1986] AC 240, 249, in treating a power which is abused as a power which has not been lawfully exercised.

71. Fairness in such a situation, if it is to mean anything, must for the reasons we have considered include fairness of outcome. This in turn is why the doctrine of legitimate expectation has emerged as a distinct application of the concept of abuse of power in relation to substantive as well as procedural benefits, representing a second approach to the same problem. If this is the position in the case of the third category, why is it not also the position in relation to the first category? May it be (though this was not considered in *Findlay* or *Hargreaves*) that, when a promise is made to a category of individuals who have the same interest it is more likely to be considered to have binding effect than a promise which is made generally or to a diverse class, when the interests of those to whom the promise is made may differ or, indeed, may be in conflict? Legitimate expectation may play different parts in different aspects of public law. The limits to its role have yet to be finally determined by the courts. Its application is still being developed on a case by case basis. Even where it reflects procedural expectations, for example concerning consultation, it may be affected by an overriding public interest. It may operate as an aspect of good administration, qualifying the intrinsic rationality of policy choices. And without injury to the *Wednesbury* doctrine it may furnish a proper basis for the application of the now established concept of abuse of power.

72. A full century ago in the seminal case of *Kruse v. Johnson* [1898] 2 QB 91 Lord Russell of Killowen CJ set the limits of the courts' benevolence towards local government bylaws at those which were "manifestly unjust, partial, made in bad faith or so gratuitous and oppressive that no reasonable person could think them justified". While it is the latter two classes which reappear in the decision of this court in the *Wednesbury* case, the first two are equally part of the law. Thus in *R. v. IRC ex parte MFK Underwriting Agents Ltd*. [1990] 1 WLR 1545 a Divisional Court (Bingham LJ and Judge J.) rejected on the facts a claim for the enforcement of a legitimate expectation in the face of a change of practice by the Inland Revenue. But having set out the need for certainty of representation, Bingham LJ went on (at 1569):

> "In so stating these requirements I do not, I hope, diminish or emasculate the valuable developing doctrine of legitimate expectation. If a public authority so conducts itself as to create or legitimate expectation that a certain course will be followed it would often be unfair if the authority were permitted to follow a different course to the detriment of one who entertained the expectation, particularly if he acted on it. If in private law a body would be in breach of contract in so acting or estopped from so acting, a public authority should generally be in no better position. The doctrine of legitimate expectation is rooted in fairness."

73. This approach, which makes no formal distinction between procedural and substantive unfairness, was expanded by reference to the extant body of authority by Simon Brown LJ in ***R.*** *v. Devon County Council ex parte Baker* [1995] 1 All ER 73, 89. He identified two categories of substantive legitimate expectation recognised by modern authority:

"(1) Sometimes the phrase is used to denote a substantive right: an entitlement that the claimant asserts cannot be denied him. It was used in this sense and the assertion upheld in cases such as *R. v. Secretary of State for the Home Dept, ex p Khan* [1985] 1 All ER 40, [1984] 1 WLR 1337 and *R v Secretary of State for the Home dept, ex p Ruddock* [1987] 2 All ER 518, [1987] 1 WLR 1482. It was used in the same sense but unsuccessfully in, for instance, ***R v. Board of Inland Revenue, ex p MFK Underwriting Agencies Ltd*** [1990] 1 All ER 91, [1990] 1 WLR 1545 and *R v. Jockey Club, ex p RAM Rececourses Ltd* [1993] 2 All ER 225. These various authorities show that the claimant's right will only be found established when there is a clear and unambiguous representation upon which it was reasonable for him to rely. Then the administrator or other public body will be held bound in fairness by the representation made unless only its promise or undertaking as to how its power would be exercised is inconsistent with the statutory duties imposed upon it. The doctrine employed in this sense is akin to an Estoppel. In so far as the public body's representation is communicated by way of a stated policy, this type of legitimate expectation falls into two distinct sub-categories: cases in which the authority are held entitled to change their policy even so as to affect the claimant, and those in which they are not. An illustration of the former is ***R v. Torbay BC, ex p Cleasby*** [1991] COD 142; of the latter, *Ex p Khan.*

(2) Perhaps more conventionally the concept of legitimate expectation is used to refer to the claimant's interest in some ultimate benefit which he hopes to retain (or, some would argue, attain). Here, therefore, it is the interest itself rather than the benefit that is the substance of the expectation. In other words the expectation arises not because the claimant asserts any specific right to a benefit but rather because his interest in it is one that the law holds protected by the requirements of procedural fairness; the law recognises that the interest cannot properly be withdrawn (or denied) without the claimant being given an opportunity to comment and without the authority communicating rational grounds for any adverse decision. Of the various authorities drawn to our attention, *Schmidt v Secretary of State for Home Affairs* [1969] 1 All ER 904, [1969] 2 Ch 149, *O'Reilly v. Mackman* [1982] 3 All ER 1124, [1983] 2 AC 237 and the recent decision of Roch J. in *R. v. Rochdale Metropolitan BC, ex p Schemet* [1993] 1 FCR 306 are clear examples of this head of legitimate expectation."

Simon Brown LJ has not in that passage referred expressly to the situation where the individual can claim no higher expectation than

to have his individual circumstances considered by the decision maker in the light of the policy then in force. This is not surprising because this entitlement, which can also be said to be rooted in fairness, adds little to the standard requirements of any exercise of discretion: namely that the decision will take into account all relevant matters which here will include the promise or other conduct giving rise to the expectation and that if the decision maker does so the courts will not interfere except on the basis that the decision is wholly unreasonable. It is the classic *Wednesbury* situation, not because the expectation is substantive but because it lacks legitimacy.

74. Nowhere in this body of authority, nor in *Preston*, nor in *Findlay*, is there any suggestion that judicial review of a decision which frustrates a substantive legitimate expectation is confined to the rationality of the decision. But in *R. v. Home Secretary ex parte Hargreaves* [1997] 1 WLR 906 Hirst LJ. (with whom Peter Gibson LJ. agreed) was persuaded to reject the notion of scrutiny for fairness as heretical, and Pill LJ. to reject it as "wrong in principle".

75. *Hargreaves* concerned prisoners whose expectations of home leave and early release were not to be fulfilled by reason of a change of policy. Following *Re. Findlay* [1985] AC 318 this court held that such prisoners' only legitimate expectation was that their applications would be considered individually in the light of whatever policy was in force at the time: in other words the case came into the first category. This conclusion was dispositive of the case. What Hirst LJ went on to say under the head of "The proper approach for the court to the Secretary of State's decision" was therefore obiter. However

Hirst LJ. accepted in terms the submission of leading counsel for the Home Secretary that, beyond review on *Wednesbury* grounds, the law recognised no enforceable legitimate expectation of a substantive benefit. In relation to the decision in *Hamble Fisheries* (above), he said:

> "Mr. Beloff characterised Sedley J's approach as heresy, and in my judgment he was right to do so. On matters of substance (as contrasted with procedure) *Wednesbury* provides the correct test".

A number of learned commentators have questioned this conclusion (see e.g. P.P. Craig, "Substantive legitimate expectations and the principles of judicial review" in *English Public Law and the Common Law of Europe,* ed. M. Andenas 1998; T.R.S. Allan, "Procedure and Substance in judicial review", [1997] C.L.J. 246; S. Foster, "Legitimate expectations and prisoners' rights" (1997) 60 M.L.R. 727).

76. *Hargreaves* can, in any event, be distinguished from the present case. Mr. Gordon has sought to distinguish it on the ground that the present case involves an abuse of power. On one view all cases where proper effect is not given to a legitimate expectation involve an abuse of power. Abuse of power can be said to be but another name for acting contrary to law. But the real distinction between *Hargreaves* and this case is that in this case it is contended that fairness in the statutory context required more of the decision maker than in *Hargreaves* where the sole legitimate expectation possessed by the prisoners had been met. It required the Health Authority, as a matter

of fairness, not to resile from their promise unless there was an overriding justification for doing so. Another way of expressing the same thing is to talk of the unwarranted frustration of a legitimate expectation and thus an abuse of power or a failure of substantive fairness. Again the labels are not important except that they all distinguish the issue here from that in *Hargreaves*. They identify a different task for the court from that where what is in issue is a conventional application of policy or exercise of discretion. Here the decision can only be justified if there is an overriding public interest. Whether there is an overriding public interest is a question for the court.

77. The cases decided in the European Court of Justice cited in *Hamble Fisheries* all concern policies or practices conferring substantive benefits from which member states were not allowed to resile when the policy or practice was altered. In this country *R. v. Home Secretary ex parte Ruddock* [1987] 1 WLR 1482 and *R. v. Home Secretary ex parte Khan* [1984] 1 WLR 1337 were cited as instances of substantive legitimate expectations to which the courts were if appropriate prepared to give effect. Reliance was also placed, as we would place it, on Lord Diplock's carefully worded summary in *CCSU v. Minister for Civil Service* [1985] 374, 408 of the contemporary heads of judicial review. They included "benefits or advantages which the applicant can legitimately expect to be permitted to continue to enjoy". Not only did Lord Diplock not limit these to procedural benefits or advantages; he referred expressly to *Re Findlay* (a decision in which he had participated) as an example of a case concerning a claim to a legitimate expectation – plainly a substantive one, albeit that the

claim failed. One can readily see why: Lord Scarman's speech in *Findlay* is predicated on the assumption that the courts will protect a substantive legitimate expectation if one is established; and Taylor J so interpreted it in ***Ruddock***. None of these cases suggests that the standard of review is always limited to bare rationality, though none developed it as the revenue cases have done.

78. It is from the revenue cases that, in relation to the third category, the proper test emerges. Thus in *R. v. IRC, ex parte Unilever Plc* [1996] STC 681 this court concluded that for the Crown to enforce a time limit which for years it had not insisted upon would be so unfair as to amount to an abuse of power. As in other tax cases, there was no question of the court's deferring to the Inland Revenue's view of what was fair. The court also concluded that the Inland Revenue's conduct passed the "notoriously high" threshold of irrationality; but the finding of abuse through unfairness was not dependent on this.

79. It is worth observing that this was how the leading textbook writers by the mid-1990s saw the law developing. In the (still current) seventh edition of Wade and Forsyth's Administrative Law (1994) the authors reviewed a series of modern cases and commented (p.419):

> "These are revealing decisions. They show that the courts now expect government departments to honour their statements of policy or intention or else to treat the citizen with the fullest personal consideration. Unfairness in the form of unreasonableness is clearly allied to unfairness by violation of natural justice. It was in the latter context that the doctrine of legitimate expectation was invented but it is now proving to be a source of substantive as well as of procedural rights. Lord Scarman [in Preston] has

> stated emphatically that unfairness in the purported exercise of power can amount to an abuse or excess of power, and this may become an important general doctrine."

To similar effect is De Smith, Woolf and Jowell, **Judicial Review of Administrative Action**, fifth edition (1995) para 13-035. Craig, **Administrative Law**, third edition (1994), pp 672-5, links the issue, as Schwarze (op.cit.) does, to the fundamental principle of legal certainty.

80. In *Unilever* Simon Brown LJ. proposed a valuable reconciliation of the existing strands of public law:

> "Unfairness amounting to an abuse of power as ..... in *Preston* and the other revenue cases is unlawful not because it involves conduct such as would offend some equivalent private law principle, not principally indeed because it breaches a legitimate expectation that some different substantive decision will be taken, but rather because it is illogical or immoral or both for a public authority to act with conspicuous unfairness and in that sense abuse its power. As Lord Donaldson MR said in *R. v. ITC ex p TSW:*
>
> > "The test in public law is fairness, not an adaptation of the law of contract or estoppel."
>
> In short, I regard the *MFK* category of legitimate expectation as essentially but a head of *Wednesbury* unreasonableness, not necessarily exhaustive of the grounds upon which a successful substantive unfairness challenge may be based."

81. For our part, in relation to this category of legitimate expectation, we do not consider it necessary to explain the modern doctrine in *Wednesbury* terms, helpful though this is in terms of received jurisprudence (cf. Dunn LJ. in *R.v. Home Secretary, ex p Khan* [1984] 1 WLR 1337, 1352: "an unfair action can seldom be a

reasonable one"). We would prefer to regard the *Wednesbury* categories themselves as the major instances (not necessarily the sole ones: see *CCSU v. Minister for the Civil Service* [1985] AC 374, 410, per Lord Diplock) of how public power may be misused. Once it is recognised that conduct which is an abuse of power is contrary to law its existence must be for the court to determine.

82. The fact that the court will only give effect to a legitimate expectation within the statutory context in which it has arisen should avoid jeopardising the important principle that the executive's policy-making powers should not be trammelled by the courts (see *Hughes v. DHSS* [1985] AC 766, 788, per Lord Diplock). Policy being (within the law) for the public authority alone, both it and the reasons for adopting or changing it will be accepted by the courts as part of the factual data – in other words, as not ordinarily open to judicial review. The court's task – and this is not always understood – is then limited to asking whether the application of the policy to an individual who has been led to expect something different is a just exercise of power. In many cases the authority will already have considered this and made appropriate exceptions (as was envisaged in *British Oxygen v. Board of Trade* [1971] AC 610 and as had happened in *Hamble Fisheries*), or resolved to pay compensation where money alone will suffice. But where no such accommodation is made, it is for the court to say whether the consequent frustration of the individual's expectation is so unfair as to be a misuse of the authority's power.

Fairness and the Decision to Close

83. How are fairness and the overriding public interest in this

particular context to be judged? The question arises concretely in the present case. Mr. Goudie argued, with detailed references, that all the indicators, apart from the promise itself, pointed to an overriding public interest, so that the court ought to endorse the Health Authority's decision. Mr. Gordon contended, likewise with detailed references, that the data before the Health Authority were far from uniform. But this is not what matters. What matters is that, having taken it all into account, the Health Authority voted for closure in spite of the promise. The propriety of such an exercise of power should be tested by asking whether the need which the Health Authority judged to exist to move Miss Coughlan to a local authority facility was such as to outweigh its promise that Mardon House would be her home for life.

84. That a promise was made is confirmed by the evidence of the Health Authority that:

> "...the Applicant and her fellow residents were justified in treating certain statements made by the Authority's predecessor, coupled with the way in which the Authority's predecessor conducted itself at the time of the residents' move from Newcourt Hospital, as amounting to an assurance that, having moved to Mardon House, Mardon House would be a permanent home for them".

And the letter of 7 June 1994 sent to the residents by Mr Peter Jackson, the then General Manager of the predecessor of the Health Authority, following the withdrawal of John Grooms stated:

> "During the course of a meeting yesterday with Ross Bentley's father, it was suggested that each of the former Newcourt residents now living at Mardon House would appreciate a further letter of reassurance from me.

> I am writing to confirm therefore, that the Health Authority has made it clear to the Community Trust that it expects the Trust to continue to provide good quality care for you at Mardon House for as long as you choose to live there. I hope that this will dispel any anxieties you may have arising from the forthcoming change in management arrangements, about which I wrote to you recently."

As has been pointed out by the Health Authority, the letter did not actually use the expression "home for life."

85. The Health Authority had, according to its evidence, formed the view that it should give considerable weight to the assurances given to Miss Coughlan; that those assurances had given rise to expectations which should not, in the ordinary course of things, be disappointed; but that it should not treat those assurances as giving rise to an absolute and unqualified entitlement on the part of the Miss Coughlan and her co-residents since that would be unreasonable and unrealistic; and that

> "if there were compelling reasons which indicated overwhelmingly that closure was the reasonable and-other things being equal-the right course to take, provided that steps could be taken to meet the Applicant's (and her fellow residents') expectations to the greatest degree possible following closure, it was open to the Authority, weighing up all these matters with care and sensitivity, to decide in favour of the option of closure".

Although the first consultation paper made no reference to the "home for life" promise, it was referred to in the second consultation paper as set out above.

86. It is denied in the Health Authority's evidence that there was any misrepresentation at the meeting of the Board on 7 October 1998 of the terms of the "home for life" promise. It is asserted that the Board had

taken the promise into account; that members of the Board had previously seen a copy of Mr Jackson's letter of 7 June 1994, which, they were reminded, had not used the word "home"; and that every Board member was well aware that, in terms of its fresh decision-making, the starting point was that the Newcourt patients had moved to Mardon on the strength of an assurance that Mardon would be their home as long as they chose to live there. This was an express promise or representation made on a number of occasions in precise terms. It was made to a small group of severely disabled individuals who had been housed and cared for over a substantial period in the Health Authority's predecessor's premises at Newcourt. It specifically related to identified premises which it was represented would be their home for as long as they chose. It was in unqualified terms. It was repeated and confirmed to reassure the residents. It was made by the Health Authority's predecessor for its own purposes, namely to encourage Miss Coughlan and her fellow residents to move out of Newcourt and into Mardon House, a specially built substitute home in which they would continue to receive nursing care. The promise was relied on by Miss Coughlan. Strong reasons are required to justify resiling from a promise given in those circumstances. This is not a case where the Health Authority would, in keeping the promise, be acting inconsistently with its statutory or other pubic law duties. A decision not to honour it would be equivalent to a breach of contract in private law.

87. The Health Authority treated the promise as the "starting point" from which the consultation process and the deliberations proceeded. It was a factor which should be given "considerable weight", but it could be outweighed by "compelling reasons which indicated overwhelmingly that

closure was the reasonable and the right course to take". The Health Authority, though "mindful of the history behind the residents' move to Mardon House and their understandable expectation that it would be their permanent home", formed the view that there were "overriding reasons" why closure should nonetheless proceed. The Health Authority wanted to improve the provision of reablement services and considered that the mix of a long stay residential service and a reablement service at Mardon House was inappropriate and detrimental to the interests of both users of the service. The acute reablement service could not be supported there without an uneconomic investment which would have produced a second class reablement service. It was argued that there was a compelling public interest which justified the Health Authority's prioritisation of the reablement service.

88. It is, however, clear from the Health Authority's evidence and submissions that it did not consider that it had a legal responsibility or commitment to provide a home, as distinct from care or funding of care, for the Applicant and her fellow residents. It considered that, following the withdrawal of the John Grooms Association, the provision of care services to the current residents had become "excessively expensive", having regard to the needs of the majority of disabled people in the Authority's area and the "insuperable problems " involved in the mix of long term residential care and reablement services at Mardon House. Mardon House had, contrary to earlier expectations, become:

> "a prohibitively expensive white elephant. The unit was not financially viable. Its continued operation was dependent upon the Authority supporting it at an excessively high cost. This did not represent value for money and left fewer resources for other services".

The Health Authority's attitude was that:

> "It was because of our appreciation of the residents' expectation that they would remain at Mardon House for the rest of their lives that the Board agreed that the Authority should accept a continuing commitment to finance the care of the residents of Mardon for whom it was responsible."

But the cheaper option favoured by the Health Authority misses the essential point of the promise which had been given. The fact is that the Health Authority has not offered to the Applicant an equivalent facility to replace what was promised to her. The Health Authority's undertaking to fund her care for the remainder of her life is substantially different in nature and effect from the earlier promise that care for her would be provided at Mardon House. That place would be her home for as long as she chose to live there.

89. We have no hesitation in concluding that the decision to move Miss Coughlan against her will and in breach of the Health Authority's own promise was in the circumstances unfair. It was unfair because it frustrated her legitimate expectation of having a home for life in Mardon House. There was no overriding public interest which justified it. In drawing the balance of conflicting interests the court will not only accept the policy change without demur but will pay the closest attention to the assessment made by the public body itself. Here, however, as we have already indicated, the Health Authority failed to weigh the conflicting interests correctly. Furthermore, we do not know (for reasons we will explain later) the quality of the alternative accommodation and services which will be offered to Miss Coughlan. We cannot prejudge

what would be the result if there was on offer accommodation which could be said to be reasonably equivalent to Mardon House and the Health Authority made a properly considered decision in favour of closure in the light of that offer. However, absent such an offer, here there was unfairness amounting to an abuse of power by the Health Authority.

D. HUMAN RIGHTS

90. One further element must be considered by the court. Mardon House is Miss Coughlan's home, and by Article 8(1) of the European Convention on Human Rights:

> "Everyone has the right to respect for ….. his home …".

Once the Human Rights Act 1998 is in force it will be the obligation of the court as a public authority to give effect to this value, except to the extent that statutory provision makes this impossible. In the interim between the enactment and the coming into force of the Act it is right that the courts should pay particular attention to them. Article 8(2) provides:

> "There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of … the economic wellbeing of the country…"

91. Not one but two policy decisions were in play. The first, which we have considered separately, was to let Miss Coughlan's nursing care be provided by the local social services authority. The second was to evict Miss Coughlan from the home which had been promised to her for

life in order to make better and more economic use of the premises. For reasons which we have given we do not consider that the kind of nursing care needed by Miss Coughlan could lawfully be provided by the local authority under section 21; but this need not have affected the second decision, since the Health Authority has in any case been prepared to pay for Miss. Coughlan's future nursing care wherever she is located. So the Health Authority's decision to move Miss Coughlan from Mardon House falls to be matched, irrespective of the larger healthcare provision issue, against its promise that this would not happen. To consider this properly the Health Authority needed to be in a position, which it was not, to compare what Mardon House offered with what the alternative accommodation would offer Miss Coughlan.

92. The extent to which the public cost was going to be reduced by moving Miss Coughlan to local authority care was not dramatic. The local authority and the Health Authority between them would still be paying for the whole of her care – for we have no doubt that the undertaking to pay was rightly given. The saving would be in terms of economic and logistical efficiency in the use respectively of Mardon House and the local authority home. The price of this saving was to be not only the breach of a plain promise made to Miss Coughlan but, perhaps more importantly, the loss of her only home and of a purpose-built environment which had come to mean even more to her than a home does to most people. It was known to the Health Authority, as it is known to this court, that Miss Coughlan views the possible loss of her accommodation in Mardon House as life-threatening. While this may be putting the reality too high, we can readily see why it seems so to her; and we accept, on what is effectively uncontested evidence, that an enforced move of this kind

will be emotionally devastating and seriously anti-therapeutic.

93. The judge was entitled to treat this as a case where the Health Authority's conduct was in breach of Article 8 and was not justified by the provisions of Article 8(2). Mardon House is, in the circumstances described, Miss Coughlan's home. It has been that since 1993. It was promised to be just that for the rest of her life. It is not suggested that it is not her home or that she has a home elsewhere or that she has done anything to justify depriving her of her home at Mardon House. By closure of Mardon House the Health Authority will interfere with what will soon be her right to her home. For the reasons explained, the Health Authority would not be justified in law in doing so without providing accommodation which meets her needs.. As Sir Thomas Bingham MR said in R.v. Ministry of Defence , ex parte Smith [1996] QB 517 at 554E-

> "The more substantial the interference with human rights, the more the court will require by way of justification before it is satisfied that the decision is reasonable..."

or, we would add, in a case such as the present, fair.

E. ASSESSMENT AND PLACEMENT

94. Miss Coughlan's case on this issue was that there had been no multi-disciplinary assessment of her individual needs and no risk assessment of the effects of moving her from Mardon House. These assessments were required both by the Guidance in both HSG(95)8 (paras 17-20) and HSC 1998/048 and also by the general obligation to take all relevant factors into account in making the closure decision. There should be assessment or consideration by the Health Authority of the

patients' health and social needs, including emotional and psychological needs; whether their needs are met at Mardon House; whether and to what extent their needs can be met elsewhere; and what would be the effect on each patient of a forced move from Mardon House. All this should be viewed against the background of the home for life promise.

95. Mr Gordon submitted that the only clinical assessments that were made were directed to the different issue of whether she and the other patients met the Health Authority's eligibility criteria for continuing in-patient NHS care. Those criteria were unlawful for other reasons (see paras 33-50). There was a Social Services assessment of the Applicant on 8 January 1998 which concluded that Mardon House was ideally suited to her needs. In the absence of proper multi-disciplinary and risk assessments the Health Authority could not make a lawful decision to close Mardon House.

Further, the Health Authority and the Social Services Department were required to identify an alternative placement in which her needs could be as, or more, appropriately met before they were in a position to balance the individual interests of Miss Coughlan against the reasons for closing Mardon House and make a lawful decision to close. No alternative placements were ever identified. A place in, for example, a geriatric nursing home would not be a suitable alternative placement. Against the background of the home for life promise the identification of alternative suitable homes for Miss Coughlan and the other residents should have been of paramount importance, but it was impossible to consider suitable alternative placements without the information which would have been

derived from a multi-disciplinary assessment. In the absence of such consideration the Health Authority was in no position to consult properly on the closure of Mardon House or to reach a lawful decision whether the home for life promise should be broken. Furthermore our decision as to what nursing services have to be provided by the Health Authority may result in greater demand for places at Mardon House.

96. The judge held the Health Authority had failed, prior to consultation and a decision on closure, to conduct any lawful and rational multi-disciplinary assessment of the needs of Miss Coughlan and the other patients or of the risk in relation to their health. The Health Authority had also failed to identify any alternative placement to Mardon House.

97. The Health Authority rely on the fact that it had identified 43 potential alternative new care settings prior to making the closure decision and had to the extent practicable investigated their suitability. To the extent that the Health Authority had failed to identify alternative placements, Mr Goudie submits that the judge ought to have held that that Miss Coughlan ought not to be permitted to rely on such failure since she was unwilling to co-operate with the Health Authority in any collaborative process aimed at identifying an alternative placement for her.

98. The Health Authority appeals on the ground that the judge was wrong to hold that it was required to carry out a multi-disciplinary assessment before consulting on and arriving at its closure decision. Under the 1995 Guidance what was required was such an assessment of the patient's needs before any decision was made about the discharge of the patient

from NHS care or on how their continuing care needs might best be met. The closure decision was not, as Miss Coughlan contended, a collective decision to discharge the individual patients. Under the 1998 Guidance there were four distinct stages in the transfer process, the first of which was the closure decision and it was only after that that the detailed transfer procedures operated. It was submitted that it would be impracticable and unrealistic in the vast majority of cases to carry out the assessments and to identify alternative placements prior to a closure decision, let alone prior to consultation on a proposed closure. Funds for the development of alternative facilities might only become available after the closure decision is taken; only then would the range of alternative available placements become clear; large closure programmes might take years to implement, in which case assessments and alternative facilities considered at the time of consultation or closure would change over time; and in practice the necessary co-operation of individual patients for effective assessments and alternative placements might be more difficult to obtain before rather than after a final decision has been taken on closure. Mr Goudie QC submitted that these issues are of great practical importance for health and social services authorities throughout the country.

99. The Health Authority contended that, in any event, the judge was wrong in holding that multi-disciplinary assessment of Miss Coughlan's needs had not been undertaken in accordance with the 1995 Guidance. Prior even to consultation on the closure there had been three clinical assessments of Miss Coughlan as well as a Social Services assessment.

100. To the extent that the required assessments had not been carried out in accordance with the Guidance, the Health Authority submitted that the judge had failed to address the question whether this was the result of Miss Coughlan's unwillingness to co-operate in the assessment with the Health Authority and the Social Services in the manner and to the extent contemplated by the Guidance. This was disputed by Miss Coughlan, who contended that she co-operated with the assessments that were made and that she would have fully co-operated with any multi-disciplinary assessment had it been offered. It was also pointed out that this criticism has not been made of the other two residents.

101. The Health Authority also contended that the judge was wrong to hold that it was under an obligation to identify alternative placements for Miss Coughlan prior to the closure decision. Reliance was placed on the stages of the transfer procedure referred to above. It was submitted that the obligation to consider the options for where care might best be provided only arose at the third stage of the four stage process. The new care setting for each individual patient was only identified at the fourth stage of the transfer process.

102. In our judgment the Health Authority's handling of the assessments and the finding of suitable alternative placement was not established as a separate ground for challenging the decision to close Mardon House.

103. The concerns of the Health Authority about the practical implications of the judge's decision on these two points are well understood. In the absence of special circumstances, normally we would

expect it to be unrealistic and unreasonable, on grounds of prematurity alone, for the Health Authority in all cases to make assessments of patients and to take decisions on the details of placement ahead of a decision on closure. Neither the statutory provisions nor the Guidance issued expressly require assessments to be made or decisions on alternative placements to be taken before a decision to close can be lawfully made.

104. If and when a decision is taken to discharge Miss Coughlan and to place her in alternative accommodation, it may be open to her, on the grounds of the alleged shortcomings in the assessment procedures and in the consideration of alternative placements, to challenge the lawfulness of those decisions.

105. It is, however, unnecessary to say more generally about the timing of those decisions in view of the special circumstances of this case, namely the impact of both the promise of a home for life issue and the unlawfulness of the eligibility criteria on the assessment and placement issues.

106. If, as we hold, the promise of a home for life at Mardon House rendered the decision to close it at this stage an abuse of power, there is no need to address the question of whether a suitable alternative placement could be found offering conditions similar to those available at Mardon House.

107. Further, if, as we hold, the eligibility criteria were in themselves unlawful, it follows that those assessments of Miss Coughlan

(and the other patients) which have been made on the basis of the criteria cannot fairly be treated as assessments for the purpose of making a decision, whether it be before closure, as she contended it should be, or after closure, as the Authority contended it should be, to discharge Miss Coughlan from Mardon House or to place her elsewhere.

CONSULTATION

108. It is common ground that, whether or not consultation of interested parties and the public is a legal requirement, if it is embarked upon it must be carried out properly. To be proper, 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 LBC ex parte Gunning* [1986] 84 LGR 168).

109. We have dealt separately with the impact of the home-for-life promise and with the assessments made of the applicant. These had a bearing, of course, on the content of the consultation process, but we are concerned here with the machinery of consultation. Central to Miss Coughlan's successful critique of it was the report of Dr Clark, which is summarised in paragraph 16 above. Hidden J held:

> "... the decision process ended with the Board considering the ethical decision-making paper which said that 'Professionals advise that leaving the residents isolated will do particular harm to two residents' (page 1760). Next to that sentence

> was the further information that "Professionals advice that no moving the acute service will do harm to other disabled people". Such a combination of arguments in favour of the decision to close Mardon House ... were unseen by the applicant and therefore not something upon which she could comment or which she could refute. They are far from the stuff of which true consultation is made.
>
> The same is true of the report of Dr Clark which was commissioned by the respondent and seen by the Board who drew comfort from it but not seen by the applicant and the other consultees who would have wished to refute it".

110. Hidden J was also impressed by the letter from the Health Authority commissioning Dr Clark's report. It anticipated a judicial review hearing following the "final decision" , suggesting an anticipation that the decision would be in favour of closure. He rejected the Health Authority's reason – lack of time – for the non-disclosure of Dr Clark's report; and he went on to deduce from it that the consultation process had been too hurried to meet the *Gunning* standard. He concluded that none of the four *Gunning* criteria were met.

111. Although the notice of appeal does not contest every one of the judge's findings about consultation, Mr Goudie attacks his conclusion in relation to three critical issues: Dr Clark's report, the length of the consultation period and the question of pre-judgment.

112. Miss Coughlan's solicitor received Dr Clark's report only two working days before the Board met on 7 October, a date well after the end of the consultation period, which had run only to 24 September 1998. Although Mr Goudie's skeleton argument focuses upon the substance of Miss Coughlan's opportunity to respond, he has taken in oral argument a point which seems to us to be sound and to bypass this debate: there

was, he submits, no need to consult on Dr Clark's report, which was external advice on the opinions of local clinicians and was therefore itself a response to the consultation, albeit one solicited by the Health Authority. It has to be remembered that consultation is not litigation: the consulting authority is not required to publicise every submission it receives or (absent some statutory obligation) to disclose all its advice. Its obligation is to let those who have a potential interest in the subject matter know in clear terms what the proposal is and exactly why it is under positive consideration, telling them enough (which may be a good deal) to enable them to make an intelligent response. The obligation, although it may be quite onerous, goes no further than this.

113. We accept, too, Mr Goudie's submission that the letter went from an officer of the Authority and not from any of its decision-makers. It did undoubtedly reveal an anticipated outcome, but the mind was not that of a decision-maker. It may well be, as Mr Gordon suggests, that Dr Clark would have had little difficulty in deducing which way Mrs Jefferies, who wrote the letter to him, would prefer his advice to go; but this is a long way from a case of pre-judgment in either the Authority or the adviser.

114. The formal consultation period lasted just over three weeks, from 2 to 24 September 1998. It had, however, been preceeded by an eight-week consultation period in the first months of the year, leading to the first closure decision which was quashed by consent. Among the effects of the shortage of time identified by Mr Gordon is the loss of a proper opportunity to comment on Dr Clark's report. Mr Goudie relies not only on the pre-history of consultation but on the fact that the consultation

paper itself had an input from the applicant and her advisers: they had had it in draft some weeks before the beginning of the consultation period, and had made their view known. There seems to us to be strength in the Health Authority's position in this regard.

115. Mr Gordon, however, defends Hidden J's conclusion by reference to a number of other aspects of the consultation. It turned out when the consultation was over that the Health Authority had had before it a paper on ethical decision-making which Miss Coughlan and her advisers would have wanted an opportunity to comment on. The paper, it seems to us, is of the same character as Dr Clark's report. It was not a part of the proposal and not necessary to explain the proposal. The risk an authority takes by not disclosing such documents is not that the consultation process will be insufficient but that it may turn out to have taken into account incorrect or irrelevant matters which, had there been an opportunity to comment, could have been corrected. That, however, is not this case.

116. There is, it is true, a further list of flaws with which Mr Gordon submits the consultation process was riddled. Without reciting these, we consider that all are points which within the admittedly modest time available were fully capable of being pointed out to the Health Authority before it met to take its decision. To draw attention to them now is not to the point.

117. We conclude therefore that although there are criticisms to be levelled at the consultation process, and although it ran certain risks, it was not flawed by any significant non-compliance with the *Gunning*

criteria.

CONCLUSIONS

It follows that, although we disagree with some of the reasoning of the judge, Miss Coughlan was entitled to succeed and we dismiss the appeal.

Our conclusions may be summarised as follows :

(a) The NHS does not have sole responsibility for all nursing care. Nursing care for a chronically sick patient may in appropriate cases be provided by a local authority as a social service and the patient may be liable to meet the cost of that care according to the patient's means. The provisions of the Health Act and the Care Act do not, therefore, make it necessarily unlawful for the Health Authority to decide to transfer responsibility for the general nursing care of Miss Coughlan to the local authority's social services. Whether it was unlawful depends, generally, on whether the nursing services are merely (i) incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide and (ii) of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide. Miss Coughlan needed services of a wholly different category.

(b) The consultation process adopted by the Health Authority preceding the decision to close Mardon House is open to criticism, but was not unlawful.

(c) The decision to close Mardon House was, however, unlawful on the

grounds that:

(i) The Health authority reached a decision which depended on a misinterpretation of its statutory responsibilities under the Health Act.

(ii) The eligibility criteria adopted and applied by the Health Authority for long term NHS health care were unlawful and depended on an approach to the services which a local authority was under a duty to provide which was not lawful.

(iii) The decision was an unjustified breach of a clear promise given by the Health Authority's predecessor to Miss Coughlan that she should have a home for life at Mardon House. This constituted unfairness amounting to an abuse of power by the Health Authority. It would be a breach of Article 8 of the European Convention

(d) In these circumstances assessments of Miss Coughlan and other patients on the basis of the eligibility criteria were also similarly flawed.

Order: Appeal dismissed with costs.