Neutral Citation Number: [2023] EWHC 43 (Admin)

Case No: CO/4311/2021

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 16/01/2023

Before:

MR JUSTICE CHAMBERLAIN

- -

Between:

THE KING
on the application of
(1) AA (a child, acting by her father and litigation friend SW)
(2) AK (a child, acting by her mother and litigation friend CK)
(3) ALEXANDER HARVEY
(4) EVA ECHO
(5) GENDERED INTELLIGENCE
(6) GOOD LAW PROJECT LIMITED

Claimants

-and-

NATIONAL HEALTH SERVICE COMMISSIONING BOARD
(operating under the name of NHS ENGLAND)

Defendant

-and-

(1) TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST
(2) DEVON PARTNERSHIP NHS TRUST

Interested Parties

- -

David Lock KC and Jason Pobjoy (instructed by **Rook Irwin Sweeney LLP**) for the **Claimants**
Eleanor Grey KC (instructed by **Blake Morgan LLP**) for the **Defendant**

Hearing dates: 29 and 30 November 2022

- -

Approved Judgment

This judgment was handed down remotely at 10.30am on 16 January 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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MR JUSTICE CHAMBERLAIN

Mr Justice Chamberlain:

Introduction

1 Since 2012, NHS England ("NHSE") has had the function of commissioning specified services for rare and very rare conditions. These include gender identity development services for children and adolescents ("children's GID services") and gender identity disorder services for adults ("adults' GID services"). The demand for these services increased substantially from 2012 to 2017, but capacity did not keep pace with this demand. The result has been very long waiting times for the children, adolescents and adults referred for these services.

2 The first two claimants, AA and AK, are children who have been referred to the Tavistock and Portman NHS Foundation Trust ("Tavistock"), which is currently the sole provider of children's GID services. When this claim was filed, AA had been waiting 18 months for a first appointment and AK had been waiting nearly three years. The third and fourth claimants, Alexander Harvey and Eva Echo, are adults. Both have been referred for treatment at a gender dysphoria clinic. At the time when the claim was filed, Mr Harvey had been waiting over 2 years for a first appointment and Ms Echo over 4 years, though she has had some treatment for which she paid privately. The fifth claimant is a trans-led charity working across the UK, whose mission is to increase understanding of gender diversity and improve the lives of trans people. The sixth claimant is a not-for-profit company which campaigns on a wide variety of issues, including the rights of the transgender community.

3 There were originally six grounds of challenge. Only five are now pursued. These are that NHSE has acted unlawfully by:

(a) breaching its statutory duty under reg. 45(3) of the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ("the 2012 Regulations") to ensure that 92% of NHS patients referred for the services it commissions have commenced appropriate treatment within 18 weeks of referral (**Ground 1**);

(b) breaching its statutory duty under s. 3B of the National Health Service Act 2006 ("the 2006 Act") by arranging services for children who may need puberty-delaying treatment in such a way that the children will be unable to access the services before the onset of puberty (**Ground 2**);

(c) breaching its statutory duty under s. 2 of the Health Act 2009 by failing to have regard to the right of adult gender dysphoria patients under the NHS Constitution to commence treatment within 18 weeks of referral (**Ground 3**);

(d) directly or alternatively indirectly discriminating against the first to fourth claimants, because they have the protected characteristic of gender reassignment, contrary to s. 29 of the Equality Act 2010 ("the 2010 Act") (**Ground 4**); and

(e) failing to comply with the public sector equality duty in s. 149 of the Equality Act 2010 in making arrangements for the provision of services to people seeking treatment for gender dysphoria (**Ground 6**).

Background

Conditions and treatments

4 In this field, terminology matters. I have followed the terminology recommended by one of the claimants' witnesses, Dr Michael Toze, Senior Lecturer Public Health and Social Determinants at Lincoln Medical School.

5 "Trans" is an umbrella term describing people who do not identify with the sex they were assigned at birth. Some, but not all, trans people undergo a process of social, legal and/or medical transition in order to live a life that better aligns with their sense of self. This case concerns a sub-set of trans people: those seeking medical help in connection with their gender identity.

6 The understanding of the medical condition for which treatment is given has changed over the years. The two diagnoses currently in use are "gender dysphoria" (the term used in the current edition of the Diagnostic and Statistical Manual: DSM-V) and "gender incongruence" (the term used in the current edition of the International Classification of Diseases: ICD-11). ICD-11 distinguishes between "gender incongruence of childhood" and "gender incongruence of adolescence and adulthood". Neither is classified as a mental health condition; both are "conditions relating to sexual health".

7 A number of therapies are available to help those with gender incongruence to live and present themselves in a way they feel comfortable with. These include hormonal therapies, surgery, voice therapy and electrolysis to remove hair. Specialist psychological therapy is also available, though it is not routinely offered to adults. Some trans people referred for treatment decide not to have any of these therapies; some decide to have one or more, but not others.

The services provided

8 The principal evidence as to the services provided to those referred for treatment for gender dysphoria/gender incongruence comes from the witness statements of Jeremy Glyde, Head of the Medical Projects Team (Specialised Commissioning Directorate) at the NHS Commissioning Board. As he explains, NHSE has operated alongside a legally distinct body, NHS Improvement. The two organisations operated as a single team and were referred to as "NHSE/I" until 1 July 2022, when the functions of NHS Improvement were formally assumed by NHSE under the Health and Care Act 2022. In this judgment, I have used the term "NHSE" throughout, rather than distinguishing between NHSE/I (pre-1 July 2022) and NHSE (afterwards).

Services for children and adolescents

9 A service for children and adolescents presenting with gender incongruence has been commissioned by the NHS since the 1990s. The current Service Specification came into effect in 2016, following stakeholder engagement and public consultation. It follows the World Professional Association for Transgender Health Standards of Care, version 7 (which is currently under revision). It was also informed by existing practice at Tavistock, a Mental Health Trust, which runs the children's GID service and is currently the sole commissioned provider of that service in England.

10 The service is led not by a consultant medical practitioner, but by a clinical psychologist. The service specification describes the psychosocial and psychological aspects of the clinical pathway delivered directly by the children's GID service and also provides that referrals may be made to consultant paediatric endocrinologists at University College London Hospital or Leeds Teaching Hospital for assessment for suitability for treatment with gonadotropin releasing hormone analogues ("puberty blockers") or, from the age of around 16, exogenous gender affirming hormones.

11 The service receives 93% of its funding from NHSE and the remainder from NHS Wales and other commissioning bodies, such as those for the Channel Islands and the Republic of Ireland. The portion of annual funding which comes from NHSE has increased from £2.6m in 2015/16 to £4.1m in 2016/17, to £5.5m in 2017/8, to £5.7 in 2018/9, to £8.1m in 2019/20, to £8.2m in 2020/21, to £8.3m in 2021/22. The increase in funding from 2015/16 to 2021/22 was 219%. Tavistock has, however, been unable to increase its capacity commensurately. In the 15 months to May 2020, it had particular difficulty recruiting and retaining staff. Its clinical establishment was 62.5 whole time equivalents ("wte"), 20% lower than it had been in 2020, of whom only 43.6 were capable of independently assessing and diagnosing patients.

12 Despite the attrition in staff numbers, NHSE did not reduce the funding available to Tavistock and, during 2020/21 and 2021/22, invited Tavistock to submit proposals for deploying additional investment to increase clinical capacity or otherwise support children and adolescents on the waiting list. NHSE has indicated that it is prepared to make available funding without the need for prior authorisation for Tavistock to fill vacant clinical posts up to its previous clinical establishment of 84.5 wte. At the time of signing his statement in June 2022, Mr Glyde said that it was not likely that this would be achieved before December 2022 at the earliest and, even then, new staff would have to receive training, which would reduce the number of clinical staff available for treating patients.

13 In 2019, NHSE asked Dr Hilary Cass OBE, a retired consultant paediatrician and former President of the Royal College of Paediatrics and Child Health, to chair a working group to examine the published evidence so as to inform a review of how the NHS commissions puberty blocking drugs and exogenous hormone drugs for children seen by the children's GID service. Initially the work centred on requests to NICE for a formal review of the evidence on the efficacy of puberty blockers and gender affirming hormones. NICE delivered its evidence reviews in 2021, concluding that the evidence about risks, benefits and long-term outcomes remained uncertain.

14 Over 2020, a number of concerns began to be expressed publicly about the clinical practice of the children's GID service. Mr Glyde says that Dr Cass became "something of a lightning rod for whistle-blowers, including clinicians who had worked in [the service], worried about the processes and clinical approach they felt were adopted by [the service], including a perception of affirmation bias". By the summer 2020, some of these concerns had reached the Care Quality Commission, the Office of the Children's Commissioner and NHSE. There was litigation before the Divisional Court and the evidence filed "served to highlight the acute socially and medically contested nature of the work of the [children's GID service] and, in particular, the use of puberty blocking hormones for children presenting to the service". There was also increasing concern about the referral trajectory, the growing prominence of a cohort of natal females and the incidence of children being referred to the service with autism or who were neuro-

diverse. This contributed to the decision, in September 2020, to commission a wider review by Dr Cass ("the Cass Review"), a decision welcomed by Tavistock.

15 On 1 December 2020, the Divisional Court handed down its judgment in *R (Bell) v Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin), [2021] PTSR 593. The court held that it was highly unlikely that a child aged 13 or under would be competent to give consent for treatment with puberty blockers and doubtful that a child aged 14 or 15 could do so. This caused Tavistock to suspend immediately new referrals for puberty blockers and related endocrinology clinics at University College London Hospital and Leeds Teaching Hospital. NHSE made an urgent amendment to withdraw from the Service Specification all new referrals of children under 16 to endocrinology clinics for puberty blockers, save where there was a "best interests" court order in place.

16 In January 2021, the CQC published its report into the children's GID service. Its contents concerned NHSE because of inadequacies relating to consent and capacity assurance and the development of properly recorded care plans.

17 In March 2021, Lieven J handed down her judgment in *AB v CD* [2021] EWHC 741 (Fam). She held that parents could validly consent to treatment with puberty blockers in cases where the child was not *Gillick*-competent. However, she expressed concerns, which she considered were better dealt with by regulators than by courts, and suggested that it may be appropriate that "additional safeguards" should be built into clinical decision-making, for example a requirement for a second opinion. She also said that finely balanced cases should be brought to court: see [122]-[128].

18 This led to the establishment of a Multi-Professional Review Group, chaired by Prof. Judith Ellis, who had been Director of Nursing, Education, Workforce Development and HR at Great Ormond Street Hospital for Children and Chief Executive of the Royal College of Paediatrics and Child Health. The task of this Review Group was to achieve assurance about clinical practices and safeguarding disciplines in individual cases where referrals to endocrinology were made by Tavistock. Prof. Ellis has given a statement in these proceedings.

19 In September 2021, the Court of Appeal handed down judgment in *Bell*, overturning the decision of the Divisional Court: [2021] EWCA Civ 1363, [2022] PTSR 544. The response was a further change to the Service Specification reversing the change made in the light of the Divisional Court's judgment and formalising the status of the Multi-Professional Review Group.

20 Dr Cass published interim advice in February 2022 in which she concluded that the current delivery model is not sustainable and a new national service was needed, comprising regional services working to a fundamentally different service model more in line with other paediatric provision. She said this:

> "The staff working within the specialist service demonstrate a high level of commitment to the population they serve. However, the waiting list pressure and lack of consensus development on the clinical approach, combined with criticism of the service, have all resulted in rapid turnover of staff and inadequate capacity to deal with the increasing workload. Capacity

> constraints cannot be addressed through financial investment alone; there are some complex workforce (recruitment; retention; and training) and cultural issues to address".

21 Dr Cass sent a follow-up letter in July 2022 in which she said that there was a need to move away from the current model of a sole provider and to establish regional services working to a new clinical model. Regional centres should be established, led by experienced providers of tertiary paediatric care, to ensure a focus on child health and development, with strong links to mental health services. These should generally be specialist children's hospitals with established academic and education functions. The original services should be networked to connect with other local services including children's and young people's mental health services and primary care. The services should have an appropriate multi professional workforce. Staff should maintain a broad clinical perspective.

22 NHSE published its response on 28 July 2022 indicating that the children's GID service at Tavistock would be decommissioned on a managed basis by the spring of 2023. NHSE would commission new services for children and young people by the spring of 2023, managed by two centres: Alder Hey Children's Hospital in Liverpool, working in partnership with Manchester Children's Hospital; and Great Ormond Street Hospital for Children, working in partnership with Evelina Children's Hospital and South London and Maudsley NHS Foundation Trust. Other regional services will be commissioned by NHSE from 2023/24 and NHS he will work with the Cass review to develop a substantive service specification for the new services.

23 NHSE's planning assumption is that seven or eight new services for children and young people will be established and operational by 2024, on a phased basis. These new services will be directly commissioned and funded by NHSE. This will require "a significant increase in funding over the current level of funding for the [children's GID service] at Tavistock".

Services for adults

24 Adults' GID services have been provided under an interim specification put in place soon after NHSE assumed commissioning responsibility on 1 April 2013. Capacity was under pressure from the outset as a result of rising demand for the services and the lack of specialist clinical practitioners. Pressure has increased over time.

25 Prior to 2019/20, there were seven specialist centres in England, based in or near Newcastle, Leeds, Sheffield, Northampton, Nottingham, London and Exeter. These are now known as gender dysphoria clinics. Each of them is staffed by a multidisciplinary team led by a senior clinical lead with appropriate experience and expertise. The clinicians involved include consultant endocrinologists, clinical nurse specialists, clinical psychologists, consultant psychiatrists, consultant physicians and voice and communications specialists. Mr Glyde says that it has been, and continues to be, difficult to attract clinicians with the required specialisms into gender identity healthcare.

26 The current service specification relies on general practitioners ("GPs") to support the work of the gender dysphoria clinics by prescribing endocrine interventions recommended by specialists and by monitoring patients receiving treatment with these drugs. However, in recent years professional bodies representing primary care

practitioners have expressed concerns about competency to prescribe these interventions and the workability of shared care arrangements.

27 NHSE's work to address long waiting times for gender identity treatment began in 2015, when it began to develop a new Service Specification. This involved a large public consultation supported by face-to-face events across the country. New surgical and non-surgical specifications were agreed in 2018/19 and formally adopted on 1 April 2020 following conclusion of a new tender. Five new pilot services have been developed. The model used gives much greater emphasis to addressing an individual's health needs holistically in partnership with other local health and social care services and it is hoped that the new Integrated Care Boards will be well placed to "grow" this integrated model. The models operated by the pilot services differ to some extent. All prioritise patients on existing waiting lists. Further detail about the new pilot services is provided in the witness statement of Dr John Dean, formerly Chair of NHSE's Gender Identity Services Clinical Reference Group, who considers that the new capacity building measures "will result in an exponential increase in capacity to deliver gender identity health care over the next few years", though this is not expected to happen immediately.

28 NHSE has also agreed to establish and fund the UK's first accredited training programme in gender identity healthcare, which was launched in 2020 with the assistance of the Royal College of Physicians. The programme leads to a postgraduate certificate of diploma awarded by the University of London. The purpose is to increase substantially the specialist clinical workforce available to contribute to the assessment and care of those presenting with gender incongruence and to the treatment of those with a diagnosis of gender dysphoria.

29 Discussions began in 2019 with the Royal College of Surgeons with a view to the introduction of a new accreditation for surgeons specialising in this area of practice. These have not yet yielded results, but as an interim measure, NHSE is funding a number of surgical fellowships. Surgeons are also being brought in from abroad to train surgeons here in the required techniques.

30 The total funding for adult gender dysphoria services has progressively increased from £10m in 2015/16 to £19.2m in 2022/3, in addition to the £8.9m allocated for the five pilot services in 2022/23.

Waiting times

31 Andrew Jackson is Director of Performance Information at NHSE. He explains in his witness statement that NHSE collects Referral to Treatment Time ("RTT") data for its consultant-led services. These data are published on a monthly basis. For NHSE commissioned services, the proportion of patients whose first appointment is less than 18 weeks after referral has dropped from 85% in January 2019 to 57% in March 2022. The figures for CCG/ICB commissioned services are broadly comparable (87% in January 2019, dropping to 63% in March 2022). It is plain that the pandemic is a major cause of these drops.

32 Tavistock's website explains that, in May 2022, young people seen for the first time following a children's GID service referral waited on average for 1066 days (i.e. 152

weeks). Between 1 January and 31 March 2021, the average waiting time from referral to first appointment was 95 weeks.

33 As at August 2022, there were 26,234 adults waiting for a first appointment at a gender dysphoria clinic, 90% of whom had been waiting over 18 weeks.

34 Mr Glyde says this:

> "The position with regard to waiting lists and waiting times remains one of acute difficulty, in relation to both access to gender dysphoria services and the wider services commissioned by NHS England. Sustained efforts are however being made by NHS England to address these issues; I have outlined the work to expand the quality and capacity of services in relation to the specific topic of the gender dysphoria services above but, as I set out in my first witness statement, this is not a problem that can be addressed by financial investment alone. There are well-reported chronic workforce shortages across many clinical specialties that impede progress, including for paediatric and adult gender dysphoria services. Additionally, the approach for commissioning the [children and young persons'] gender dysphoria service in particular has to address a number of unique and complex challenges relating to safety, safeguarding and quality – against a limited and contested evidence base and lack of professional consensus."

The effect of long waiting times on the claimants

35 AA's father explains that AA was born as a boy but gravitated towards girls' clothes and toys from a young age. She had problems with bullying at school. At the age of 9, she went from saying that she wanted to be a girl to saying, "I am a girl". She was referred by her GP to the children's GID service at Tavistock in May 2020. When school started after the lockdown in September 2020, she returned as a girl and changed her first name. She was happy in her new identity for about a year, but this happiness has been disrupted by the early signs of male puberty. As time goes on, her anxiety increases. By April 2021, AA's father had heard nothing from Tavistock. He contacted AA's GP, but was told that they would have to wait, though mental health support was available. The impact on AA of progressing through male puberty is "absolutely devastating". Her father explains: "As her body develops into a man's body, she is becoming increasingly distressed and sad." Her father is concerned that, if she does not access treatment soon, she will be left with lifelong mental health issues.

36 AK's mother explains that AK was born male. At around the age of 8, she started to express an interest in girls' clothes and wanted to grow her hair long. At the age of 9, she started to say, "I want to be a girl". By the age of 10, she was adamant that she wanted to be known as a girl, have a girl's name and to be treated by others as a girl. In January 2021, when she was 11, AK was referred by her GP to the children's GID service at Tavistock. Her mother chased Tavistock in December 2021 and was told that the waiting time was around 2 years. At the time of writing her statement (December 2021), AK was 13. She had not then started to go through puberty. She has said that she does not want to be a boy or look like a boy. The thought of going through male puberty distresses her.

AK's mother is worried about this. She has asked about private treatment, but it is not affordable.

37 Alexander Harvey was 20 at the time of signing his witness statement. He was assigned as female at birth, but, at around the age of 13, started to realise he did not feel like a cisgender woman. As other girls grew up and started wearing more grown-up clothes, he felt strongly that he did not wish to dress like them. At the age of 15, with support from a friend, he started to explore his gender identity. He tried on some men's clothing and felt what is sometimes referred to as "gender euphoria". He felt like the person he was looking at was the "real" him. In the summer of 2019, when he was 17, he went to his GP to request referral to NHS gender identity services. He was referred to Tavistock, which is his local gender identity clinic. Since the referral, Tavistock has not contacted him. Whenever he contacts them, he is told that waiting times are long and they do not know when he will receive his first appointment. The delay causes him "extreme distress, as it means that I have to continue to live in a body which I don't feel is mine and which does not reflect who I am". He suffers from anxiety and sometimes panic attacks when confronted with his female body. His breasts feel like tumours that should not be there. He has changed his name by deed poll.

38 Eva Echo was 41 at the time of signing her statement. She is a freelance blogger, spokesperson, educator and activist, with a focus on trans rights and inclusion. Though assigned as male at birth, she has known since she was 4 or 5 years old that she felt different from those around her. The feeling stayed with her through puberty and into adult life. In 2016, she was playing drums for a band on a UK tour and felt like a fraud presenting as a man. In 2017, at the age of 37, she reached a point where she could no longer keep her feelings under the surface and was at risk of taking her own life. She came out as trans. She requested a referral to a gender identity clinic and, having done some research, discovered that The Laurels in Nottingham had the shortest waiting times. She was put on the waiting list in October 2017 and, at the time of writing her statement (December 2021) had not received any further correspondence to indicate when her first appointment would be. She felt she had no choice but to seek private treatment. She says that, although she has now had various private treatments, "[d]uring a time of intense distress and need, my suffering has been made worse because of the lack of support".

Legal framework

39 Part 1 of the 2006 Act, as amended by the Health and Social Care Act 2012, is concerned with the promotion and provision of the National Health Service in England. Section 1 imposes on the Secretary of State the duty "to continue the promotion in England of a comprehensive health service designed to secure improvement (a) in the physical and mental health of the people of England, and (b) in the prevention, diagnosis and treatment of physical and mental illness". Section 1H(1) establishes NHSE as a body corporate. Section 1H(2) provides that the duty in s. 1 is owed jointly by the Secretary of State and the NHSE, except in relation to that part of the health service provided in pursuance of the public health functions of the Secretary of State or local authorities. Section 1H(3) confers on NHS England the function of arranging for the provision of services for the purposes of the health service in England.

40 Section 3A confers on integrated care boards ("ICBs") the power to arrange for the provision of services or facilities for those for whom they have responsibility. Most services are commissioned under this power. But, by s. 3A(3), the services or facilities

which an ICB may commission do not include those whose provision NHSE is required to arrange for.

41 Section 3B confers on the Secretary of State the power to make regulations requiring NHSE to arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision as part of the health service of four categories of services. The fourth, (d), is "such other services or facilities as may be prescribed".

42 Section 6E(1) empowers the Secretary of State to make regulations to impose requirements in relation to the commissioning functions of NHSE or ICBs, including "(a) requiring [NHSE] or [ICBs] to arrange for specified treatments or other specified services to be provided or to be provided in a specified manner or within a specified period".

43 Regulation 11 of the 2012 Regulations deals with specified services for rare and very rare conditions. It imposes on NHS England the duty to arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision as part of the health service of the services specified in Schedule 4. These include, in paras 56 and 57, "Gender identity development services for children and adolescents" and "Gender identity disorder services" (for adults).

44 Regulation 45 imposes a duty on a "relevant body" to "make arrangements to ensure that at the end of each data collection period, not less than 92% of the persons falling within paragraph (4) have been waiting to commence appropriate treatment for less than 18 weeks". Relevant bodies are ICBs (in respect of the mainstream services they are required to commission) and NHSE (in respect of the services they are required to commission, including those for rare and very rare conditions). A person falls within para. (4) if (a) the relevant body has responsibility for that person, (b) there has been a start date in respect of that person and (c) the person's waiting time, as specified in reg. 46, has not come to an end.

45 "Start date" is defined by reg. 44(1) as:

> "…the date on which the person's referral request was received by the health service provider to whom that person has been referred for the provision of health care services by—
>
> (a) in regulations 45 to 51—
>
> (i) an eligible referrer; or
>
> (ii) themselves, with the prior approval of an eligible referrer, or
>
> (b) in regulations 52 and 53, a general medical practitioner, a general dental practitioner or a person authorised to act on their behalf".

46 "Eligible referrer" is defined in reg. 44(1) as:

> "(a) a general dental practitioner,
>
> (b) a general medical practitioner,

> (c) a person approved to make an elective referral under arrangements made by the relevant body which has responsibility for the person being referred, and
>
> (d) any other person whose request to refer is accepted by—
>
> (i) a consultant,
>
> (ii) a member of a consultant's team, or
>
> (iii) persons providing interface services where a person who has been referred may be referred on from those services to a consultant or consultant-led team, who is to provide the assessment or treatment required as a result of a referral".

47 "Health service provider" is defined in reg. 2 as "a person, other than a relevant body, who has entered into a commissioning contract".

48 Regulation 46 defines when the waiting time comes to an end. Materially for present purposes, it is when "[t]he referred person commenced therapy or received a healthcare science intervention where a consultant, a member of a consultant-led team or an individual providing an interface service decides that the therapy or that intervention is the treatment that is most appropriate for that person".

49 Regulations 47 and 48 impose the duty to offer an alternative provider. Regulation 47 explains when the duty arises, namely, when the conditions in paras (2) to (6) are met. Those conditions are as follows:

> "(2) A person has been referred to a health service provider ('the relevant health service provider') for the provision of health care services by—
>
> (a) an eligible referrer; or
>
> (b) themselves, with the prior approval of an eligible referrer.
>
> (3) The referral is for assessment or treatment in the course of the provision of health care services by—
>
> (a) a consultant;
>
> (b) a member of a consultant's team; or
>
> (c) persons providing interface services where a person who has been referred may be referred on from those services to a consultant or consultant-led team.
>
> (4) The relevant health service provider, or the relevant body which has responsibility for the person referred, has been notified that the person referred—
>
> (a) has not commenced appropriate treatment; or

> (b) will not have commenced appropriate treatment, within eighteen weeks, beginning with the start date.
>
> (5) The notification referred to in paragraph (4) was given by—
>
> (a) in the case of the relevant health service provider or an integrated care board lawfully acting on their behalf; or
>
> (b) in the case of the Board, an integrated care board lawfully acting on their behalf.
>
> (6) The relevant body which has responsibility for the person referred is satisfied that the person has not commenced or will not commence appropriate treatment within eighteen weeks, beginning with the start date."

50 Regulation 48 imposes on the relevant body the duty, subject to reg. 49, to take all reasonable steps to ensure that the person is offered an appointment in accordance with a consultant or a member of a consultant's team or persons providing interface services at a suitable health care provider other than the relevant health service provider. "Suitable health care provider" is defined in reg. 44(1) as a health service provider who (a) can provide services which consist of, or include, treatment which is clinically appropriate for that person in response to the reasons for the referral, and (b) will provide those services pursuant to a commissioning contract with a relevant body. The effect of this is that reg. 48 has no application in any case where there is no alternative health care provider which has a commissioning contract.

51 Regulation 49 sets out a series of exceptions to the duty in reg. 48 to offer an alternative provider.

52 Regulation 50 provides that in carrying out its duties under regs 45 and 48, a relevant body must have regard to the document entitled *The Referral to Treatment Consultant-led Waiting Times Rules Suite dated October 2015* ("the Rules Suite"), which includes this:

> "Under the NHS Constitution patients have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of alternative providers if this is not possible and the patient requests it."

53 Guidance issued by the Department of Health in January 2012 provides:

> "The 18 weeks commitment is a universal right, as set out in the NHS Constitution and the NHS Operating Framework. This commitment should be delivered for every patient, in every specialty and in every organisation unless the patient chooses otherwise or it is not in their best clinical interest. The tolerances provided by the national 18 weeks operational standards (a minimum of 90 percent for admitted patients and 95 percent for non-admitted patients to start treatment within 18 weeks) are for

> patients who choose to wait longer or for whom this is clinically appropriate."

54 These references to the NHS Constitution are to a document last updated in January 2021 and said to establish the "principles and values of the NHS in England". By s. 2 of the Health Act 2009, NHSE, ICBs and certain other NHS bodies are required, in performing their health service functions, to have regard to it. It says this:

> "You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution."

55 The NHS Constitution is supplemented by a Handbook which states that the right to access certain services commissioned by NHS bodies within maximum waiting times includes the right to start consultant-led treatment within a maximum of 18 weeks for non-urgent conditions.

Ground 1

Submissions for the claimants

56 For the claimants, David Lock KC submits that reg. 45 imposes a "hard-edged" legal duty to ensure that treatment commences for at least 92% of patients within 18 weeks of referral. On its face, this applies to all referrals to a "health service provider" – and not only referrals to consultant-led or interface services. Paragraph 3.7 of the Service Specification for the children's GID service at Tavistock requires the assessment process to begin within 18 weeks of referral. This is a binding legal obligation: see by analogy *R (National Aids Trust) v NHSE* [2016] EWHC 2005 (Admin), [2016] PTSR 1093.

57 Tavistock had been in breach of that obligation for several years prior to the pandemic. NHSE is the only party able to enforce compliance, but has not taken action to do so. NHSE recognises that, despite the increasing demand for the service, clinical capacity at Tavistock has been falling so severely that it has decided to move away from the current model entirely. NHSE is also failing to make arrangements which ensure that adults referred for gender identity disorder services are able to commence treatment within 18 weeks. The same extreme waiting times are seen in relation to these services and the same contractual provisions govern service provision.

58 Mr Lock accepts that NHSE is failing to meet the 18-week target across all its services, including adult and children's gender identity services. It therefore appears, he submits, that NHSE accept that it is acting unlawfully, though it contests the appropriateness of the remedy sought. The duty imposed by reg. 45 is not a "target duty" in the sense in which that term is used in the authorities. It specifies exactly what standard must be met and there is no reason why it should not be enforceable. Even if it is properly characterised as a "target duty", NHSE has not shown that it is doing all it reasonably can to meet the target.

Submissions for the defendant

59 For NHSE, Eleanor Grey KC submits that the duties imposed by Part 9 of the Regulations, including under reg. 45, apply only in respect of referrals for non-urgent treatment by a "consultant-led" service or an interface service. She accepts that reg. 45 does not say that on its face, but submits that this is the clear intention, given that, in December 2012, when the Regulations were made, the NHS Constitution and Operating Framework conferred rights on patients to start "consultant-led" treatment within 18 weeks. The current NHS Constitution refers to the Handbook, which in turn refers to the same entitlement, again framed to apply to "consultant-led treatment". The Handbook gives the source of the right as the Regulations. The Rules Suite, to which NHSE is required under reg. 50 to have regard when carrying out its duties under regs 45 and 48, also refers to "consultant-led treatment" and acknowledges that "much mental health activity will be outside of the scope of consultant-led waiting times".

60 The current gender identity development service for children and young people is not "consultant-led" (although it is planned to be under the new commissioning arrangements due to start in May 2023). So, like many other mental health referrals, it falls outside the scope of the duty in reg 45. This is consistent with the right conferred by reg. 48 (which applies only where the referral is for consultant-led or interface services: reg. 47(3). It would make little sense if the duty in reg. 45 applied to a broader range of services than the individual rights in reg. 48. Ms Grey submits that reg. 44 should therefore be read as if, in the definition of "eligible referrer" in reg. 44(1), there were a "hard return" after "any other person" in (d), so that the qualifications which follow apply to the whole definition.

61 In any event, the "cohort duties" imposed by regs 45 and 46 (unlike the duties conferred by regs 47-49) are not owed to specific individuals: see by analogy *R (Ahmad) v Newham LBC* [2009] UKHL 14, [2009] 3 All ER 755. They are "target duties". The obligation is to make arrangements to secure that 92% of the cohort are treated within 18 weeks, not to secure that outcome *simpliciter*. NHSE is required "to aim to make the prescribed provision" and the legislative language "does not regard failure to achieve it without more as a breach": *R (Rixon) v London Borough of Islington* (1996) 32 BMLR 136 (Sedley J), citing *R v Inner London Education Authority ex p. Ali* (1990) 2 Admin LR 822, 828 (Woolf LJ).

62 If it is right that the duties imposed by reg. 45 are "target duties", the evidence shows that NHSE is doing all it can reasonably be expected to do to reduce waiting times, which are the result not of under-funding, but of the many other factors described by their witnesses. Even if a breach were found, public law remedies (including declarations) should not be granted if an authority is doing all that it reasonably can to meet an obligation: *Family Planning Association of Northern Ireland v Minister of Health and Social Services* [2004] NICA 37. In this regard, the fact that the duty in reg. 45 applies to the whole cohort (and not just those referred for gender identity services) means that any declaration would be meaningless. The legislator intended the duties in the Regulations to be enforced through the mechanism provided for in regs 47-49.

Discussion

Does the duty in reg. 45 apply only to consultant-led services?

63 There is no doubt that, prior to the coming into force of the Regulations, the 18-week "referral to treatment" commitment was understood as applicable to "consultant-led waiting times" (emphasis added): that was the subtitle of the Department of Health's guidance document dated January 2012.

64 The NHS Constitution says:

> "You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution."

65 The Handbook says:

> "You have the right to:
>
> • start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions…
>
> …
>
> If this is not possible, the CCG or NHS England, which commissions and funds your treatment, must take all reasonable steps to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative providers, that would be able to see or treat you more quickly than the provider to which you were referred." (Emphasis added.)

It then gives the source of the right as Part 9 of the Regulations.

66 The Suite of Rules is entitled *Referral to treatment consultant-led waiting times: Rules Suite* (emphasis added) and specifically acknowledges that "much mental health activity will be outside the scope of consultant-led waiting times".

67 These documents explain why the NHS has assumed that both the cohort duty in reg. 45 and the duties owed to individuals in regs 47-49 are applicable to consultant-led waiting times only. The question for me, however, is not whether there is an explanation for the assumption, but whether the assumption is correct.

68 As to this, the starting point is the language of the Regulations. Ms Grey accepts that this is clear. The individual rights in regs 47-49 apply only to referrals to consultant-led and interface services. However, as drafted, reg. 45 applies more broadly to any referral by an "eligible referrer" to a "health service provider", which means "a person, other than a relevant body, who has entered into a commissioning contract". Ms Grey's suggestion that a "hard return" be inserted after the words "any other person" in para. (d) of the definition of "eligible referrer" in reg. 44(1) is, in reality, a concession that her "interpretation" requires a re-writing of the legislation.

69 Outside contexts where retained EU law or s. 3 of the Human Rights Act 1998 apply, there are very limited circumstances in which a court can "read down" clear legislative words. In the course of argument I drew attention to the decision of the House of Lords in *Inco Europe Ltd v First Choice Distribution* [2000] 1 WLR 586, where Lord Nicholls explained that the court could correct an obvious drafting mistake if it could be sure of three matters: "(1) the intended purpose of the statute or provision in question; (2) that by inadvertence the draughtsman and parliament failed to give effect that purpose in the provision in question; and (3) the substance of the provision Parliament would have made, although not necessarily the precise words Parliament would have used, had an error in the bill been noticed".

70 This was applied recently in the context of subordinate legislation by the Court of Appeal: see *R (SSE Generation Ltd) v Competition and Markets Authority* [2022] EWCA Civ 1472. At [121]-[126], Green LJ (with whom Sir Julian Flaux C and Snowden LJ agreed) emphasised the limits of the power to correct mistakes and the need to avoid engaging in judicial legislation. The court decided that it would be better to leave it to the Secretary of State to decide whether and how to correct the error.

71 Here, Ms Grey could not explain the rationale for excluding from the duty in reg. 45 referrals to services that were not consultant-led. She could find no document showing the drafting intention behind reg. 45. There is no necessary or inherent inconsistency in an approach which makes the cohort duty in reg. 45 applicable to all referrals to a "health service provider" but the individual duties in regs 47-49 applicable only to referrals to consultant-led or interface services. The best Ms Grey can do is point to non-legislative documents showing that the reg. 45 duty has not been understood in that way.

72 The reference in the Handbook does not help at all, because it is dealing with the individual rights in reg. 47-49, which are limited to referrals to consultant-led or interface services, and the Handbook is in any event purporting to summarise the effect of the Regulations. The reference in the Suite of Rules comes closer to being relevant because that document is referred to in reg. 50 as one to which regard is to be had in discharging the duty under reg. 45 as well as that under regs 47-49. Ultimately, however, this is in my judgment not sufficient to displace the clear words of reg. 45 (when taken with the definitions). I cannot be sure of any of the three matters referred to by Lord Nicholls in *Inco Europe*. As in *SSE*, I would leave it to the Secretary of State to decide whether to amend the Regulations. As those Regulations stand, the duty in reg. 45 applies to all referrals by an "eligible referrer" to a "health service provider".

The case law on target duties and declaratory relief

73 In *R v ILEA ex p. Ali,* the applicant brought judicial review proceedings because a large number of children (400 to 500) in a part of East London had not been provided with school places against the background of a large increase in the school-age population in that area. It was said that, while ILEA had recently embarked on a school-building programme, their response to the problem had been ineffective and insufficient to meet their statutory duty. The applicants asked the Secretary of State to issue a statutory direction in relation to ILEA's statutory duties, but he refused, having formed the view that ILEA was taking reasonable steps to improve the situation. There was a preliminary issue about the court's jurisdiction to consider ILEA's compliance with its statutory duty in the light of the Secretary of State's refusal to issue a direction and about whether, if the court did have jurisdiction and found that there was a breach, it could grant any relief.

74 The duty which the applicants had sought to enforce was "to secure that there shall be available for their area sufficient schools (a) for providing primary education… and (b) for providing secondary education": s. 8 of the Education Act 1944 as amended. Section 99 of the same Act empowered the Secretary of State to make an order declaring the local education authority, or the governors, to be in default and giving directions for enforcing the duty.

75 At 828, Woolf LJ (with whom Pill J agreed) held that the duty was framed in "very broad and general terms" and was the counterpart of the even wider duty imposed by s. 1 ("to promote the education of the people of England and Wales and the progressive development of institutions devoted to that purpose, and to secure the effective execution by local authorities, under his control and direction, of the national policy for providing a varied and comprehensive educational service in every area"). The s. 8 duty was of a type "designed to benefit the community" and could be described as a "target duty" in that a "degree of elasticity" was built into it. Thus, Woolf LJ said:

> "While there are a number of standards which are required to be achieved by the local educational authority, the setting of those standards is, in the first instance, for the local education authority alone to determine as long as those standards are not outside the tolerance provided by the section.
>
> There are going to be situations, some of which can and others of which cannot reasonably be anticipated, where the education provided falls below the statutory standard and the standards which the local education authority would set for itself. It is undoubtedly the position that within the area for which ILEA is responsible at the present time, the statutory standards and the standards that it would set for itself are not being met but this does not mean that ILEA are necessarily in breach of their duty under s. 8. The question is whether ILEA has taken the steps which the statute requires to remedy the situation which exists."

76 The court held that a local education authority faced with a situation where, without any fault on its part, it had not complied with the standard which the section sets for a limited period was not automatically in breach of the section. And, even where there was a breach of s. 8, the court should not intervene if by the time the matter came before it, the local education authority was doing "all that it reasonably can to remedy the situation". The situation was "best left in the hands of the bodies to whom parliament has entrusted performance of the statutory duty, if they are seeking to fulfil that duty": see 829.

77 The court held at 836-7 that there was no prospect that the claimant would be granted relief. This was not only because the defendant authority would shortly cease to exist, but also because both a mandatory order and a declaration would serve no purpose:

> "Merely to order a public body to perform its statutory duty does not add anything to that duty. Furthermore, in this case it is clear that a declaration would not assist. To declare that a public body should perform its duty does not add to or clarify the public body's obligations where, as here, that body accepts obligations. At this stage it is possible to say that there are not in this case

> any specific steps which will be able to be identified which it can be said that the public body is not taking which it should take. The only purpose of continuing the proceedings would be to ascertain whether or not the authority was culpable in reaching the present unsatisfactory situation. Inquests of that sort are not the purpose of judicial review.
>
> In coming to this conclusion, I derive support from the decision of the Secretary of State not to intervene. He is usually in a better position than the courts to assess whether intervention would be constructive and, while not bound in anyway by his decision, the courts will have regard to his decision in deciding how to exercise their discretion."

78 In *Rixon,* the severely disabled claimant sought judicial review of the council's failure to make provision for his social, recreational and educational needs. Sedley J noted that the "target duty" metaphor coined by Woolf LJ in the *Ali* case "recognises that the statute requires the relevant public authority to aim to make the prescribed provision but does not regard failure to achieve it without more as a breach". Section 2 of the Chronically Sick and Disabled Persons Act 1970 was not a "target duty", but "a duty owed to the individual".

79 *Ahmad* concerned a local authority's compliance with s. 167 of the Housing Act 1996, which required local housing authorities to have a scheme for determining priorities in the allocation of housing accommodation, which ensured that reasonable preference was given to specified groups. Lady Hale (with whom the other members of the court agreed) noted at [11] that the first instance judge had approached the problem from the point of view of the proper assessment of the claimant, whereas he should have focussed on "the overall legality of a policy which would have to apply to everyone". At [12], she noted that the relief claimed was important. No-one was claiming that the claimant had a right to a house. At most he had a right to have his application determined according to a lawful allocation policy. At [13], Lady Hale said this:

> "…there is a fundamental difference in public law between a duty to provide benefits or services for a particular individual and a general or target duty which is owed to a whole population. One example of the former is in Pt VII of the 1996 Act, which deals with the housing authority's duties towards individual homeless people. If certain conditions are fulfilled, s 193(2) requires that the authority 'shall secure that accommodation is available for occupation by the applicant'. The individual applicant has the right to challenge a decision that the duty is not owed in the county court. Another example is in s 20 of the Children Act 1989, which requires a local children's services authority to provide accommodation for 'any child in need' because, in effect, he has no one who can look after him properly. An example of a target duty is in s 17 of the 1989 Act, which provides that '[i]t shall be the general duty' of local children's services authorities to provide a range of services to safeguard and promote the welfare of children in need within their area. This does not give any particular child a right to be provided with

> a particular service: see *R (on the application of G) v Barnet London BC, R (on the application of W) v Lambeth London BC, R (on the application of A) v Lambeth London BC* [2003] UKHL 57, [2004] 1 All ER 97, [2004] 2 AC 208. In the case of social housing, there is not even a duty to provide it, although there is a duty to have and to operate a lawful allocation policy."

80 In the *Family Planning Association of Northern Ireland's* case, Shiel LJ, sitting in the Northern Ireland Court of Appeal, held that the duty in Article 4 of the Health and Personal Social Service (Northern Ireland) Order 1972 (the equivalent of s. 1 of the 2006 Act) was a target duty. He read *R v ILEA ex p. Ali* as authority for the proposition that "the remedies in public law, such as by way of judicial review in the present case, are discretionary remedies and would not normally be granted if an authority is doing all that it reasonably can to meet an unqualified statutory obligation".

81 In *R (Hunt) v North Somerset Council* [2015] UKSC 51, [2015] 1 WLR 3375, the claimant sought judicial review of a decision of the defendant local authority to approve its budget in relation to the provision of youth services. The claim failed substantively at first instance but succeeded on appeal. However, the Court of Appeal refused the relief sought (a quashing order) on the ground that it was by that time too late to unwind the council's budget for the previous financial year. The claimant did not seek a declaration. The only issue for the Supreme Court was whether the Court of Appeal should nonetheless have granted one. Lord Toulson (with whom the other members of the court agreed) said this at [12]:

> "…in circumstances where a public body has acted unlawfully but where it is not appropriate to make a mandatory, prohibitory or quashing order, it will usually be appropriate to make some form of declaratory order to reflect the court's finding. In some cases it may be sufficient to make no order except as to costs; but simply to dismiss the claim when there has been a finding of illegality is likely to convey a misleading impression and to leave the claimant with an understandable sense of injustice. That said, there is no 'must' about making a declaratory order, and if a party who has the benefit of experienced legal representation does not seek a declaratory order, the court is under no obligation to make or suggest it."

82 In the *National Aids Trust* case, the question was whether NHSE had power to commission a prophylactic treatment for those at high risk of contracting AIDS. Green J held that the 2012 Regulations imposed on NHSE a "free-standing duty" distinct from the duties imposed on NHSE under the 2006 Act: see at [77]. This assists in interpreting reg. 11 but tells one very little about the proper interpretation of reg. 45, which was not in issue. In any event, the Court of Appeal's reasoning differed from that of Green J: [2016] EWCA Civ 1100, [2017] 1 WLR 1477. Nothing in it assists on the question of construction raised by this case.

83 More pertinently, in *R (Justice for Health) v Secretary of State for Health* [2016] EWHC 2338 (Admin), at [89], Green J described the duties imposed by ss. 1A-1G of the 2006 Act as:

> "'target duties' because although cast in mandatory terms they lay down broad objectives to be achieved and impose upon the Minister the obligation to act in a way which is eg 'designed to achieve' or 'secure' the objective (section 1(1)) or to act "with a view to securing" the objective (section 1A(1)) or to "have regard to" the objective (section 1B(1)). They are target duties in the sense that (a) they do not specify a particular or precisely defined end result as opposed to a broad aim or object and (b) their mandatory nature is diluted by the fact that they do not compel the achievement of that end result instead requiring the Secretary of State only to factor those objectives into consideration."

84 Finally, in *R (Good Law Project) v Secretary of State for Health and Social Care* [2021] EWHC 346 (Admin), a challenge brought by the sixth claimant, I had to consider whether to grant declaratory relief in relation to a failure by the Secretary of State to comply with a legal obligation to publish contract award notices within 30 days. By the time of the hearing, the Secretary of State accepted that he was in breach of this obligation in a significant number of cases: see at [137]. Having cited various authorities, including *Hunt*, I said this at [152]:

> "These decisions establish that a claimant who establishes that a public body has acted unlawfully will normally be entitled to a declaration to mark the illegality in cases where no other relief is appropriate. I say "normally", because, as Lord Toulson JSC emphasised, declaratory relief is always discretionary… Another circumstance in which it might be appropriate to withhold relief is where the proceedings were unnecessary because the breach was admitted at the outset: it is no part of the court's function to rub a defendant's nose in his admitted breach."

85 On the facts, the Secretary of State had made no clear admission of the breach (or its extent) until shortly before the hearing. There were, therefore, no grounds for departing from the ordinary position that a claimant who has established unlawful conduct on the part of a public authority is entitled to a declaration to that effect: [153]-[154].

The principles to be applied

86 Much of the debate between the parties centred on the question whether reg. 45 of the 2012 Regulations imposes a "target duty". A review of the authorities demonstrates that the phrase "target duty" has been used to describe duties with a number of different features. Sometimes, more than one of these features is present. Nonetheless, it is important to distinguish them.

87 First, a duty may be framed in terms so open-textured that the legislator must have intended to confer a broad discretion on the public authority, subject only to the constraints of rationality. And, depending on the breadth of the language used, it may be difficult to conceive of a case where the authority's judgment could sensibly be stigmatised as irrational. The duty in s. 3B of the 2006 Act is one example. It empowers the making of regulations requiring NHSE to arrange for the provision of certain specified services "to such extent as it considers necessary to meet all reasonable

requirements". But, as *R v ILEA ex p. Ali* shows, the statute need not use phrases like "to such extent as it considers necessary". The use of a broad term like "sufficient" may be enough on its own to signal the legislator's intent that the authority is to decide in the first instance how to discharge the duty. Wade & Forsyth, *Administrative Law* (11th ed., 2014), at p. 499, notes:

> "Parliament has become fond of imposing duties of a kind which, since they are of a general and indefinite character, are perhaps to be considered as political duties rather than as legal duties which a court could enforce. Many such duties may be found in statutes concerned with social services and nationalisation… Only in the unlikely event of its making total default would any of the above-mentioned authorities be at risk of legal compulsion in respect of its general duties."

88 Second, a duty may, on its proper construction, require the person who owes it to act with a view to achieving a particular result, rather than simply to achieve that result. This is feature (b) in [89] of Green J's judgment in *Justice for Health*. Sometimes statutory language which has the first feature (broad, open-textured language) will also have this second feature. It is, however, quite possible to conceive of a statutory duty with the second feature, but not the first – in other words, a statutory duty to act so as to achieve (rather than simply to achieve) a precisely defined result. Whether a particular statutory duty is to be read in this way depends on whether the legislator intended the public authority to be in breach if the result is not achieved despite reasonable attempts by the authority to achieve it: see *Rixon* and the passage set out at [64] above from Woolf LJ's judgment in *R v ILEA ex p. Ali*, at p. 828. (In that case, whatever "sufficient" meant, it was obvious that the authority had not provided "sufficient" places, since between 400 and 500 children lacked one. Yet, the authority was not in breach because it was taking reasonable steps to remedy the position.)

89 Third, a duty may be owed to the population as a whole rather than to any individual. This was the sense in which, according to Lady Hale in *Ahmad*, s. 17 of the Children Act 1989 was a "target duty". Although in general "[p]ublic law is not about private rights but about public wrongs" (*Hunt*, [16]), the court will be cautious about interpreting a duty framed as owed to the population as a whole (or a section of it) as enforceable at the suit of an individual, particularly where the legislative scheme provides bespoke individual remedies (as in the case of the Children Act) or default powers in the hands of Ministers (as in *R v ILEA ex p. Ali*). As always, the question whether the duty is intended to be enforceable at the suit of an individual is one of statutory construction.

90 The question whether to grant relief (including declaratory relief) can only arise once it has been established that the defendant has acted unlawfully. *Hunt* establishes that declaratory relief (at least) should generally follow a finding of unlawful conduct by a public authority. But that does not mean that, when considering how to interpret the duty, courts should close their minds to the relief that might be appropriate. If the only relief that could realistically be granted is a declaration, it is legitimate to ask what would likely be achieved by that. The answer to that question may well inform the proper interpretation of the duty.

Application of the principles to this case

91 In this case, the duty imposed by reg. 45 of the 2012 Regulations is a duty to make arrangements to secure that 92% of the cohort commence treatment within 18 weeks. There are precise definitions explaining who is in the cohort and when treatment will be regarded as having commenced. The standard is therefore hard-edged, rather than open-textured. Whether it is being met will be capable of being ascertained precisely.

92 As the above analysis shows, however, that is not the end of the story. On its face, the duty is not to achieve the standard, but rather to "make arrangements to ensure" that the standard is met. Mr Lock said that it would be wrong to draw too much from this, given that one statutory power under which the Regulations were made (s. 6E of the 2006 Act) empowers the making of Regulations requiring NHSE to "arrange for the specified treatments or other specified services to be provided… within a specified time". But even this language does not indicate conclusively whether the requirements imposed by the regulations are to act so as to achieve the standard or simply to achieve the standard.

93 One thing that can certainly be said of the standard is that it applies to the cohort, and not to individuals. It would be possible to comply with it even though particular individuals have been waiting more than 18 weeks for treatment. Indeed, because the cohort is comprised of all patients referred to the services under NHSE's responsibility, it would be possible for the standard to be met even if no child or adult referred for gender identity services were treated within 18 weeks. Thus, even if reg. 45 imposed a duty to meet the standard, it would be a paradigm of the kind of duty identified by Lady Hale in *Ahmad*, i.e. one owed to the population as a whole, rather than to individuals.

94 Moreover, the legislative scheme includes both a power in the Secretary of State to give directions as to how NHSE is to exercise its functions (s. 13ZC of the 2006 Act) and bespoke remedies for individuals whose treatment does not commence within 18 weeks (regs 47-49 of the Regulations). Both these features suggest that the legislator did not intend the duty imposed by reg. 45 to be an absolute duty to achieve the standard, enforceable by individuals. The provisions in regs 47-49 show that the legislator considered carefully the circumstances in which remedies should be available to individuals who have to wait more than 18 weeks for treatment. The fact that the claimants in the present case have no such remedies (because there is no alternative provider of gender identity services with a commissioning contract) does not detract from this point.

95 In my judgment, the clearest pointer to the content of the duty imposed by reg. 45 comes from considering the effect of the relief sought by the claimants. Mr Lock conceded from the outset that mandatory relief to enforce the duty would be inappropriate. He was right to make that concession and the reasons why are instructive. In the first place, such an order might not assist the claimants. As I have said, NHSE could comply with the standard set by reg. 45 without treating any gender identity patient within 18 weeks. More importantly, if the court ordered NHSE to comply with the standard set by reg 45 by a particular time, that would impose a legal obligation on NHSE to divert resources from elsewhere. Where would these resources come from? One possibility is that they could be taken away from the ICBs responsible for more mainstream services, but they too are subject to the same 18-week standard and they too are failing to meet it. More generally, mandatory relief would be inappropriate because it would inevitably result in a diversion of resources from one health service purpose to another. The court is not equipped, in terms of the information available to it or in terms of expertise, to form a judgment about whether such a diversion would be optimal.

96 I am not convinced that these difficulties would be avoided by the grant of declaratory, rather than mandatory relief. Public authorities are expected to, and in practice do, take action to end unlawfulness established by a declaration (or indeed by a judgment without a declaration). If they do not, the declaration (or judgment) may be relied upon in subsequent proceedings. In their own skeleton argument, the claimants' counsel point out that:

> "[NHSE] has many calls on its budget and has a discretion to decide how much to focus on its directly commissioned services. A declaration would have the important effect of marking and acknowledging the continuing unlawful conduct in respect of the provision and commissioning of public health services by [NHSE] and ensuring that future budget allocations will be sufficient to fund services to meet [NHSE's] legal duties (assuming those duties remain in force)."

97 This, as it seems to me, is an acknowledgement that one purpose (indeed, perhaps the principal purpose) of these proceedings is to encourage NHSE to spend a greater portion of its budget on directly commissioned services. But just as it would be inappropriate to order NHSE to do that, so it would also be inappropriate to grant relief which encourages that outcome. As with a mandatory order, the practical result might be to divert resources from other important health service purposes in circumstances where the court could not gauge whether or not such a diversion would be beneficial overall.

98 These considerations tell strongly against the grant of any relief, even declaratory. They are also, however, relevant at the stage of considering the content and scope of the legal duty imposed by reg. 45. A duty to act with a view to achieving the 18-week target fits better than an absolute duty to achieve that standard with a scheme in which NHSE has multiple and potentially competing functions, all of them important, whose prioritisation cannot sensibly have been intended to be supervised by a court. As I have said, a duty to act with a view to achieving the 18-week standard also fits better with the provision for individual remedies in regs 47-49.

99 I therefore conclude that the duty in reg. 45, on its proper construction, is a duty to make arrangements with a view to ensuring that the 18-week standard is met. As Sedley J put it in *Rixon*, the regulation does not regard failure to achieve that standard, without more, as a breach.

100 In considering NHSE's compliance with that duty, it is important to bear in mind that judicial review remedies are, in general, forward-looking. They are appropriate where the public authority cannot or will not remedy the breach itself. As Woolf LJ emphasised in *R v ILEA ex p. Ali*, the function of judicial review is not, generally, to conduct inquests into whether an authority is culpable for an admittedly unsatisfactory situation. I say "generally" because, when a judicial review claimant also claims a compensatory remedy, it may be necessary to conduct a backward-looking analysis. But it is not and could not sensibly be suggested that reg. 45 gives rise to any right of action sounding in damages. (Apart from anything else, given that the duty could be complied with without meeting the 18-week standard in respect of any particular individual, it would be impossible to show that the breach gave rise to loss on the part of that individual.) That being so, the question whether NHSE is in breach of reg. 45 falls to be answered against the background of what it is doing now.

101 The causes of the current long waiting times include: (i) the very marked increase in demand for these services in the five years up to 2017; (ii) the recent clinical controversy surrounding GID treatment, especially but not only for children; (iii) the difficulty, across both children's and adults' services, of recruiting and retaining sufficient clinical specialists, despite the availability of funding for them; and (iv) the need, in the light of the foregoing matters, to redesign the commissioning model. It may be that NHSE was too slow to respond to the increase in demand for both children's and young people's and adults' services. Be that as it may, the evidence shows that concrete steps are now being taken with a view to reducing waiting times for both children and young people's and adults' services. These steps include not only the deployment of significant additional resources, but also restructuring the model on which the services are provided and encouraging the development of the relevant clinical specialisms.

102 NHSE has provided a detailed account of the steps now being taken and a cogent explanation of the reasons why it is expected that these steps will be successful in reducing waiting time, albeit not immediately. In my judgment, it is impossible to stigmatise these steps as unreasonable or inadequate ones. As in *R v ILEA ex p. Ali*, in the light of the evidence, it is impossible to say that NHSE is currently in breach of its duty.

103 For completeness, I should mention that the claimants' evidence contains criticisms of NHSE for not exercising its contractual remedies and for establishing the Multi-Professional Review Group (the latter relevant mainly to the now abandoned Ground 5). As to the first, it is true that NHSE has a contract with Tavistock (for children's GID services) and with the existing providers of adults' GID services. In each case, the Service Specification is incorporated into the contract. It provides for a referral to treatment time of 18 weeks. In principle, NHSE could exercise contractual remedies, but it has to consider whether doing so would help. In this case, it is difficult to see how the exercise of contractual remedies would help, where the delays are mainly attributable to a lack of trained clinical staff. Certainly, the decision not to exercise those remedies cannot be characterised as irrational.

104 It is not clear to me that the establishment of Multi-Professional Review Group will have <u>any</u> impact on waiting times for a first appointment, because the Group's function applies only once a second referral has been made, by the Tavistock, to endocrinology specialists at University College London Hospital or Leeds Teaching Hospital. In any event, given the material I have seen about the clinical and safeguarding reasons for the decision to establish the Group, including from Prof. Ellis herself, there is no way in which that decision could be characterised as irrational.

Ground 2

Submissions for the claimants

105 Mr Lock accepts that s. 3B of the 2006 Act imposes a target duty only: *R (Grogan) v Bexley NHS Care Trust* [2006] EWHC 44 (Admin). Even so, the court must be able to intervene if the arrangements being made to discharge it are not rationally capable of doing so. For example, if NHSE is required to arrange for the provision of an abortion service, but the service has a 10-month waiting time, the arrangements would be irrational.

106 The position is the same here. NHSE is required to arrange for the provision of a children's GID service. One of the functions of such a service is to enable children to access (where clinically appropriate) puberty blocking hormones. But waiting times are such that many children referred to the service will already have gone through puberty by the time of their first appointment, by which time many of the changes which the puberty blocking hormones could have arrested will have happened, irreversibly. Thus, the purpose for which the treatment is being provided is frustrated. This falls outside the (admittedly wide) scope of the discretion which s. 3B of the 2006 Act gives to NHSE.

Submissions for the defendant

107 Ms Grey submits that the obligation imposed by s. 3B of the 2006 Act is not to meet all reasonable requirements, but rather to arrange their provision "to such extent as it considers necessary". This confers a twofold discretion: first as to what are "reasonable requirements"; second, as to what is "necessary" to meet those requirements. It is no part of the commissioning aims or the Service Specification that delays of the order actually experienced should take place. Given the capacity constraints and the efforts being made to overcome them, the NHS's response is within the range of reasonable responses open to it.

Discussion

108 It is important to acknowledge the serious effects of long waiting times on the first two claimants. Their distress and fear, as described by their parents, is particularly affecting because its source lies in their own changing bodies. It is a matter of great regret that many other children and adolescents waiting for children's GID services must face the same distress and fear. The question for me, however, is not whether the first two claimants and others in a similar position have been well served by NHSE, but whether NHSE is in breach of the legal duty imposed by s. 3B of the 2006 Act.

109 In answering that question, there are five points to bear in mind. First, as Ms Grey submits, the arrangements made by the NHS are, in the first instance, the preparation of the Service Specification. That requires the contractor to adhere to the 18-week waiting time. Second, as I have said, the failure to exercise contractual remedies against Tavistock cannot be considered irrational in circumstances where the main cause of the delay is the lack of trained clinical staff. Third, although it is true that children's GID services are in many cases time-critical, the analogy with abortion services is not a good one. No-one suggests that a consultation at Tavistock is useless after puberty has begun. It is true that, for some patients, its potential utility may decrease as the waiting time increases, but this is true of a great number of NHS services. Fourth, having recognised that the model needs to be changed, NHSE has now embarked on new arrangements for the delivery of the children's GID service. Fifth, NHSE expects these new arrangements to bring down waiting times substantially, albeit not immediately.

110 Against this background, NHSE's failure so far to reduce the long waiting times endured by children and adolescents waiting for referral to the children's GID service at Tavistock no more breaches s. 3B of the 2006 Act than it breaches the duty imposed by reg. 45 of the Regulations.

111 Ground 2 therefore fails.

Ground 3

Submissions for the claimant

112 Mr Lock submits that the long waiting times for those referred to adults' GID services give rise to a breach of the duty imposed by s. 2 of the 2009 Act to have regard to the right to start consultant-led treatment within 18 weeks. In particular, the efforts underway to increase funding and widen access to services cannot be enough to demonstrate compliance with s. 2 because (i) NHSE accepts that it has a funding model which is "not optimal in terms of promoting quality or service development", (ii) the retendering exercise in 2019 did not result in an increase in clinical capacity and (iii) the measures adopted have been insufficient to improve waiting times for patients referred to gender dysphoria clinics.

Submissions for the defendant

113 Ms Grey submits that the NHS Constitution records the right of access to services as set out in the Handbook. That simply describes the rights derived from Part 9 of the Regulations (i.e. the provisions, including reg. 45 already relied upon by the claimants). So the obligation to have due regard to the rights conferred by the NHS Constitution cannot enlarge the scope of the right already conferred by the Regulations.

114 In any event, NHSE did not fail to have due regard to those rights. It continues to make strenuous efforts to solve the problems regarding access to GID services for both children and adults. The claimants' submissions overlook the evidence that the cause of these problems is the lack of specialist clinical capacity and that efforts are being made to develop this.

Discussion

115 The duty imposed on NHSE by s. 2 of the 2009 Act is a duty, in performing its health service functions, to have regard to the NHS Constitution. But, as Ms Grey submitted, the NHS Constitution refers to rights as set out in the Handbook. That in turn sets out the rights found in Part 9 of the Regulations. So, the NHS Constitution does not impose duties additional to those in Part 9. It follows that, if NHSE has complied with its duties under Part 9 of the Regulations, a breach of the duty to have regard to the NHS Constitution could not separately justify relief.

116 Mr Lock's arguments based on the failure (so far) to achieve better outcomes following the 2019 tendering exercise are an attempt to read s. 2 of the 2009 Act as a duty to achieve a particular result. Those arguments run up against the plain words of s. 2 of the 2009 Act, which unmistakably imposes a procedural – and not a substantive – duty. NHSE's evidence makes clear that it is well aware that the 18-week waiting times are not being met and is taking action to address this problem. This is sufficient, in substance, to discharge its duty to "have regard" to the NHS Constitution.

117 Ground 3 therefore fails.

Ground 4

Submissions for the claimant

118 Mr Lock notes that gender reassignment is a protected characteristic under s. 4 of the 2010 Act and that under s. 7(1) a person has this characteristic if he is "proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex". Whilst NHSE does not directly provide GID services to people with the protected characteristic, it is "concerned with the provision of a service" within s. 29(1), or alternatively is exercising a public function within s. 29(6), when it decides who to contract with and sets the payment terms.

119 Mr Lock submits that the first four claimants all share the protected characteristic of gender reassignment and have been treated less favourably because of this characteristic in that they have been denied medical services which they would have received, or waited longer than they would have waited, if they suffered from other medical conditions. The comparators are those in other groups referred for specialist medical treatment, who face shorter waiting times. This is direct discrimination, which cannot be justified.

120 Alternatively, Mr Lock says that the arrangements made by NHSE constitute indirect discrimination. Those arrangements are provisions, criteria or practices ("PCPs") within s. 19(1) of the 2010 Act. They put patients who suffer from gender dysphoria at a disadvantage compared to patients suffering from other conditions, by making them wait longer for treatment. The first four claimants have suffered this disadvantage. The arrangements cannot be said to constitute a proportionate means of achieving a legitimate aim.

Submissions for the defendant

121 Ms Grey accepts that adult gender dysphoria patients possess the protected characteristic of gender reassignment. She submits, however, that children and young persons awaiting their first appointment at Tavistock do not, because, as a class or cohort, they will not yet have progressed to the stage where they are "proposing to undergo… a process (or part of a process) for the purpose of reassigning" their sex. Only a small percentage (200 of 2500 in 2019) are referred to the endocrine pathway, although the evidence base is poor, as Dr Cass has pointed out.

122 In any event, there is no direct discrimination. Direct discrimination requires a comparison between a particular case and another with which there are no material differences apart from the protected characteristic: *City of London Police v Geldart* [2021] EWCA Civ 611, at [34] and [57]-[58]. It cannot be enough to point out that waiting lists for GID services are longer than for other kinds of care. Patients with different clinical conditions – each with a different care pathway – are not in comparable circumstances. If one asks <u>why</u> the complainant was treated differently from others, it was not because of his protected characteristic but because the particular services he was seeking were subject to increasing demand and limited specialist resources.

123 As to indirect discrimination, there is no "provision, criterion or practice" applied equally to those with and those without the protected characteristic. Alternatively, if the commissioning arrangements qualify as PCPs, they are justified under s. 19(2)(d) by the

need to provide clinically appropriate and safe services that make effective use of the available healthcare resources.

Discussion

Who has the protected of gender reassignment?

124 Section 4 of the 2010 Act identifies the protected characteristics, including "gender reassignment". Section 7 provides:

> "(1) A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex."

125 In *Taylor v Jaguar Land Rover* (Case No. 1304471/2018), an Employment Tribunal sitting in Birmingham (Employment Judge Hughes, Mr T.C. Liburd, Mrs R.J. Pelter) had to consider whether this definition was broad enough to encompass the claimant in that case, who described herself as "gender-fluid" and was "transitioning" but had no intention of undergoing surgery.

126 At [173], the Tribunal noted that there was no authority on the subject. The phrase "proposing to undergo" could be read in a number of ways, covering a spectrum from "actively considering" to "intends" to "has decided". In those circumstances, the Tribunal considered it important to consider the intention of Parliament in enacting s. 7(1). At [174], the Tribunal continued:

> "…One of the issues the EA10 sought to deal with (and to some degree has) was moving away from medicalising protected characteristics. It is not clear that that has entirely been achieved in relation to the definition of disability. Be that as it may, in terms of gender-reassignment, the intention was to make it clear that a person need not intend to have surgery, or indeed ever have surgery, in order to identify as a different gender to their birth sex. We consider that the words we have highlighted in paragraph 173 make it clear, and beyond dispute, that gender reassignment need never be a medical process."

127 Since the words "proposing to undergo" were ambiguous, the Tribunal looked to the reported statements of the Minister proposing the Bill which became the 2010 Act. The Tribunal continued as follows:

> "177. We had regard to the following extracts. In Column 168: 'It concerns a personal move away from one's birth sex, into a state of one's choice… a personal process which may be proposed but never gone through. It may have happened. Its nature may be medical one. It may be choosing to dress in a different way, and moving a gender identity away from birth sex'. In Column 179: 'Someone who was driven by a characteristic would be in the process of gender reassignment,

> however intermittently it manifested itself'. Column 171: 'Gender reassignment, as defined, is a personal process, so there is no question of having something to do something medical, let alone surgical, to fit the definition'. Column 172: 'Fourthly [as regards the definition], someone who has a gender-identity that is different from that expected from a person of their recorded natal sex is covered too. Where is the deficiency in our clause?'. Finally, Column 204: 'At what point [proposing to undergo] amounts to "considering undergoing" a gender reassignment is pretty unclear. However, "proposing" suggests a more definite decision point, at which the person's protected characteristic would immediately come into being. There are lots of ways in which that can be manifested – for instance, by making their intention known. Even if they do not take a single further step, they will be protected straight away. Alternatively, a person might start to dress, or behave, like someone who is changing their gender or is living in an identity of the opposite sex. That too, would mean they were protected. If an employer is notified of that proposal, they will have a clear obligation not to discriminate against them' (our emphasis added).
>
> 178. We thought it was very clear that Parliament intended gender reassignment to be a spectrum moving away from birth sex, and that a person could be at any point on that spectrum. That would be so, whether they described themselves as 'non-binary' i.e. not at point A or point Z, 'gender fluid' i.e. at different places between point A and point Z at different times, or 'transitioning' i.e. moving from point A, but not necessarily ending at point Z, where A and Z are biological sex. We concluded that it was beyond any doubt that somebody in the situation of the Claimant was (and is) protected by the legislation because they are on that spectrum and they are on a journey which will not be the same in any two cases. It will end up where it does. The wording of section 7(1) accommodates that interpretation without any violence to the statutory language. Consequently, there is jurisdiction to hear the gender reassignment claim."

128 I am not convinced that the conditions for taking into account statements made in Parliament during the passage of a Bill are satisfied. The first condition is that the legislation is "ambiguous or obscure or leads to an absurdity": *Pepper v Hart* [1993] AC 593, 640 (Lord Browne-Wilkinson). Subsequent cases have insisted upon strict observance of these conditions: see, most recently, *R (Project for the Registration of Children as British Citizens) v Secretary of State for the Home Department* [2022] UKHL 3, [2022] 2 WLR 343, [32] (Lord Hodge). The words of s. 7(1) may be difficult to apply in individual cases, but they are not, in my view, ambiguous.

129 Nonetheless, the conclusions drawn by the Tribunal seem to me to follow from the plain words of the statute, even without elucidation by reference to Parliamentary statements. There are three important aspects of the definition in s. 7(1) of the 2010 Act. First, it refers to "a process… for the purpose of reassigning the person's sex by changing

physiological <u>or other</u> attributes of sex". The underlined words make clear that the process will not necessarily be a medical one. It may involve changing non-physiological aspects of sex, such as one's name and/or how one dresses, or wears one's hair, or speaks, or acts.

130 Second, the reference to "a process (or any part of a process)" reflects the fact that trans people will give effect to their gender identity in a variety of ways. Some will embark on a process which they intend will include hormone treatment and surgery, or other forms of medical intervention – as well as changing some of the non-physiological aspects of gender. But some may decide, on reflection, that they only wish to make some of these changes. The words in parenthesis make clear that this does not matter: they are still protected by the 2010 Act.

131 Third, the reference to those who are "proposing to undergo", as well as those who are undergoing or have undergone, this process (or part of it) shows that Parliament intended the protection to start before the process (or any part of it) has started. All that is required is that they <u>propose</u> to undergo at least a part of such a process. The word "proposing" connotes a conscious decision, which can properly be described as settled, to adopt some aspect of the identity of a gender different from that assigned at birth. A passing whim will not do, but nor is an intention required that the change should be permanent. (There is a contrast here with the requirements for a gender recognition certificate in s. 2(1) of the Gender Recognition Act 2004, which include that the applicant has or has had gender dysphoria, has lived in the acquired gender for 2 years and "intends to continue to live in the acquired gender until death".)

132 Not every child referred to the children's GID service will have the protected characteristic of gender reassignment. Dr Cass in her report describes those being referred as "gender questioning children and young people" who "seek help from the NHS in managing their gender-related distress". Some of these may present with symptoms of gender-related distress, for which they may in due course receive psychological help. They may not, at the time of referral, have taken any settled decision to undergo any part of a process of changing any attribute of sex (to use the language of the 2010 Act). This is particularly likely to be true in the case of very young children.

133 But there is no reason of principle why a child could not satisfy the definition in s. 7, provided that they have taken a settled decision to adopt some aspect of the identity of the other gender. Many of the children referred to children's GID services will have taken such a decision. Determining whether any particular child has the protected characteristic of gender reassignment will involve a case specific factual assessment.

134 In this case, there is good evidence about the position of the two child claimants. AA's circumstances are set out in para. 36 above. She has changed her name to a girl's name. She attends school as a girl. She has now been living as a girl for more than 2 years. She wishes to receive medical treatment to delay the onset of male puberty. She has taken a decision to adopt some aspects of the identity of the other gender. At the present time, it would be an abuse of language to describe this decision as other than settled.

135 AK's circumstances are set out in para. 37 above. At the age of 10, she expressed the desire to be known as a girl, have a girl's name, wear girls' clothes and have her hair long. She has been referred to the children's GID service and the thought of going

through male puberty distresses her. Again, she has clearly taken a settled decision to change aspects of her gender identity.

136 In my judgment, both AA and AK very clearly satisfy the definition in s. 7(1) of the 2010 Act. They have the protected characteristic of gender reassignment. It is common ground that the same is true of Alexander Harvey and Eva Echo. This means that it is necessary to consider whether the claimants have been subject to directly or indirectly discriminatory treatment.

Direct discrimination

137 Section 13 of the 2010 Act provides:

> "A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others."

138 Section 23 provides:

> "On a comparison of cases for the purposes of section 13, 14, or 19 there must be no material difference between the circumstances relating to each case.

139 Typically, a direct discrimination claim will involve a comparison of how the claimant was treated with how a comparator was or would have been treated. The comparator can be actual or hypothetical.

140 In *Shamoon v Chief Constable of the Royal Ulster Constabulary* [2003] UKHL 11, [2003] ICR 337, Lord Nicholls noted at [7] that a tribunal would normally ask, first, whether the claimant received less favourable treatment than the appropriate comparator and, secondly, whether the less favourable treatment was on the relevant proscribed ground. At [8], he observed that, while it was no doubt convenient and helpful to adopt this approach in some cases, in others it could give rise to needless problems, because the "less favourable treatment" and "reason why" issues were intertwined. At [9], he continued:

> "This analysis seems to me to point to the conclusion that employment tribunals may sometimes be able to avoid arid and confusing disputes about the identification of the appropriate comparator by concentrating primarily on why the claimant was treated as she was. Was it on the proscribed ground which is the foundation of the application? That will call for an examination of all the facts of the case. Or was it for some other reason? If the latter, the application fails. If the former, there will be usually be no difficulty in deciding whether the treatment, afforded to the claimant on the proscribed ground, was less favourable than was or would have been afforded to others."

141 More recently, in *Geldart v Commissioner of the City of London Police* [2021] EWCA Civ 611, [2021] ICR 1329, Underhill LJ (with whom Baker and Newey LJJ agreed) said

at [58] that the "reason why" question was "what caused the treatment in question?". He continued as follows:

> "Answering the causation question in this context may involve two different kinds of inquiry. In a straightforward case the putative discriminator will have overtly applied a criterion based on the protected characteristic. But in other cases, although the ostensible criterion is something else, the putative discriminator may still have been influenced in his or her decision by the proscribed factor, consciously or unconsciously: in such a case it is necessary to examine their mental processes to establish what caused them to act as they did. In the jargon of discrimination lawyers the former are sometimes described as 'criterion cases' and the latter as 'motivation' cases. The distinction is not black-and-white, but it is a useful working tool."

142 In a footnote, Underhill LJ noted that "motivation" was not an ideal word, because it could be confused with "motive", which was not relevant.

143 In *R (Coll) v Secretary of State for Justice* [2017] UKSC 40, [2017] 1 WLR 2093, the Supreme Court had to consider whether the provision of approved premises for those leaving prison was directly discriminatory against women because, owing to the much smaller number of women prisoners and the decision to make provision on a single sex basis, a woman was more likely to be placed in premises far from her home. Lady Hale (with whom the other members of the court agreed) said at [30] that it was not a requirement of direct discrimination that all the people who share the protected characteristic must suffer the less favourable treatment. It was enough that some did. At [32], she said this:

> "It was argued in the courts below that there was a material difference between the circumstances of the male and female offenders so that their cases were not comparable for the purpose of section 23 (para 22 above). Cranston J [2013] EWHC 4077 at [54] accepted that comparing the women prisoners with the men prisoners was not comparing like with like. The women had different characteristics from the men, fewer being of high or very high risk, and the criteria for admitting them to APs were different. However, in the Court of Appeal, Elias LJ rejected this argument. Those differences were not material to the present issue, which was accommodating them close to home [2015] 1 WLR 3781, para 44. I agree. The question of comparing like with like must always be treated with great care—men and women are different from one another in many ways, but that does not mean that the relevant circumstances cannot be the same for the purpose of deciding whether one has been treated less favourably than the other. Usually, those circumstances will be something other than the personal characteristics of the men and women concerned, something extrinsic rather than intrinsic to them. In this case, the material circumstances are that they are offenders being released on licence on condition that they live in an

> AP. Those circumstances are the same for men and women. But the risk of being placed far from home is much greater for the women than for the men."

144 *Coll* shows that, when considering whether a difference between the claimant and a comparator is "material" it is necessary to ask whether it is relevant in terms of the detriment complained of. In the case of prisoners, the differences between men (as a cohort) and women (as a cohort) were not relevant to the detriment complained of in *Coll* (being placed far from home). In this case, however, the differences between the claimants (who are seeking children's and adults' GID services) and the comparators they rely on (who are seeking other specialist services) are relevant to the detriment complained of (long waiting times).

145 To the question "what caused the long waiting times for children's and adults' GID services?" the answer, on the evidence, is a combination of: (i) the very marked increase in demand for these services in the five years up to 2017; (ii) the recent clinical controversy surrounding GID treatment, especially but not only for children; (iii) the difficulty, across both children's and adults' services, of recruiting and retaining sufficient clinical specialists, despite the availability of funding for them; and (iv) the need, in the light of the foregoing matters, to redesign the commissioning model. There is no evidence that any other specialist service has this particular combination of features. It follows that comparing those referred to GID services with those referred to other specialist services will not be comparing like with like.

146 During the course of argument, I asked counsel whether a disparity between the waiting times for treatment for diseases affecting only natal men (e.g. prostate cancer) and those affecting only natal women (e.g. ovarian cancer) could give rise to a claim of direct discrimination. Ms Grey answered that it could not, because the diseases would have different treatment pathways and require different specialist treatments, so the comparison would not be like for like. For my part, I think that such a disparity could, in principle, generate a well-founded claim of direct discrimination. But establishing such a claim would involve showing that the "reason why" the waiting times were different was sex-related. Thus, if it could be shown that a decision had been taken to prioritise services for one sex over those for the other, for a sex-related reason, the claim should succeed. (This would be a "motivation" claim, using Underhill LJ's classification.)

147 Equally, if there were evidence that the long waiting times for GID services were the result of a decision about the allocation of resources which was related to the shared protected characteristic of many services users (gender reassignment), a direct discrimination claim would succeed. The difficulty for the claimants is that there is no such evidence. On the contrary, as I have said, the evidence shows that the long waiting times have increased despite NHSE's willingness to increase very substantially the resources available for this service area. So far as the children's GID service is concerned, it is a striking fact that NHSE remains willing to fund a larger number of clinical specialists than Tavistock can currently persuade to take up the relevant roles.

148 In my judgment, the claimants have not established that NHSE treated them, because of their protected characteristic of gender reassignment, less favourably than they treat or would treat others. The direct discrimination claim therefore fails.

Indirect discrimination

149 Section 19 of the 2010 Act provides in relevant part as follows:

> "(1) A person (A) discriminates against another (B) if A applies to B a provision, criterion or practice which is discriminatory in relation to a relevant protected characteristic of B's.
>
> (2) For the purposes of subsection (1), a provision, criterion or practice is discriminatory in relation to a relevant protected characteristic of B's if—
>
> (a) A applies, or would apply, it to persons with whom B does not share the characteristic,
>
> (b) it puts, or would put, persons with whom B shares the characteristic at a particular disadvantage when compared with persons with whom B does not share it,
>
> (c) it puts, or would put, B at that disadvantage, and
>
> (d) A cannot show it to be a proportionate means of achieving a legitimate aim."

150 The PCPs relied on here are "the arrangements made by [NHSE] with providers of services to meet the needs of patients suffering from gender dysphoria". Mr Lock argues that these arrangements put patients who suffer from gender dysphoria at a disadvantage compared to patients suffering from other conditions by being required to wait longer for treatment: see para. 82(a) and (b) of the Claimants' Skeleton Argument.

151 The difficulty with this is that, by s. 19(2)(a), a PCP must be one that the alleged discriminator applies, or would apply, to persons with whom the claimant does not share the protected characteristic. But the only patients to whom the identified arrangements are applied to are those suffering from gender dysphoria. The arrangements made to meet the needs of these patients are not applied at all to patients suffering from other conditions. So, in my judgment, the indirect discrimination claim falls at the first hurdle.

152 If one assumes that a few of the patients to whom the arrangements applied do not share the protected characteristic of gender reassignment (because they have not yet made a settled decision to change some aspect of their gender identity), the arrangements do not place those who do share the protected characteristic at a disadvantage compared to these patients. There is no evidence that there is any difference in waiting times for gender dysphoria treatment between those who share the protected characteristic and those who do not.

153 The indirect discrimination claim therefore fails.

Ground 6

Submissions for the claimants

154 Mr Lock notes that, to comply with the public sector equality duty, a public authority must exercise its functions with more than just a "general awareness of the duty". What is required is "a substantial, rigorous and open-minded approach": *R (Boyejo) v Barnet London Borough Council* [2009] EWHC 3261 (Admin), [58]-[59] (HHJ Milwyn Jarman QC, sitting as a Deputy High Court Judge). The duty must be considered as an "integral part of the formation of a proposed policy", rather than as a "rearguard action following a concluded decision": *R (Kaur) v Ealing London Borough Council* [2008] EWHC 2062 (Admin), at [24] (Moses LJ).

155 Compliance with the duty requires a public authority to be informed about which protected groups will be impacted by a decision. That involves a continuing duty of enquiry: *Bracking v Secretary of State for Work and Pensions* [2013] EWCA Civ, [2014] EqLR 60, [27(8)] (McCombe LJ).

156 NHSE has conducted four equality impact assessments ("EIA"). These assess the equality impacts of: (1) the adoption of a new Service Specification for specialised gender identity services; (2) the adoption of a new Service Specification for GID services; (3) the operation of the Multi-Professional Review Group; and (4) the adoption of a new interim Service Specification for provision of healthcare to children and young people. The approach demonstrates that NHSE has breached the public sector equality duty by consistently failing to address the discrimination which has arisen as described in ground 4.

157 In particular, it is said that:

(a) The second EIA states that the Service Specification "would not advance or hinder any specific equality issue experienced by gender variant young people, as compared to non-gender variant young people of the same age". This demonstrates a failure to compare the proposed changes with changes in healthcare provision for children with different protected characteristics. The inappropriate comparator meant that differential treatment between those referred to GID services and those referred to other services was ignored.

(b) The fourth EIA operated on the false basis that children who had not been formally diagnosed with gender dysphoria could not have the protected characteristic of gender reassignment. It was therefore incapable of properly addressing the issue of the discriminatory wait times faced by those referred for children's GID services.

Submissions for the defendant

158 Ms Grey points out that EIAs are not the only means by which a public authority can show compliance with the public sector equality duty. EIAs are appropriate to assess the equality impacts of particular proposed policies. But where, as here, a claimant challenges a more general failure to drive down waiting times, it is not surprising that there is no EIA directed towards that failure.

159 The Service Specifications specify that patients should receive timely and appropriate treatment in accordance with national waiting time requirements, so one would not expect the EIAs associated with these documents to consider whether a failure to meet these requirements is discriminatory or impacts on equality of opportunity between those who share the protected characteristic of gender reassignment and those who do not.

160 So far as adults' services are concerned, the document which evidences compliance with the s. 149 duty is the Clinical Business Case for Gender Dysphoria Services, published in January 2019, which explains the case for the new tendering process, designed to encourage new applications to provide adults' GID services. This recognises the patient experience as "increasingly poor most notably because of excessive waiting times" (para. 16) and notes that this is in breach of the NHS Constitution requirements (para. 22). At para. 27, the document says this:

> "The direct consequences of long waiting times and waiting lists are increased risk of harm to the individual and increased pressures on other parts of the NHS system. Trans people are at higher risk of physical and mental health problems, exacerbated by barriers to access of specialised gender identity services. Incidence of 'minority stress' is high. Evidence is that coping strategies include self-sourcing of cross-sex hormone drugs from un-regulated sources, self-harm, use of drugs, alcohol, tobacco or high risk sexual activity. The incidence of suicidal ideation is high compared to the general population. Un-met trans-healthcare is a contributing factor to the increased disproportionate risk of acquiring HIV in the trans-population. Trans people have complex interactions with other health services which will be exacerbated if there is unmet transgender specific care, particularly: primary care, mental health, CAMHS, sexual health, A&E and crisis services."

161 Para. 40 outlines NHSE's hopes for the new procurement exercise. Paras 118-128 describes the consultation exercise proposed, which includes significant patient and user input, including from the Trans Network, which comprises around 100 trans and non-binary people and representatives of campaign groups.

162 As to children's GID services, the most recent EIA (dated 12 October 2022 and accompanying the Interim Service Specification for Specialised Services for Children and Young People) post-dates the issue of this claim. It describes the "main potential positive or adverse impact" of the proposal as follows:

> "Not all children and young people who will be impacted by the proposals are likely to share this protected characteristic:
>
> - Children and young people who are on the waiting list for GIDS, or who may be referred to a Phase 1 service in the future, or who are receiving an assessment by GIDS and who are without a diagnosis of gender dysphoria, do not share the protected characteristic of 'gender reassignment' as a class or cohort of patients. They cannot be treated as "proposing to undergo" a process (or part of a process) for the "purpose of reassigning" their sex "by changing physiological or

> other attributes of sex". To apply such a definition to these individuals is to make assumptions upon the aims and intentions of those referred, the certainty of those desires and their outward manifestation, and upon the appropriate treatment that may be offered and accepted in due course.
>
> - Children and young people who are under the care of GIDS and who have a clinical diagnosis of gender dysphoria may share the protected characteristic of 'gender reassignment' though none of the relevant clinical information will be known to NHSE, which has no knowledge of each individual's situation in regard to treatment goals.
>
> The cohort of children and young people who are most likely to share this protected characteristic are therefore those who are currently under the care of GIDS with an individualised care plan in place. This cohort of patients will not be positively impacted by the terms of the proposed interim service specification, which intends to describe an interim delivery model that is safe, and that is more focused on addressing a child / young person's overall health needs in an integrated way. However although not a direct impact of the proposed service specification itself – NHSE will be mindful that this cohort of individuals may be disproportionately impacted by the potential risks of a transfer of ongoing care to another provider, including: anxiety and distress about the perceived uncertainty of the outcome of the process of transfer; loss of clinical staff and interruption to ongoing care; inconvenience and anxiety about visiting a different provider."

163 Under "main recommendation… to reduce any key identified adverse impact or to increase the identified positive impact", the following appears:

> "A clinically led process for the transfer of clinical responsibility from the Tavistock and Portman NHS Foundation Trust to a new provider will be established to mitigate risk.
>
> The proposed interim service specification would prevent referrals by non-health professionals; for the reasons explained, it is not possible to determine whether children and young people who may be impacted by this provision are likely to share the protected characteristic of 'gender reassignment'. As a mitigation to any adverse impact, as new regional pathways are established it is planned that managed networks will be developed that will provide support resources for GPs, schools and families in regard to children and young people who present with less severe manifestations of gender incongruence or gender diversity or who otherwise do not meet the access criteria for a specialised gender dysphoria service.
>
> The proposed interim service specification provides further clarity to the terms of the current GIDS service specification in

> regard to children and young who source puberty blockers drugs and endocrine drugs from unregulated sources; for the reasons explained, it is not possible to determine whether children and young people who may be impacted by this provision are likely to share the protected characteristic of 'gender reassignment'. These provisions are in line with the advice of senior clinicians and reflect, in part, the legal duties on NHS bodies in regard to safeguarding. The independent Multi Professional Review Group will continue to operate in the case of referrals of children under 16 years to the endocrine clinics until the research protocol is established.
>
> Mitigating actions in regard to children and young people who are currently under the care of GIDS, and their families, will focus on ongoing, clear and timely individual communication."

164 This sets out "a reasonable account of the "cohort" point and discusses the mitigation that will manage the risk of change for all children and young people, whether they share the protected characteristic of gender reassignment or not. The substantive work to protect those with protected characteristics is described in the witness statements of Mr Glyde, the work of Dr Cass and a paper to the National Quality Innovation Committee dated 4 September 2020.

Discussion

165 Section 149 of the 2010 Act requires NHSE, in the exercise of its functions, to have due regard to the need to "(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act; (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it."

166 The principal way in which the s. 149 point was put for the claimants was that the material relied upon by NHSE does not address the discrimination identified in Ground 4. Having found under Ground 4 that the waiting lists do not give rise to direct or indirect discrimination, NHSE cannot be in breach of s. 149 by failing to have regard to the need to eliminate discrimination. Section 149(1)(b) and (c), however, can apply even in situations where there is no discrimination to eliminate. Here, the long waiting times have the potential to affect both equality of opportunity and good relations between those who share the protected characteristic of gender reassignment and those who do not.

167 As the claimants' evidence shows, those referred for treatment will have a range of presentations, but all will be experiencing some form of incongruence between their assigned gender and the gender with which they identify. The effects of this incongruence will vary, but in some cases can be very debilitating and profoundly affect their ability to live fulfilling social lives. The starkest, though by no means the only, manifestation of this is the high rate of suicidal ideation among the trans population, both among adolescents and among adults.

168 Section 149 imposes duties of substance, not form. The duty must be exercised "in substance, with rigour and with an open mind", but equally, "there is no duty to make

express reference to the regard paid to the relevant duty": *Bracking*, [27(5)(iii)]. In my view, therefore, the question is whether NHSE, in deciding what action to take about the acknowledged long waiting times, had due regard to their real-life effects on the needs to advance equality of opportunity and foster good relations between trans people and others (in this context, using "trans" as a shorthand for those with the protected characteristic of gender reassignment).

169 In its latest EIA, published after this claim was issued (see para. 161 above), NHSE proceeded on the basis that children and young people on the waiting list for a first appointment "do not share the protected characteristic of 'gender reassignment' <u>as a class or cohort of patients</u>". This is correct. As I have sought to explain, not all of those referred to the children's GID service will share the protected characteristic. It would have been better to state expressly that many children and young people in this position will share the protected characteristic. On a fair reading, however, the EIA shows that NHSE <u>did</u> proceed on this basis: see especially the discussion of "mitigations". Moreover, it is important to bear in mind that the EIA was published as part of a consultation on the proposed new Service Specification. The consultation closed in December 2022, so the policies which the EIA assesses are still under consideration, as are the equality impacts. That will be a continuing process, which will take into account not only consultation responses, but also (no doubt) this judgment. Overall, the contents of the October 2022 EIA do not show that NHSE's substantive consideration of the needs identified in s. 149(1) of the 2010 Act was flawed.

170 More important in gauging the substantive compliance with s. 149 with respect to children's GID services is the interim report of Dr Cass and the decisions to accept her recommendations. In my judgment, no fair reader of that report could conclude that NHSE had failed to inform itself of the effects of long waiting times on those with the protected characteristic of gender reassignment. See, e.g. the references to: "considerable distress for those on the waiting list" (para. 3.10); "the distress that young people experience through puberty and the risk of self-harm or suicide" (para. 3.28); "children and young people facing the stress of being on a prolonged waiting list with limited support available from statutory services, lack of certainty about when and if they might reach the top of that list and subsequent impacts on mental health" (para. 4.2); and "current long waiting lists that gender-questioning children and young people and their families/carers face" which are "unacceptable for all parties involved" (para. 4.36).

171 The witness evidence of Mr Glyde shows that NHSE is and has been aware of the impacts of long waiting times and that its decision to accept the recommendations of Dr Cass has been driven in large part by the need to drive down these waiting times.

172 Against that background, I consider that NHSE has complied in substance with its duty to have due regard to the need to advance equality of opportunity and foster good relations between trans people and others (again using "trans" for these purposes as a shorthand for those sharing the protected characteristic of gender reassignment) in the exercise of its functions with respect of children's GID services.

173 The position with regard to compliance with s. 149 in respect of adult GID services is, if anything, even clearer. The passages cited in para. 160 above from the 2019 Business Case seem to me to acknowledge very candidly the adverse effects of waiting times on patients referred to adults' GID services and the action being taken to address these effects. It is quite clear from this document, and from NHSE's evidence as a whole, that

it considers the action being taken will improve the position of those with the protected characteristic of gender reassignment. The fact that this was not framed in terms as a positive effect on equality of opportunity or as capable of improving relations between trans people and others does not affect the conclusion that the s. 149 duty has been complied with in substance.

Conclusion

174 For these reasons, none of the claimants' grounds succeeds. The claim will therefore be dismissed.

Postscript: the standing of the fifth and sixth claimants

175 NHSE did not dispute the standing of the fifth or sixth claimants. Permission was granted without comment on that issue. Accordingly, I heard no argument on it. In the light of my conclusions on the substance, it does not matter. However, given that the first four claimants plainly do have standing to bring this challenge, it is not obvious to me why there was any need to add the fifth and sixth. The availability of a better placed, directly affected challenger will generally tell against according standing to an individual or organisation seeking to litigate in the public interest: see my judgment in *R (Good Law Project) v Secretary of State for Health and Social Care* [2021] EWHC 246 (Admin), [2021] PTSR 1251, [106]; *R (Good Law Project) v Prime Minister* [2022] EWHC 298 (Admin), [28] (Singh LJ and Swift J); *R (AAA) v Secretary of State for the Home Department* [2022] EWHC 3230 (Admin), [432] (Lewis LJ and Swift J). See also paras 3.3.1 and 6.3.2.7 of the Administrative Court Judicial Review Guide (2022).