APPENDIX 1

Case No: CO/2440/2011

Neutral Citation Number: [2011] EWHC 2986 (Admin)
IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 07/11/2011

Before :

THE HONOURABLE MR JUSTICE OWEN

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Between :

ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	**Claimant**
- and -	
(1) JOINT COMMITTEE OF PRIMARY CARE TRUSTS	**Defendants**
(2) CROYDON PRIMARY CARE TRUST (on its own behalf and as representative of all Primary Care Trusts in England)	

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Alan Maclean QC and **David Scannell** (instructed by **Hempsons Solicitors**) for the **Claimant**
Neil Garnham QC and **Marina Wheeler** (instructed by **Capsticks Solicitors LLP**) for the **Defendants**

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Judgment

The Honourable Mr Justice Owen:

1. The claimant, the Royal Brompton and Harefield NHS Foundation Trust (the RBH Trust) seeks to quash as flawed and unlawful a consultation by the first defendant, the Joint Committee of Primary Care Trusts (the JCPCT) concerning the reconfiguration of paediatric congenital cardiac services (PCCS) in England.

2. The RBH Trust is a specialist heart and lung centre based at the Royal Brompton Hospital London and Harefield Hospital, Middlesex. It is the largest specialist heart and lung centre in the UK and among the largest centres in Europe. Its hospitals have, for many decades, been at the forefront of specialised treatment for complex heart and lung disease. Its paediatric service provides a specialist service for children's heart and lung disease and comprehensive paediatric critical care services.

3. On 29 May 2008 the National Health Service Medical Director, Sir Bruce Keogh, acting on behalf of the National Health Service Management Board, requested the NHS National Specialised Commissioning Group (NSCG) to review the provision of paediatric congenital cardiac services, a review that came to be called the 'Safe and Sustainable Review' (the Review). In 2010 the JCPCT was established as the formal consulting body with responsibility for the conduct of the consultation on the Review and for taking decisions on issues the subject of the consultation.

4. On 1 March 2011, the JCPCT published a Consultation Document entitled "*Safe and Sustainable: A New Vision for Children's Congenital Heart Services in England"* (the Consultation Document).

5. The central proposal in the Consultation Document is that the number of centres providing paediatric cardiac surgical services be reduced from eleven to either six or seven, and that the paediatric congenital cardiac service be reconfigured into one of four national configuration options. Each of the four options includes two London surgical centres, namely Evelina Children's Hospital (Evelina) and Great Ormond Street Hospital for Children (GOSH).

6. The claimant challenges the consultation process on the basis that the decisions to exclude a three London centre option from the proposed options, and to exclude the RBH Trust from the preferred two London centre options are legally flawed. By its application for judicial review the RBH Trust seeks a declaration that the consultation is unlawful, and an order that it be quashed.

7. The application for judicial review was issued on 16 March 2011. Permission was granted at an oral hearing on 15 July 2011 by Burnett J, who also considered, but rejected, an application for interim relief, an assurance having been given on behalf of the defendant that the decision to be taken following the consultation process would not be taken pending judgment on the claim.

8. <u>The Legal Framework</u>

<u>The Decision Making Structures within the NHS</u>

It is necessary first to set the context within which the Review has been undertaken. Sections 1 and 3 of the National Health Service Act 2006 (the "Act"), oblige the

Secretary of State for Health to provide or secure certain medical services. By regulation 3 of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 (SI 2002/2375) (the "2002 Regulations"), as amended, that function has for the most part been delegated to Primary Care Trusts ("PCTs"), of which there are 152 in England.

9. PCTs commission services from 'providers', including NHS Foundation Trusts to meet the needs of the populations for which they are responsible.

10. Section 242 (2) (b) of the Act imposes a duty on each body to which it applies, which includes PCTs, to consult persons to whom services are being or may be provided on "*the development and consideration of proposals for changes in the way those services are provided*".

11. Paragraph 10.3.2 of the Department of Health's Overview and Scrutiny of Health Guidance provides that:

> *"… where a proposed service change spans more than one PCT, they will need to agree a process of joint consultation. The Board of each will need to formally delegate responsibility to a Joint Committee, which should act as a single entity. Following consultation the Joint PCT Committee will be responsible for making the final decision on behalf of the PCTs for which it is acting."*

12. Specialised paediatric cardiology and cardiac surgery services are "specialised services", as defined in the National Specialised Services Definition Set. Specialised services are commissioned regionally by Specialised Commissioning Groups ("SCGs"), which are constituted as joint committees of the PCTs in their catchment area. There are ten SCGs in England corresponding to the ten Strategic Health Authorities.

13. The NSCG coordinates the work of the ten SCGs and oversees pan-regional commissioning where a specialised service has a catchment area or population greater than that of a single SCG.

14. <u>The Requirements of a Lawful Consultation</u>

The requirements of a lawful consultation were identified by the Court of Appeal in *R v North & East Devon HA Ex parte Coughlan* [2001] QB 213. The judgment of the court was given by Lord Woolf MR.

> "*108. It is common ground that, whether or not consultation of interested parties and the public is a legal requirement, if it is embarked upon it must be carried out properly. To be proper, consultation must be undertaken at a time when proposals are still at a formative stage; it must include sufficient reasons for particular proposals to allow those consulted to give intelligent consideration and an intelligent response;*

> *adequate time must be given for this purpose; and the product of consultation must be conscientiously taken into account when the ultimate decision is taken: R v Brent London Borough Council, Ex parte Gunning (1985) 84 LGR 168."*

> *"112. … it has to be remembered that consultation is not litigation: the consulting authority is not required to publicise every submission it receives or (absent some statutory obligation) to disclose all its advice. Its obligation is to let those who have a potential interest in the subject matter know in clear terms what the proposal is and exactly why it is under positive consideration, telling them enough (which may be a good deal) to enable them to make an intelligent response. The obligation, although it may be quite onerous, goes no further than this."*

15. The requirements of a lawful consultation identified by Lord Woolf reflect the underlying requirement of fairness to those who may be affected by the decision to which the consultation is directed.

16. The requirement that consultation must be at a time when proposals are at a formative stage can be expressed as a requirement that the decision maker has not pre-determined the issue upon which he goes out to consultation, i.e. that he has an open mind. That said, and as Mr Garnham QC submitted in the course of argument, to have an open mind does not mean an empty mind.

17. As Lord Woolf observed at paragraph 112 of *Coughlan*, the obligation on the consulting authority is to let those with a potential interest in the subject matter know in clear terms what the proposal is, and why it is under consideration. Where a number of options are under consideration by the decision maker, it is properly open to him to identify the option or options that he favours, provided that his mind is open to the possibility that further information or argument may lead to a different conclusion.

18. Thus in *Sardar & Others and Watford Borough Council* [2006] EWHC 1590 (Admin), Wilkie J observed at paragraph 29:

> *"29. … the description "a formative stage" may be apt to describe a number of different situations. A Council may only have reached the stage by identifying a number of options when it decides to consult. On the other hand it may have gone beyond that and have identified a preferred option upon which it may wish to consult. In other circumstances it may have formed a provisional view as to the course to be adopted or may "be minded" to take a particular course subject to the outcome of consultations. In each of these cases what the Council is doing is consulting in advance of the decision being consulted about being made. It is, no*

> *doubt, right that, if the Council has a preferred option, or has formed a provisional view, those being consulted should be informed of this so as better to focus their responses. The fact that a Council may have come to a provisional view or has a preferred option does not prevent a consultation exercise being conducted in good faith at a stage when the policy is still formative in the sense that no final decision has yet been made … "*

19. Similarly in *R (Medway Council & Others) v Secretary of State for Transport* [2002] EWHC 2516 (Admin), Maurice Kay J held that:

> *"26. In my judgment, subject to other issues such as those raised by the other grounds of challenge in this case, the Secretary of State was entitled to proceed in that way. Other things being equal, it was permissible for him to narrow the range of options within which he would consult and eventually decide. Consultation is not negotiation. It is a process within which a decision-maker, at a formative stage in the decision-making process, invites representations on one or more possible courses of action …"*

20. The above passage was cited by Bean J in *R (on the application of Tinn) v Secretary of State for Transport & Another* [2006] EWHC 193 (Admin), who went on to observe that:

> *"32. But in public law context is everything. The defendants' decision announcing a preferred route has yet to be made. There is no dispute that in the context of major highway schemes single route consultation is not unusual; and it has not been suggested to be ipso facto unlawful. The requirement to consult while the proposals are at a formative stage cannot mean that there must be first round of consultation on whether to reduce the options consulted upon to one, and then a second round of consultation on that one … "*

21. In the context of the NHS the Court of Appeal held in *R v Worcestershire Health Council* [1999] EWCA (Civ) 1525, per Simon Brown LJ that:

> "*If, as is clearly established (and is, in any event, only plain common sense) an authority can go out to consultation upon its preferred option, per O'Connor LJ* ["in Nichol v Gateshead Metropolitan Council (1988) 87 LGR 435 at 456 where in effect, he found it permissible for an authority to have a preferred option] *or with regard to a "course it would seek to adopt if after consultation it had decided that that is the proper course to adopt" per Woolf J (*R v Hillingdon Heath Authority Ex parte Goodwin [1984] ICR 800 at page 809), "*then it seems*

> *to me plain that it can choose not to consult upon the less preferred options. It does not, in other words, have to consult on all possible options merely because at some point they were developed, crystallised, canvassed and considered."*

22. In this context Mr Maclean QC sought to rely upon the decision of Munby J in *R (Montpeliers & Trevors Association) v City of Westminster* [2005] EWHC 16 (Admin) as authority for the proposition that fairness may require consultation on every viable option. At paragraph 29 of his judgment Munby J observed that:

> *"… fairness required a consultation process in which all those interested, whether pro or con, were invited to express their views on all the various options."*

23. But it is important to have in mind the context in which that observation was made. When addressing the first issue to which the claim gave rise, the question of whether there had been a failure properly to consult, Munby J was satisfied on the evidence that:

> *"25… the statutory process was not a process of consultation meeting the Partingdale Lane criteria; and the subsequent process, although a process of consultation, was vitiated by the fact that one of the options – and an option which on any view was of central significance – had already been excluded from further consideration."*

The reference to Partingdale Lane criteria was a reference to *R (Partingdale Lane Residents Association) v Barnet London Borough Council* [2003] EWHC 947 (Admin), [2003] All ER (D) 29, a decision of Mr Rabinder Singh QC, sitting as a Deputy High Court Judge, in which he observed at paragraph 47 that:

> "*… consultation must take place at a stage when a policy is still at a formative stage … a proposal cannot be at a formative stage if a decision maker does not have an open mind on the issue of principle involved.*"

Thus *Montpeliers* is an example of a case in which a consultation was flawed by predetermination of a central issue.

24. The second requirement of a fair consultation identified in *Coughlan* is that:

> "*… it must include sufficient reasons for particular proposals to allow those consulted to give intelligent consideration and an intelligent response"*.

25. The corollary is that the information contained in a consultation document should not be so inaccurate or incomplete as to mislead potential consultees in their responses. Inaccurate or incomplete information may preclude an informed and intelligent response, which may in turn operate to the disadvantage of a party that may be

affected by the decision to which the consultation is directed, and in consequence render the consultation process so unfair as to be unlawful. The point is of particular importance where the information contained in a document that is put out to consultation is outside the knowledge of those consulted, and upon which they are therefore obliged to rely in formulating their response.

26. The Review – The Factual Background

The 2001 Report of the Public Inquiry into deaths at Bristol Royal Infirmary chaired by Professor Sir Ian Kennedy, noted that "*the healthcare needs of children are different from those of adults"*, and described healthcare services for children as "*fragmented and uncoordinated*". Relevant recommendations included:

> "*192. National standards should be developed as a matter of priority for all aspects of the care and treatment of children with congenital heart disease.*
>
> *193. With regard to paediatric cardiac surgery, the standards should stipulate the minimum number of procedures which must be performed in a hospital over a given period of time in order to have the best opportunity of achieving good outcomes for children*;
>
> *194. With regard to those surgeons who undertake paediatric cardiac surgery... it may be that four sessions a week should be the minimum number required. Agreement on this should be reached as a matter of urgency after appropriate consultation;*
>
> *198. An investigation should be conducted as a matter of urgency to ensure that PCS (*paediatric cardiac surgery*) is not currently being carried out where the low volume of patients or other factors make it unsafe to perform such surgery"*.

27. In response to the Kennedy report, the Department of Health convened a group, the Paediatric and Congenital Cardiac Services Review Group, jointly chaired by James Monro and David Hewlett, to make recommendations for the safe organisation of such services. The Monro report, published in December 2003, reached conclusions similar to those of the Kennedy report, recognising that there was a case for some re-organisation of the centres providing paediatric cardiac surgery services.

28. In 2006 a meeting was convened of children's heart surgeons and cardiologists from the surgical centres providing paediatric cardiac surgery services and other interested parties. The meeting, which was chaired by Professor Sir Roger Boyle CBE, National Director for Heart Disease and Stroke and Dr Sheila Shribman CBE, National Clinical Director for Children, Young People and Maternity Services, concluded that children's heart surgery services as currently configured in England were not sustainable.

29. In 2007 a report by the Children's Surgical Forum of the Royal College of Surgeons of England, … "*Surgery for Children – Delivering a First Class Service*", recommended inter alia fewer and larger paediatric cardiac surgical centres.

30. It was in response to such concerns that on 29 May 2008 Sir Bruce Keogh wrote to the NSCG on behalf of the NHS Management Board asking it to undertake a review of the provision of paediatric cardiac surgical services in England with a view to their reconfiguration.

31. At that point there were eleven hospital centres of varying size in England with 31 surgeons performing approximately 3,600 paediatric heart surgery procedures per year. The eleven surgical centres were:

    i) Newcastle Upon Tyne Hospitals NHS Foundation Trust

    ii) Leeds Teaching Hospitals and NHS Trust

    iii) Alder Hey Children's Foundation Trust

    iv) University Hospitals of Leicester NHS Trust

    v) Birmingham Children's Hospital NHS Foundation Trust

    vi) Great Ormond Street Hospital for Children NHS Trust (GOSH)

    vii) University Hospitals Bristol NHS Foundation Trust

    viii) Royal Brompton & Harefield NHS Foundation Trust (RBH Trust)

    ix) Guys & St. Thomas' NHS Foundation Trust (Evelina)

    x) Southampton University Hospitals NHS Trust

    xi) John Radcliffe Hospital Oxford.

32. The aim of the Review was to develop a national service that has:

    "(i) Better results in surgical centres with fewer deaths and complications following surgery;

    (ii) Better, more accessible assessment services and follow up treatment delivered within regional and local networks;

    (iii) Reduced waiting times and fewer cancelled operations;

    (iv) Improved communication between parents and all of the services in the network that see their child;

    (v) Better training for surgeons and their teams to ensure the service is sustainable for the future;

    (vi) A trained workforce of experts in the care and treatment of children and young people with congenital heart disease;

(vii) Surgical centres in the forefront of modern working practices and new technologies that are leaders in research and development; and

(viii) A network of specialist centres collaborating in research and clinical development, encouraging the sharing of knowledge across the network."

33. The Review was guided by the five principles set out in the pre-consultation business case (the Business Case), and in very similar terms in the Consultation Document, namely:

"(i) The welfare of the child is paramount in all considerations;
(ii) Quality: all children in England and Wales with congenital heart disease must receive the very highest standard of care;
(iii) Equity: the same high quality of service must be available to each child regardless of where they live;
(iv) The NHS must plan and deliver care that is based around the needs of the child (children are not just little adults);
(v) Local where possible".

34. <u>The Administrative Structure for the Review</u>

The administrative machinery for managing the Review has evolved as the Review has progressed.

35. Day to day management of the Review has been led by a project team of the NSCG (the "NSCG Team"), assisted by a number of specialist working groups, in particular:

1. a Steering Group;

2. a Standards Working Group (a sub-group of the Steering Group) and

3. an Independent Assessment Panel (the "Independent Panel")

36. <u>The Steering Group</u>

The Steering Group was chaired by Dr. Patricia Hamilton, past President of the Royal College of Paediatrics and Child Health and Director of Medical Education in England. It comprised about 25 – 30 members drawn from professional and lay associations and commissioners representing a broad geographical spread. The original membership included Dr (now Professor) Shakeel Qureshi, a consultant paediatric cardiologist at the Evelina and then President elect of the British Congenital Cardiac Association (BCCA). It was subsequently expanded to include Professor Martin Elliott, a consultant paediatric cardiothoracic surgeon at GOSH, and a senior member of the BCCA.

37. The role of the Steering Group was originally to steer the development of proposals, reporting to the NSCG on, inter alia, the appropriate model of care, standards, and criteria for the designation of services.

38. Proposals for reconfiguration were initially to be developed by the SCGs organised into four regional zonal teams (" The SCG Collaboratives") reporting to the Steering Group. London was included within the South Eastern Zone which also comprised the East of England and SE Coast SCGs. The SCGs Collaboratives were charged with identifying reconfiguration options within their zones.

39. The Standards Working Group

The Standards Working Group was a multi-disciplinary panel of experts, set up as a sub-group of the Steering Group, to research and develop a framework of clinical and service standards. Draft Standards were to be presented to the Steering Group, then to the NSCG for endorsement. Once agreed, they were to be used to assess the existing 11 centres and their ability to provide a high quality service in the future.

40. The Independent Panel

The Independent Panel, chaired by Professor Sir Ian Kennedy, was tasked with reviewing each of the existing 11 providers of PCCS services and evaluating their compliance with the proposed service standards. Panel membership comprised experts in paediatric cardiac surgery, paediatric cardiology, paediatric anaesthesia/paediatric intensive care, paediatric nursing, paediatrics and child health, together with lay representatives and NHS commissioners. It was a requirement that members should have no existing or direct relationship with any of the 11 current providers.

41. In the Spring of 2009 concerns emerged as to how the arrangements for the Review would work in practice. It was considered that the process by which SCG Collaboratives would recommend centres within their zones might not result in an appropriate distribution of services. Secondly there was a question as to whether there was a body with authority to take decisions as to implementation of the Review.

42. At the end of 2009, and in the light of such concerns, the governance structure of the Review was revised. The SCG Collaboratives were disbanded. Secondly the NSCG recommended the establishment of a Joint Committee of Primary Care Trusts to act as a single body with delegated powers of consultation and decision making. In April 2010 the NHS Operations Board endorsed the proposed JCPCT subject to ministerial approval which was obtained in July 2010. Although the JCPCT was not formally constituted until it received ministerial approval, I shall refer to it throughout as the JCPCT.

43. With the creation of the JCPCT, the Steering Group's mandate was no longer to "steer" the Review, but to advise the JCPCT, the sole decision maker acting on behalf of all English PCTs, on clinical matters, including the design of the proposed congenital heart networks. The change was reflected in the Steering Group's revised Terms of Reference published in June 2010.

44. The progress of the Review

In January 2010, the 11 provider centres were asked to provide "baseline" information to the NSC Team setting out their current service provision. In March - April 2010, the Standards Working Group published and circulated their proposed national quality standards (Service Standards). The report endorsed the concentration of specialist

expertise, including surgery, cardiology, anesthesia and nursing, into larger teams at Specialist Surgical Centres, recommending inter alia that each such centre:

> *"C4 …must be staffed by a minimum of four full time consultant congenital cardiac surgeons;*
>
> *C6 …must undertake a minimum of 400 paediatric surgical procedures per year to avoid 'occasional practice';*
>
> *C7 …should perform a minimum of 500 paediatric surgical procedures each year."*

45. The Service Standards also set out a 'vision' for the development of a new model of care, Children's Congenital Heart Networks, identifying the constituent parts of such networks: Specialist Surgical Centres designated to perform surgical and other interventionist procedures; Children's Cardiology Centres staffed by experienced paediatric cardiologists performing in-patient and out-patient non-invasive procedures and providing care for children with coronary heart disease; and District Children's Cardiology Centres based in local hospitals with a team led by a consultant paediatrician with expertise in cardiology able to receive referrals from other hospitals, GPs and others involved in primary care. The Service Standards acknowledged that networks would develop according to local circumstances; but the national model was directed at developing formal relationships between the three main elements of the service.

46. <u>The stages of the Review</u>

There were three distinct stages to the Review:

1. self-assessment;
2. an assessment by the Independent Panel;
3. a 'configuration options assessment' to establish a shortlist of options.

47. <u>Self-assessment</u>

Following publication of the draft Service Standards in March 2010, each centre wishing to be designated as a Specialist Surgical Centre was required to complete a self-assessment template directed at their compliance with criteria derived from the Service Standards. The template addressed the criteria in relation to which evidence was sought, including "*excellence of care*", and "*deliverability and achievability"*. The former was particularized in "*Core Requirement 7"*, which included the following:

> *"Each Tertiary Centre must have, and regularly update, a research strategy and programme that documents current and planned research activity, the resource needs to support the activity and objectives for development. The research strategy must include a commitment to working in partnership with other centres in research activity which aims to address research issues that are important for the further development*

> *and improvement of clinical practice, for the benefit of children and their families"*.

48. The RBH Trust submitted its self-assessment in May 2010. It included over 100 supporting documents grouped into 20 appendices. In response to Core Requirement 7 it said, inter alia,

> *"The Trust has recently restructured its research and development arrangements including the recruitment of a new Associate Director of Research. A key aim of these changes is to improve the alignment of the Trust research activity with the objectives of the NHS at large."*

Appendix 20 to the response contained "*The Trust Research Strategy"*.

49. The centres were later sent a second template concerning the specialised nationally commissioned services that rely on cardiac surgery: paediatric heart and lung transplantation, complex tracheal surgery and respiratory extracorporeal membrane oxygenation ("ECMO"). Centres which did not currently provide such services were asked whether they wished to seek designation to do so following reconfiguration. The RBH Trust does not provide such services and did not seek designation to do so in future.

50. Under a section of the second template headed "*Other implications for reconfiguration*", information was requested about "*the likely impact on PICU* (Paediatric Intensive Care Unit) *if your centre was not designated*".

51. <u>The assessment by the Independent Panel</u>

On receipt of the self-assessments, the Independent Panel agreed initial scores for each centre. It then undertook a round of visits to the centres in May/June 2010, visiting the Royal Brompton on 9 June. Following the visits the self-assessments and scoring were reviewed, and each centre was given a score measuring its current and future compliance against the criteria.

52. On 20 August 2010, Teresa Moss, Director of National Specialised Commissioning, wrote to inform the RBH Trust that compliance with the designated standards had been scored. Similar letters were sent to the other centres. The letter explained that:

> *"The assessment visits constitute one element of the process for delivering recommendations for reconfiguration. The joint committee of NHS commissioners responsible for delivering recommendations (the JCPCT) will also take account of other criteria to ensure that eventual recommendations may lead to a safe, sustainable and accessible national service."*

53. The letter informed the Trust that each of the centres had been scored; but the covering email said that the JCPCT had decided not to divulge the scores at that stage. After making a number of observations as to the degree to which the RBH Trust had satisfied the criteria, the letter continued:

"The panel did not assess the deliverability and achievability section at any centre due to the difficulty in making this judgement given the information available to them. These criteria will be considered by the Joint Committee of PCTs in developing recommendations for configuration."

54. The scores at which the Panel arrived at that stage were subsequently made public in the Business Case and in the Consultation Document. They were as follows:

Evelina	535
Southampton	513
Birmingham	495
Great Ormond Street	464
Royal Brompton	464
Bristol	449
Newcastle	425
Liverpool	420
Leicester	402
Leeds	401
Oxford	237

55. <u>The configuration options assessment</u>

The configuration options assessment was the process by which the JCPCT identified options for inclusion in the consultation process. There were two phases to the assessment:

i) the establishment of a shortlist of viable options;

ii) the scoring of shortlisted options against evaluation criteria to determine which options to put out to formal consultation.

56. Management consultants, KPMG, were engaged to assist in the configuration options assessment. The KPMG team was led by an associate partner, Professor Hilary Thomas.

57. <u>Phase 1 – the shortlisting of viable options</u>

At the first meeting of the proposed JCPCT on 7 July 2010, Professor Thomas was asked to reduce the large number of theoretical options for reconfiguration. It was agreed by the JCPCT that the following criteria should be applied to shortlist potential options:

"*(i) Each centre should perform a minimum of 400 paediatric procedures per year, but ideally 500 paediatric procedures.*

(ii) Centres will be included in the reconfiguration options in order of preference relating to their panel ranking.

(iii) 'Best fit': equitable access."

The steps in the process by which such criteria were applied to the theoretical options are set out in detail in the witness statement of Professor Thomas. But for present purposes it is sufficient to summarise the result, namely the identification of 13 options presented to the JCPCT at its meeting on 28 July 2010.

58. At its meeting on 28 July 2010, the JCPCT agreed inter alia that there should be at least two centres in London, but further narrowed the options to eight in number, deciding at that point that only those with two centres in London should be subjected to further analysis, a decision that was subsequently reversed. The draft minutes of the meeting record that:

> "*Members discussed the recommendation that two centres was the optimum number of centres for London. Members were of the opinion that it was likely that the Royal Brompton Hospital would be excluded from the potential options given the findings and outcome of the assessment panel of visits, the absence of any advantages of access and the advantages possessed by the other London centres. Members agreed that at this stage the Royal Brompton Hospital would be excluded from further analysis around travel and access. Though Members were in agreement that all three London centres would be included in the process for evaluating the London centres against the evaluation criteria on 1 September. Sir Neil said that this was a legitimate approach in order to keep the number of potential viable options manageable.*"

59. At the following meeting on 1 September, Professor Thomas presented five short-listed options chosen from the eight options agreed at the JCPCT meeting on 28 July 2010.

60. It was originally intended that the JCPCT would score the options at its meeting on 1 September 2010; but instead the method for scoring and analysis was discussed at length and a further meeting scheduled for 28 September.

61. Between the meeting of the JCPCT on 1 September and its next meeting on 28 September, KPMG were asked to reconsider the six two London centre options and four three London centre options that had been previously discounted by them in arriving at the five options presented at the meeting of 1 September. As a result twelve options were presented to the JCPCT for discussion on 28 September, namely:

i) Four seven site options with two centres in London (as at the previous meeting).

ii) Four six site options with two centres in London (one of which had been presented at the last meeting).

iii) Four three London centre options.

The minutes of the meeting do not record any concluded view by the JCPCT as to options to be put out to consultation.

Phase 2 – the scoring of the options.

62. The options were scored against weighted criteria. In June/July 2010 the NSC team, acting on the advice of the Steering Group, consulted stake holder groups both as to the proposed criteria and as to the weightings to apply to such criteria for the purpose of the Configuration Evaluation. The stakeholders included SCG directors, parents who had registered for one of the 2010 engagement events and five clinicians nominated by the current surgical centres. They were notified that it would be for the JCPCT to agree the evaluation criteria and the weightings to be applied to them.

63. The criteria ranked in order of importance addressed:

(1) Quality: (a) centres will deliver a high quality service; (b) innovation and research are present; (c) clinical networks are manageable;

(2) Deliverability: (a) high quality NCSs will be provided; (b) the negative impact on other interdependent services will be kept to a minimum, as will negative impacts on the workforce;

(3) Sustainability: centres are likely to perform at least 400-500 procedures; will not be overburdened and will be able to recruit and retain newly qualified staff.

(4) Access and travel times: negative impact of travel times for elective admissions are kept to a minimum; retrieval standards are complied with.

64. Innovation and research had originally been factors taken into account by the Independent Panel when assessing "*Leadership and Strategic Vision*" and "*Ensuring Excellent Care*", but had not been given a discrete score. The Independent Panel was therefore asked to reconvene, and separately to assess the capacity for research and innovation of each of the centres. The panel met for this purpose on 14 December 2010 and arrived at the following scoring:

PCSS Research and innovation

Evelina	5
GOSH	5
Birmingham	4
Bristol	4
Southampton	4
Newcastle	3
Leeds	2
Leicester	2
Liverpool	2
Royal Brompton	2
Oxford	1

65. At the meeting of the JCPCT on 11 January 2011, fourteen options and supporting analysis were presented to the JCPCT and were examined in detail, two further options to the twelve before the committee on 28 September having been added by the NSC team at the request of the JCPCT.

66. The JCPCT determined that the consultation should proceed on the basis that proposals incorporating two sites in London were preferred. Having formed that view, the JCPCT went on to determine that the consultation should proceed on the basis of an expressed preference for GOSH and the Evelina over the Royal Brompton as the London centres.

67. That decision was arrived at by applying the scoring of the London centres by the Independent Panel against the 4 weighted evaluation criteria: Quality, Deliverability, Sustainability and Access and Travel times, the weighted criteria and the scoring having received the approval of the JCPCT.

68. The centres received different scores only in "Quality" and "Deliverability". The difference in "Quality" was attributable to Evelina's higher overall score by the Independent Panel (ranked first amongst the 11 centres). In "research and innovation" both Evelina and GOSH had been scored the maximum 5 by the Independent Panel, whereas the Royal Brompton had scored 2.

69. Under deliverability, the difference in scores was attributable to two elements; first the benefit to the country of maintaining the provision of three Nationally Commissioned Services at GOSH, GOSH being one of three centres providing ECMO, one of two providing transplantation services and the sole provider of complex tracheal surgery. The second element was the assessment that the loss of the Royal Brompton's paediatric intensive care unit (PICU), supporting predominantly cardiac patients, would present a limited risk to local and national PICU provision.

70. The overall result of the scoring against the weighted criteria was:

(i)	Evelina	364
(ii)	GOSH	347
(iii)	Royal Brompton	264

71. Thus by the conclusion of the meeting of 11 January, there was provisional agreement as to the consultation options, four in number each with two London centres, namely GOSH and the Evelina.

72. On 16 February 2011, the JCPCT met in public to discuss and finally to agree the preferred options to be put out to consultation, the Consultation Document, and the form the consultation was to take. Before inviting questions, Sir Neil McKay concluded the formal session by saying:

> *"let me say categorically, the consultation exercise is what it says on the tin. We are open minded about the outcome, we are prepared to listen to alternative views, as we said on three occasions during the course of the afternoon, and we will move forward with further discussions in the autumn..."*

73. <u>The consultation</u>

The four month period for consultation began on 1 March 2011. By letter dated 3 March 2011, the RBH Trust sought the suspension of the consultation, and on 16

March issued its claim for judicial review, alleging that the consultation was unlawful and vitiated by unfairness.

74. Mid-way through the consultation period, the JCPCT published a further paper "*Safe and Sustainable – Improving children's congenital heart services in London"*. The introduction contained the following paragraph:

> "*At this half way stage in the public consultation on the future of children's congential cardiac services, now is an appropriate time to look at the issues that have been raised so far and focus on the unique situation in London. Every other surgical centre is the sole centre in its city or region; London has three centres close together."*

The paper went on to set out the case for two children's heart surgical centres in London.

75. The consultation formally concluded on 1 July 2011. During the 4 month consultation period, about 50 public events were held and approximately 55,000 written responses were received.

76. <u>The Issues</u>

The claimant's case as developed in argument is that the consultation process was flawed in two respects. The first and principal contention is that the critical issues so far as the claimant was concerned, namely whether the reconfiguration of paediatric cardiac surgery services in London should result in two rather than three London centres, and secondly that the two London centres should not include the Royal Brompton, had been pre-determined. It is accepted on behalf of the defendant that if that was the case, then the claim will succeed. Accordingly the first question is whether, on the facts, those issues had been determined by the JCPCT prior to the consultation exercise.

77. Secondly, and if such issues have not been pre-determined, then it is the claimant's case that the process of consultation was nevertheless flawed as unfair in a number of respects. There were four strands to the submissions. First it was submitted that the process by which the JCPCT arrived at its four preferred options, options that excluded three London centres, and secondly excluded the Royal Brompton as one of the London centres, was irrational. The second, and related argument, is that the Consultation Document was so misleading as to preclude '*intelligent consideration and an intelligent response'*. Thirdly it is submitted that the process was tainted by an appearance of bias. Fourthly the claimant contends that the process by which the JCPCT arrived at its preferred options involved a breach of legitimate expectation.

78. The defendant's case is firstly that on the premise that there was no pre-determination of the critical issues, the consultation process cannot as a matter of law be vulnerable to challenge on grounds of irrationality, and secondly that in any event on the facts the process was not irrational. It is further submitted that there is no factual basis for the contentions that the process was flawed either by misinformation in the Consultation Document, or by bias or breach of a legitimate expectation.

79. Accordingly the issues as refined in the course of argument are:

i) Was there pre-determination of the issues of whether the configuration of paediatric cardiac surgery would incorporate two rather than three London centres, and secondly whether the two London centres would exclude the Royal Brompton?

ii) If such issues were not pre-determined?

(a) is the consultation process amenable to challenge on grounds of irrationality, and if so, was it vitiated by irrationality?

(b) was the consultation process vitiated by procedural unfairness in one or more of the following respects:

(i) misinformation?

(ii) bias?

(iii) breach of legitimate expectation?

80. The Pre-determination Issue

It is submitted on behalf of the claimant that before embarking on the consultation process the JCPCT had decided that there will be only two London centres providing paediatric congenital cardiac services, that the evidence shows that that position had been reached as far back as July 2010, that the determination to have only two London centres was probably influenced by a 'perception' that London had to 'lose' a centre in order to make the process as a whole more palatable nationally, and that the two London centres would be GOSH and the Evelina. At paragraph 115 of the amended Statement of Facts and Grounds, it is asserted that the "… *quasi-scientific approach of the early stages of the Review*" was "*replaced by what appears to have been a classic backroom stitch-up …".*

81. Mr Garnham accepted that if the issue of two as against three London centres had been determined prior to the consultation exercise, then the claimant will succeed. But he submitted that the claimant's submission is groundless, and that the evidence, whether documentary or contained in the witness statements filed on behalf of the JCPCT, clearly demonstrates that the issue had not been pre-determined.

82. The Consultation Document and the Response Form

The Consultation Document and the response form are the obvious starting point for consideration of the pre-determination issue. There are a number of passages in the Consultation Document that are of direct relevance. Section 1 contains an introduction by Professor Sir Bruce Keogh which concludes with the following paragraph:

> *"I want you to consider whether you think the proposed changes outlined in this document will deliver better care. Are there better solutions? We need an objective debate. In your deliberations refer to your own experiences but please assess*

> *the options impartially, without regard to personal or emotional influences – it is more important we give children the very best chance in life."*

83. Section 2 contains a summary headed "*The options for the number and location of hospitals that provide children's heart services in the future are:"* It then sets out the four preferred options each of which contains two London centres. Under the heading '*LONDON'* it states that "*the preferred two London surgical centres"* are the Evelina and GOSH. Section 5 addresses "*The process behind the proposed changes*", and at page 76 says:

> "*In this section we describe how we have taken advice from stakeholders and the way in which Safe and Sustainable has carried out all the necessary work to evaluate the existing surgical centres. We also explain the process of delivering four viable options for public consultation.*"

84. At page 93 there is a section headed '*LONDON'* which is in the following terms:

> "*It was recommended to the Joint Committee of Primary Care Trusts that options 10 and 12 (which included three centres in London) should not form part of the public consultation for the following reasons:*
>
> - *the joint committee of Primary Care Trusts recommends that two designated centres is the ideal configuration for the population of London, East of England and South East England. The question of whether two centres in London is the right number will be asked during consultation.*
>
> - *the forecast activity levels for London and its catchment area (currently around 1250 paediatric procedures per year) mean that two centres will be well placed to meet the proposed ideal number of procedures a year. This could only happen with three London centres if patients were diverted from neighbouring catchment areas into London. Our analysis shows this would significantly, and unjustifiably, increase travel times and impact on access for patients outside of London, South East and East of England.*
>
> - *the advice of the Safe and Sustainable Steering Group is two centres, rather than three, are better placed to develop and lead a congenital heart network for London, South East England and East of England according to the Safe and Sustainable model of care.*

The following page, page 94, poses the following questions*:*

> *"Do you support the proposal for two Specialist Surgical Centres in London?*
>
> *Do you support this choice? (i.e. Great Ormond Street Hospital for Children and the Evelina Children's Hospital) or do you think the Royal Brompton & Harefield NHS Foundation Trust should replace one of these other two London Hospitals?*"

85. At page 118 under the heading '*We Would Like Your Views'*, the following question is posed:

> "*To what extent do you support or oppose EACH of the FOUR alternative proposed options for the location of the Specialist Surgical Centres?*"

86. The Response Form by which consultees were invited to respond to the Consultation Document contained six questions of direct relevance, Q7 – Q10 inclusive, and Q15 and Q16. The section containing Q7 – Q10 had an introductory heading in the following terms:

> "*The following section asks about the proposals for specialist surgical centres in London. It is proposed that two London hospitals will be chosen as specialist surgical centres.*"

Q7 asked "*Do you support the proposal for two Specialist Surgical Centres in London?"*and provided for a 'tick box' response 'yes', 'no', or 'don't know'. Beside the 'No' box there is the explanatory note:

> "*DO NOT SUPPORT THE PROPOSAL FOR TWO SPECIALIST SURGICAL CENTRES IN LONDON.*"

Q8 invited comments on the number of London centres. Q9 set out the proposal that the two centres in London will be GOSH and Evelina, and posed the question:

> "*If there were to be only two Specialist Surgical Centres in London, please indicate whether you support this choice (*i.e. GOSH and Evelina *…), or whether you think the Royal Brompton & Harefield NHS Trust should replace one of these other two London Hospitals?*"

Q10 invited comments on the proposals for Specialist Surgical Centres in London.

87. Q15 posed the question:

> "*Given a choice, which of the following centres would form your preferred configuration for the location of Specialist Surgical Centres in the future?*"

and provided a box for each of the eleven existing centres plus a 'don't know' box. Q16 provided the consultee with the opportunity to give reasons for their preferred configuration of centres.

88. It is submitted on behalf of the claimant that the whole structure of the Consultation Document is such that an option with two as opposed to three London centres is realistically the only likely outcome of the exercise. Mr Maclean sought to place emphasis upon the summary at section 2 in which the four options for the future are identified, each of which has two London centres, the preferred centres being GOSH and Evelina. He also relies upon section 5 in which views are sought as to whether the consultee supports the proposal for two centres in London, and as to whether the RBH Trust should replace GOSH or the Evelina, and upon the fact that there is no express question as to whether a three London centre is to be preferred.

89. But in my judgment it is clear from Q7 and Q8 of the response form, that it is open to a consultee to take issue with the proposal for two London centres, and from Q9 to take issue with the exclusion of the RBH Trust. A fair reading of both documents does not lead to the conclusion that either issue had been pre-determined. Neither the Consultation Document nor the Response Form indicate that the JCPCT will not contemplate any options other than those that they have preferred or a variation of the preferred options. On the contrary as Professor Sir Bruce Keogh says in the first section of the Consultation Document:

> *"I want you to consider whether you think the proposed changes outlined in this document will deliver better care. Are there better solutions? We need an objective debate."*

90. <u>The documentary material</u>

It is then necessary to consider the documentary material upon which Mr Maclean relies in support of his contention that the irresistible inference to be drawn is that the option of a three London centre had been excluded as early as July 2010.

91. He invited my attention to a paper presented to the JCPCT by the NSCG Team at the meeting of the JCPCT on 1 September 2010, which at page 2 under the heading "*Unresolved issues to date"* said "*Before we score each option we will tidy up the following unresolved issues",* including the question "*Which 2 London sites should be designated?*" He submitted that the phrase '*tidy up'* was illuminating, and secondly that the inference inevitably to be drawn from the question as to which of two London sites should be designated, is that a decision had already been taken that there were to be only two London sites. He further submitted that the latter point was also borne out by the minutes of the meeting of 1 September in which it is recorded that:

> *"It was proposed that the matrix would be used to score each of the London sites to decide which two should be designated."* (page 8)

and furthermore that there had been pre-scoring by the NSCG Team.

92. But the passages upon which Mr Maclean sought to rely have to be considered in context. The exercise upon which the JCPCT was then engaged, with the assistance of the NSCG Team and KPMG, was in producing preferred options upon which to go out to consultation. Minutes of the meeting of the JCPCT of 28 July 2010 record that after hearing an account of the process by which the options identified by KPMG and the NSCG team had been arrived at:

> *Members discussed the recommendation that two centres was the optimum number of centres for London, Members were of the opinion that it was likely that the Royal Brompton would be excluded from the potential options given the findings and outcomes of the assessment panel visits, the absence of advantages around access and the advantages possessed by the other London centres. Members agreed that at this stage the Royal Brompton Hospital would be excluded from further analysis around travel and access though Members were in agreement that all three London centres would be included in the process for evaluating the London centres against the evaluation criteria on 1 September. Sir Neil (Sir Neil McKay, chairman of JCPCT) said that this was a legitimate approach in order to keep the number of potential viable options manageable."* (page 10)

93. As to the meeting of 1 September, it concluded with a decision to hold a further meeting on 28 September "*for a detailed review of the issues and scoring exercise"*; and in response to a question as to which options needed to be remodelled, Sir Neil is recorded as saying that "*a review of some of the existing options*" might be required to make the meeting of 28 September worthwhile (page 18).

94. The minutes of the meeting of 28 September (before the court in draft form) record that the JCPCT "*had also asked why no options with three London centres had been presented"*, and do not contain a record of a concluded view as to preferred options. The minutes of a meeting of the Steering Group on 14 October contain a record of an extensive discussion as to "*Potential options for consultation"*, including reference to 12 potential options of which "*Some were for three sites in London"*. The minutes of the next meeting of the Steering Group on 7 January 2011 note further discussion of a three as against two London centre model, before recording that the JCPCT's preference was for 2 centres (page 17).

95. It was then at the meeting of 11 January 2011 that a decision was made by the JCPCT that

> *"…three-London site options would be excluded from consultation and the choice as to which of the three closed would be offered" It would be stated that based on intelligence, the Committee's preference for closure was Brompton"*.

96. It is therefore clear that whilst in July 2010 the NSCG Team had been recommending options based on the analysis undertaken by KPMG that excluded three London sites, the JCPCT, the decision maker, did not arrive at a final decision as to its preferred options until 11 January 2011. The minutes of its meetings prior to that date demonstrate that it had been involved in the process of narrowing the options so as to identify, for the purpose of the consultation exercise, those that it favoured.

97. Secondly Mr Maclean placed reliance on the following passage in the draft Business Case dated 5 January 2011 and considered by the JCPCT at its meeting on 11 January:

> *"... it was agreed that there should be two centres in London.*
>
> *The decision regarding which of the two London sites should be designated was not made until the JCPCT meeting on the 1st September 2010. Therefore the decisions made to get to the 5 viable options to be scored against the evaluation criteria stand alone and can include, at this point, any two London sites."*

98. There are two points to be made. First the document was a draft prepared for consideration by the JCPCT. The passage relied upon by Mr Maclean is to be found in Appendix 8 under the heading "*Evidence supporting the options assessment*". In the Business Case as adopted by the JCPCT, it appears as Appendix AC, but in a different form. The passages relied upon by Mr Maclean do not appear. Appendix AC contains a summary of the analytical process by which the preferred options were identified, including a section headed "*London requires at least 2 centres*", which contains the following paragraph:

> *"Therefore it is recommended that there should be at least two centres for London".*

99. The draft Business Case was considered by the JCPCT on 11 January. The relevant minute records that "*Gaps in the document were to be fleshed out following today's meeting once the options were identified*". Unless that minute is duplicitous, the options to be put to consultation had not been decided upon by the JCPCT prior to that meeting.

100. Mr Maclean also sought to rely on a passage at page 6 of the minutes of the meeting of 11 January as revealing as to the reality of the situation, namely:

> *"Ms McLellan recommended the note under Table 1 on page 59 'All options including GOSH and Evelina' be rephrased to read 'Two London Centres'"*

Ms McLellan was the Chief Operating Officer of the London Specialised Commissioning Group. The passage in question is contained in a footnote to a table in Appendix 2 "*Travel time analysis*". In the Business Case as approved by the JCPCT, the relevant note was amended in the matching appendix, Appendix S, to read "*All options include a minimum of two sites in London.*" The original draft reflected the conclusions at which the NSCG had arrived; but the JCPCT corrected the draft to reflect the true position, namely that the preferred options to be put out to consultation all included two London sites. I do not consider that it can properly be inferred from the form of the original note that the two discrete issues, namely the number of London sites and secondly their identity, had been predetermined.

101. Mr Maclean made a similar point in relation to the Consultation Document, inviting comparison of the draft and the final versions. The relevant passage in the draft is in the following terms:

> *"Option B is the best option for retaining centres ranked highest for quality in terms of their ability to meet the proposed new standards of care. Although the Royal Brompton Hospital*

> *in London was rated highly it does not feature in this Option or any of the others because of the decision to propose just two centres in London."*

The final version reads:

> *"Option B is the best option for retaining centres ranked highest for quality in terms of their ability to meet the proposed new standards of care. Although the Royal Brompton Hospital in London was rated highly it does not feature in this Option or any of the others because of the proposal for just two centres in London."*

102. I do not consider the change from '*decision to propose'* to '*proposal for'* has the significance that Mr Maclean seeks to attach to it. It does not in my judgment indicate a closed mind on the part of the JCPCT.

103. The fourth passage upon which Mr Maclean sought to rely in this context appears in a report to the GOSH board by Professor Elliot, a member of the Steering Group on 18 February 2010.

> *"The cardiac review had recommended that the three hospitals currently undertaking cardiac surgery in London be reduced to 2 centres working together. The preferred view seemed to be Guys and St Thomas' [i.e. Evelina] and GOSH would be the two with the Brompton patients spilt (sic.) between the two sites. The Trusts had been asked to work up joint proposals by 31 March 2010."*

104. The identity of the 'cardiac review' to which Professor Elliot is recorded as referring is not specified in the minute. But his reference to the Trusts having been asked to work up joint proposals plainly relates to steps being taken by the London SCG group chaired by Dr Pinto-Duschinsky (formerly Crowther). She says in her witness statement that notwithstanding the change in the governance arrangements for the Review, the group, which included representatives of the RBH Trust, continued to meet as "*…it was a useful mechanism to bring together the SCG representatives and to facilitate discussion on proposed solutions between the providers"*. Paragraphs 13 and 14 of her witness statement are of particular relevance:

> *"13. Through the work of the zonal group, the three Trusts agreed that they were happy to work on a proposal for a single network, and try to put together a joint proposal by the end of March (2010) so that a joint proposal could be put forward to the national review. This approach was endorsed by the three Trust Chief Executives, including Robert Bell (of the Royal Brompton). My letter to the three Chief Executives on the 26th Ocotber 2009 sets out the position.*
>
> *14. I had a meeting with the three Chief Executives on the 17th February 2010. Whilst that meeting was not*

minuted, the meeting was followed immediately by the zonal group meeting. The outcome of my meeting with the Chief Executives is accurately described in section 5 of the minutes of the zonal meeting, which highlighted "PCCS collaborative meeting". As recorded the three Chief Execs agreed that further work needed to be done in modelling 2 options:

(1) a single network of clinicians with surgery and interventional procedures carried out on two sites: Evelina and GOSH.

(2) a second option also based on a single team of clinicians which would take account of potential changes in the Oxford and Southampton services by addressing the volume of surgery which could be undertaken within the three current sites.

In other words there was an acceptance in principle that a London solution with the Evelina and GOSH as the surgical centres was the preferred option, subject to the possibility that increased patient flows as a result of national changes might mean it would be better to have surgery maintained on all three sites. It is fair to say that all three Chief Executives had various concerns and Robert Bell said that his Board would have some concerns about the proposed reconfiguration. However, all three agreed to progress to work on a single network. The view to base Option 1 around GOSH and the Evelina was because work in London at the time on specialist children's services was proposing 2 networks across the north and south of London based around these 2 children's hospitals."

105. Professor Elliott was a member of the zonal group and attended the meeting on 17 February 2010. His report to the GOSH board upon which Mr Maclean seeks to place reliance, was made on the following day. It is therefore reasonable to assume that it was the work of the zonal group to which he was referring. If so then the reference does not afford any support for the contention that there had been a predetermination of the critical issues by the JCPCT.

106. It follows that I do not consider that the documentary material upon which Mr Maclean relies, support his argument. Viewed in isolation the passages in question might give rise to suspicion that there had been a predetermination, but viewed in context such suspicion is dispelled.

107. <u>The Defendant's Witness Statements</u>

Thirdly it is necessary in this context to consider the witness statements filed on behalf of the defendant. The chairman of the JCPCT, Sir Neil McKay, emphatically

rejected any suggestion that the JCPCT or any of its members had in any way made any decision about the final outcome of the Review. He concluded his witness statement by setting out the statement that he made at the public meeting on 16 February 2011:

> "*We want to know what you think. We want you to challenge us. We want you to really put us on the spot about the figures that we have emerged with … that is the whole purpose of the consultation, and let me say categorically, the consultation is what it says on the tin. We are open-minded about the outcome, we are prepared to listen to alternative views, as we said on two or three occasions during the course of this afternoon.*"

adding in his witness statement that "*I meant what I said. I am not a liar*".

108. Jeremy Glyde, the NSCG Director of the Review, gave similar evidence. So too did Professor Hilary Thomas of KPMG who was responsible for the analysis of options for reconfiguration of paediatric cardiac services. She concluded her witness statement by stating that:

> "*174. Nothing I saw or heard during the whole of my involvement in this process led me to suspect that the JCPCT were entering this consultation with their minds made up. There was nothing to suggest that they were simply going through the motions.*"

109. No application was made for cross-examination of such witnesses; but if there had been pre-determination of the issues in question, then each has given false evidence. In the course of submissions Mr Maclean drew back from asserting that that was the case. But in my judgment he cannot escape the conclusion that if there was pre-determination of the issues, then the consultation exercise was conducted in bad faith in that regard; and the witnesses to whom I have referred have not told the truth in their witness statements.

110. That is a conclusion that I emphatically reject. There is simply no basis upon which I can properly conclude that their evidence on this central issue should be rejected.

111. It follows that in my judgment the argument that there was pre-determination of either issue by the decision maker, the JCPCT, is unsustainable. The JCPCT was entitled to identify and to consult upon its preferred options which did not include a three London centre model and which excluded the RBH Trust. But such pre-disposition did not amount to pre-determination.

112. <u>The Irrationality Challenge</u>

It is submitted on behalf of the RBH Trust that the JCPCT acted irrationally in excluding three London centres from the preferred options identified in the Consultation Document and in excluding the Royal Brompton from the two London centre options, and that in consequence the consultation process was fundamentally flawed.

113. The first question that arises is whether the decision by the JCPCT to identify its preferred options is justiciable.

114. Judicial Review is available to challenge decisions with legal consequences. In *Shrewsbury and Atcham Borough Council & Another v Secretary of State for Communities and Local Government & Another* [2008] EWCA Civ 148 a challenge was made to proposals made by the Secretary of State for Communities and Local Government to replace two-tier local government in some parts of the country with unitary authorities. In his judgment Carnwath LJ addressed the issue of whether the relevant decisions were within the scope of the proceedings, and advanced the following propositions:

> "*32. Judicial Review, generally, is concerned with actions or other events which have, or will have, substantive legal consequences: for example, by conferring new legal rights or powers, or by restricting existing legal rights or interests. Typically there is a process of initiation, consultation, and review; culminating in the form of action or event ("the substantive event") which creates a new legal right or restriction. For example, the substantive event may be the grant of a planning permission, following a formal process of application, consultation and resolution by the determining authority. Although each step in the process may be subject to specific legal requirements, it is only at the stage of the formal grant of planning permission that a new legal right is created.*
>
> *33. Judicial Review proceedings may come after the "substantive event", with a view to having it set aside or "quashed"; or in advance, when it is threatened or in preparation, with a view to having it stayed or "prohibited". In the latter case, the immediate challenge may be directed at decisions or actions which are no more than steps on the way to the substantive event".*

115. Carnwath LJ therefore recognised that a challenge by way of judicial review may be made in advance of the substantive event, where that event is threatened or in preparation. But that is not this case. At this stage a reconfiguration of paediatric cardiac surgical services with two London centres is a proposal the subject of consultation. There has as yet been no decision with legal consequences for the RBH Trust or for GOSH or the Evelina. The proposals are still at the formative stage.

116. It follows that I do not consider that the decisions made by the JCPCT as to its preferred options are justiciable.

117. There is a further reason for arriving at that conclusion. The claimant's argument is advanced on the premise that the defendant was under an obligation specifically to put the options that included three London centres out to consultation on the basis that they had been found to be viable. Mr Maclean sought to derive support for that proposition from the decision of Munby J in *Montpeliers*. But it is in my judgment a misreading of the decision in *Montpeliers* to assert that it is authority for the proposition that there is a duty to consult on all viable options. The process of

consultation in *Montpeliers* was flawed because one of the options had been excluded from further consideration (see paragraph 22 above). In other words the process of consultation was vitiated by the predetermination of a central issue. In the instant case, and for the reasons set out above, I am satisfied that the issue of two against three London centres had not been predetermined.

118. It was open to the JCPCT to identify its preferred options see Lord Woolf in *Coughlan* (paragraph 14 above) and Simon Brown LJ in *Worcestershire Health Council* (paragraph 21 above). The Consultation Document set out the reasoning by which it had arrived at its preferences. The purpose of the consultation was to elicit responses to the proposals that it contained in the form of the preferred options. It was open to those responding to the consultation paper to argue that the reasoning was unsound, and to advance the case for a three London centre deploying the arguments that have been forcefully advanced in support of the submission that the decision to exclude the three London centre options from the preferred option was irrational. The weight objectively to be attached to the arguments now advanced on behalf of the RBH Trust as to the selection of the preferred options, and as to the preference for GOSH and Evelina over the Royal Brompton is not a matter for this court, but they will no doubt be carefully considered by the JCPCT when considering the responses to the consultation.

119. It follows that I reject the argument that the consultation process is flawed by irrationality. But in any event, and if wrong as to that, I do not consider that the decisions in issue can be characterised as irrational. The process by which the JCPCT arrived at its four preferred options are set out in the Consultation Document and the Business Case. Whilst there may be powerful arguments in support of a three London centre option, it cannot be said that to prefer two London centre options is irrational.

120. I am reinforced in that conclusion by the evidence from Dr Crowther, who after marriage is known as Dr Pinto-Duschinsky, who chaired the SCG Collaborative Group for the South Eastern Zone which included London. Although the SCG Collaborative Groups had been disbanded (see paragraph 42 above), Dr Crowther continued to work with GOSH, the Evelina and the RBH Trust to develop proposals to be submitted to the Review, offering a single network of care in London. To this end further meetings were held with participants from the three Trusts on 20 January 2010, 17 February 2010, 18 March 2010, 4 June 2010, 7 July 2010 and 24 November 2010.

121. At the meeting on 17 February 2010, the Chief Executives from the three Trusts agreed that further work needed to be done on modeling two options, the first of which was "*a single network of clinicians with surgery and interventional procedures carried out on two sites: Evelina and GOSH*". That is confirmed by a '*Provider collaborative - feasibility study'*, produced by the three Trusts and dated 31 March 2010 which set out the two options under consideration:

> *"Option 1 – two sites (GOSH and Evelina)" and "Option 2 – three sites (RB&H, GOSH and Evelina), in the event of changes in surgical capacity at Southampton and Oxford"*.

The report summary records that:

> *"Guidance from the commissioners present at the initial and workstream meetings has indicated that the two site model should constitute the primary focus of this report. This has been corroborated by Sarah Crowther, the Executive Chair of Commissioning in meetings with various representatives from the three hospitals".*

122. In the light of such evidence it is difficult to see how it can be suggested that the decisions by which the JCPCT arrived at its preferred options were irrational.

123. <u>The Misinformation Issue</u>

The RBH Trust contends that the Consultation Document was so flawed as fatally to undermine the integrity of the consultation process. It is submitted that the passages relied upon so distorted the consultation process as to preclude a properly informed response from consultees, and accordingly to render the process procedurally unfair.

124. The submission was based upon an analysis of two elements of the Consultation Document, first the manner in which information as to the activity level for paediatric congenital cardiac procedures in London was presented, and secondly the scoring of deliverability in the Configuration Assessment.

125. As to the first, section 5 of the Consultation Document, which sets out the process by which the JCPCT arrived at its four preferred options for reconfiguration, has a section at page 93 headed '*LONDON*' which contains the following paragraph:

> "*The forecast activity level for London and its catchment area (currently around 1,250 paediatric procedures per year) mean that two centres would be well placed to meet the proposed ideal number of 500 procedures a year. This could only happen with three London centres if patients were diverted from neighbouring catchment areas into London. Our analysis shows this would significantly, and unjustifiably, increase travel times and impact on access for patients outside of London, South East and East of England."*

The section concluded with a summary of the advice given by the Steering Group, namely: *" … two centres, rather than three, are better placed to develop and lead a congenital heart network for London, South East England and East of England …".*

126. In essence it was submitted that the paragraph set out above was grossly misleading, and would inevitably have distorted the responses of consultees, who would have assumed that to implement a three London centre model would adversely effect the service in question as numbers would fall short of the proposed optimal number of 500 procedures per annum per centre. In fact the projected London case load in each of the preferred options was 1,482. If the increase was to be divided equally between the three London centres, then GOSH would be doing 625 procedures, the Evelina 425 and the Royal Brompton 437. As Mr Glyde explained at paragraph 261 of his second witness statement, if the additional case load was to be split in proportion to

the existing share of cases, i.e. if existing referral patterns continue, GOSH would be doing 651 procedures, Evelina 406 and the Royal Brompton 425.

127. Mr Maclean argued that in either case the Royal Brompton would be doing more than 400 procedures per annum, the figure identified by the standards working group as the minimum number to avoid '*occasional practice'* (see paragraph 43 above). He therefore argued that it was misleading, and grossly unfair for the relevant section of the consultation document, to have referred to the current activity level for London and its catchment area of around 1,250 procedures per annum, but to have omitted reference to the projected case load of almost 1,500. He further argued that the projected caseload, if shared equally between the three London centres would result in each undertaking of the order of 500 procedures per annum.

128. He also made the point that in calculating the Royal Brompton's current caseload, referrals from outside England were left out of consideration, arguing that such omission was a further respect in which the analysis presented in the Consultation Document was unfair to the Royal Brompton, in that when considering the quality of service, it is the number of procedures carried out that is of significance, the source of referrals being irrelevant.

129. In his witness statement Mr Glyde sought to justify the paragraph in question, arguing that it was factually correct in that it accurately stated the current number of relevant paediatric procedures, and that two centres would be well placed to meet the optimum identified by the Standards Working Group of '*a minimum of 500 paediatric surgical procedures each year*'. He acknowledged that in retrospect it might have been clearer to have left out the reference to 1,250 procedures per annum, or alternatively to have noted the projected number of procedures in the bracketed section of the paragraph in question.

130. Mr Glyde also advanced the reason why overseas private patients were not included in the projected figures, namely that such referrals are subject to unpredictable fluctuations. That may be the case; and the total number of procedures carried out by a centre may be of relevance to an assessment of the service that it provides. But the failure to refer to the procedures carried out privately at the Royal Brompton does not appear to me to be misleading given that in the inter-London scoring exercise, the results of which were set out in tabular form at pages 95/96 of the Consultation Document, each of the centres was scored equally under the criterion 'Sustainability', the criterion that included:

> *"All designated centres are likely to perform at least 400 procedures each year, ideally 500 paediatric procedures each year."*

131. Furthermore this section of the Consultation Document was addressing the configuration of congenital cardiac surgical services to meet the demand for such services in the resident population, and in particular the number, rather than the identity, of London centres. I do not therefore consider that the absence of a reference to private patient numbers was materially misleading with regard to the latter issue.

132. I accept that it would have been preferable for reference to have been made to the projected caseload, either in place of or in addition to the reference to the current figure. But the question is whether the failure to do so of itself had the effect of

rendering the consultation process unfair in the sense that it was likely to affect the response of consultees on the issue of whether a two London centre option was to be preferred to a three London centre option.

133. In my judgment it did not. At page 93 of the Consultation Document under the heading 'LONDON' the JCPCT is recorded as recommending that:

> "*… two designated centres is the ideal configuration for the population of London, East of England and South East England.*"

The next paragraph, asserts that two centres would be well placed to meet the proposed ideal number of 500 procedures per annum. Thus it is clear that it is not being suggested that a three London centre option is not viable, rather that a two London centre configuration is ideal.

134. Secondly the proposition that a two London centre option was the ideal configuration was as valid on a caseload of 1500 as of 1250, bearing in mind that whichever apportionment of the difference between the two figures is assumed, the projected figures for two of the existing London centres, the Evelina and the RBH Trust, would have fallen well short of the figure of 500 procedures per annum.

135. I do not therefore consider that the failure to refer to the projected caseload would have so distorted the consultation process as to render it unfair to the RBH Trust.

136. The second aspect of the Consultation Document that it is submitted is misleading, is in relation to the scoring of deliverability. In the table set out at page 95/96 '*Scoring the London Sites'*, the RBH Trust received the lowest score of 2, as against scores of 4 for GOSH and 3 for the Evelina. An explanation is advanced in the text:

> "*Because the PICU at the Royal Brompton Hospital exists predominantly to support cardiac surgery, we propose it is scored lower than the Evelina Children's Hospital on the sub-criterion involving 'the negative impact for the provision of paediatric intensive care and other interdependent services is kept to a minimum.'*"

137. Mr Maclean submitted that it was common ground that should paediatric congenital cardiac surgery no longer be carried out at the Royal Brompton, its PICU would no longer be viable. Accordingly he sought to argue that the negative impact should be assessed as greater than at the Evelina rather than lesser.

138. But in my judgment his argument was misconceived. As Mr Glyde says in his second witness statement (paragraph 267) the Royal Brompton received a lower score for deliverability than the Evelina because the Royal Brompton's PICU predominantly supports cardiac patients, and if it is to be de-designated, the impact on non-cardiac patients would be more manageable than for a centre whose PICU had a large number of non-cardiac patients, the position in relation both to GOSH and the Evelina.

139. In July 2011, and as a result of the RBH Trust's representation that decommissioning of its PICU would destabilise and render unviable a number of its other paediatric

services (notably respiratory services, including cystic fibrosis), the JCPCT commissioned a review by an international independent panel of experts, chaired by Adrian Pollitt.

140. Following consideration of written material and a visit to the Royal Brompton on 6 September, the Pollitt panel reported on 16 September. It found that de-designation would render the Royal Brompton's PICU unviable (as anticipated), but that admissions as a result of interventions associated with respiratory services were rare. The panel concluded that all respiratory services would remain viable; that the great majority of paediatric respiratory activity would continue to take place at the Royal Brompton; but that arrangements would need to be put in place for some rare and complex cases.

141. Mr Maclean sought to rely upon the decision of the JCPCT to instruct the Pollitt panel as amounting to an explicit recognition by the JCPCT that "*something had gone wrong*" with the consultation process, arguing that it demonstrated that the JCPCT had failed to take any or any proper account of the consequential effect of the termination of the relevant services at the Royal Brompton in arriving at its preferred options. I do not agree. In my judgment the decision to constitute the Pollitt panel was an appropriate response to representations made by the RBH Trust, and serves to demonstrate the manner in which the process of consultation can and should work.

142. <u>The Bias Issue</u>

It is submitted on behalf of the RBH Trust that the consultation process was vitiated by bias, or by the appearance of bias. The argument was based upon the fact that Professor Qureshi and Professor Elliot were members of the Steering Group, Professor Qureshi being a consultant paediatric cardiologist at the Evelina, and Professor Elliott, a consultant paediatric thoracic surgeon at GOSH. Mr Maclean contends that the usual principles by which a decision may be impugned on grounds of actual or apparent bias apply, i.e. would a fair-minded and informed observer, having considered the facts, conclude that there was a real possibility that the process was biased, see e.g. *Magill v Porter* [2002] 2AC 357. He therefore invited me to undertake the well established two stage process, first to ascertain all the relevant circumstances, and secondly to consider whether such circumstances would lead a fair minded and informed observer to conclude that there was a real possibility of bias, see *Re Medicaments (No. 2)* [2001] 1WLR 700, and *Flaherty v National Greyhound Racing Club Ltd.* [2005] EWCA Civ 117.

143. But it is necessary first to consider whether the decision by the JCPCT to reduce the six viable options to four preferred options, and the exclusion of the RBH Trust from the preferred options, is amenable to challenge on grounds of bias.

144. There is in my judgment an insurmountable obstacle facing the RBH Trust in relation to this limb of its challenge. Its argument is based upon the membership of the Steering Group of Professor Qureshi and Professor Elliott. But I am satisfied on the evidence that the Steering Group was not the decision maker. Whilst it is clear from the minutes of the Group, see in particular the minutes of the meeting of 6 January 2011, that it had formed the view that options limited to two London centres were to be preferred, and that that would have the consequence that the Royal Brompton would be excluded, its role was to make recommendations to the JCPCT. The JCPCT

took account of the recommendations, as it was fully entitled to do, but it and not the Steering Group made the decisions in question.

145. It is of note in this context that at the meeting of the steering group on 6 January 2007 Deborah Evans, representing the South West and South Central specialised commissioning groups, *"… queried whether it might be a risk that some centres had staff members sitting on the steering group representing their associations, while others were not and co-incidentally those centres might be among those de-designated"*. The minutes go on to record that *"the group highlighted that it was not its role to make a decision"*. Thus whilst the minutes recorded sensitivity as to the perception of the role of the Steering Group, there can in my judgment be no doubt that the steering group understood that its role was limited to giving advice from the clinical perspective.

146. In this context Mr Maclean sought to rely upon the decision in *R (Goldsmith) v Wandsworth LBC* [2004] EWCA Civ 1170, (2004) 7 CCL Rep 472 as support for the proposition that where a decision maker adopts recommendations of a subordinate body, whose recommendations are vitiated by unfairness, a decision adopting the recommendations is likewise vitiated. He therefore submits that if the recommendations made to the JCPCT were tainted by bias, actual or apparent, in the Steering Group "*that vitiating flaw will necessarily pollute the JCPCT in turn, unless the JCPCT has taken remedial steps which function to sever the nexus between the decisions taken and the infected upstream process"*.

147. *Goldsmith* concerned the discharge by the Wandsworth Borough Council of its duty to provide community care services. It had taken the decision under challenge on the advice of its Local Continuing Care Panel (LCCP). The Court of Appeal came to the conclusion that the LCCP had given Wandsworth defective advice based on inadequate information, and in consequence Wandsworth's decision was flawed. But that is not this case. It is not contended, nor in my judgment could it be, that the recommendation made by the Steering Group to the JCPCT was defective. It was based upon the analysis carried out by the NSC Team with the assistance of KPMG. Secondly and in any event it is clear from the minutes of the meetings of the JCPCT and from the witness statement of Sir Neil McKay that it arrived at its decision as to its preferred options after a full and proper consideration of the material before it, and was not simply rubber stamping the recommendations of the Steering Group.

148. I therefore reject the contention that the consultation was tainted by bias, whether actual or apparent.

149. <u>Legitimate Expectation</u>

In the weighted scoring exercise summarised at paragraph 71 above, GOSH, Evelina and The Royal Brompton scored respectively, 347, 364 and 264. The Royal Brompton was scored the lowest on two criteria, quality and deliverability. As to quality, the RBH Trust scored lowest on research and innovation as a result of the assessment carried out by the Independent Panel in December 2010 (see paragraph 64 above).

150. The contention that the process of assessment of 'research and innovation' was unfair to the RBH Trust is based upon the argument that there was a failure on the part of the

JCPCT to meet a legitimate expectation that the criteria and scoring in the Assessment Evaluation undertaken by the Independent Panel, would be "*separate*" from the Configuration Evaluation, and would have no "*direct bearing*" on its scoring.

151. There is no issue between the parties as to the relevant legal principles: first per Laws LJ at paragraph 68 of *R (Nadarajah and Abdi) v Secretary of State for the Home Department* [2005] EWCA Civ 1363

> *"Where a public authority has issued a promise or adopted a practice which represents how it proposes to act in a given area, the law will require the promise or practice to be honoured unless there is good reason not to do so".*

152. Secondly a legitimate expectation requires a clear and unequivocal representation, see Lord Hoffman in *R (Bancoult) v Secretary of State for Foreign and Commonwealth Affairs (No. 2)* [2009] 1 AC 453, citing Bingham LJ in *R v Inland Revenue Commissioners, Ex parte MFK Underwriting Agents* [1990] 1 WLR 1545, 1569.

153. The issue is whether there was a clear and unequivocal representation by the JCPCT giving rise to a legitimate expectation.

154. It is submitted on behalf of the claimant that the representation is to be found in the self-assessment template form, which drew the distinction between the two stages of the evaluation process, the "*Assessment Evaluation*" and "*Configuration Evaluation.*" The form said:

> *"The evidence you supply in this exercise will be assessed as part of the evaluation process we will undertake, and therefore will ultimately inform the final recommendation.*
>
> *The entire evaluation process has 2 discrete stages – Assessment Evaluation and Configuration Evaluation. This process will fulfil the first stage of the assessment evaluation.*
>
> *...*
>
> *It should be noted that the criteria and scoring process for the Configuration Evaluation have not yet been determined. This will be communicated to all stakeholders in due course. However, the criteria and scoring for the Configuration Evaluation is separate from the Assessment Evaluation. The information supplied in the assessment stage of the process will not have any direct bearing on the scoring of the configuration evaluation process.*
>
> *...*
>
> *Scores will be allocated against each criterion, which will come together as a final score for each centre.*
>
> *Individual scores for each centre will help identify the configuration options, which will then be tested against criteria such as ease of access, affordability and deliverability, and the*

> *risks of reconfiguration. The exact scoring mechanism for this stage has yet to be determined."*

155. The claimant contends that such statements amounted to a clear and unequivocal representation, but that contrary to that representation, the scoring from the Assessment Evaluation was used in the Configuration Evaluation.

156. Mr Garnham sought to argue that the statements did not amount to a clear and unequivocal representation with the effect for which the claimant contends, relying in particular on the statement that "*Individual scores for each centre will help identify the configuration options"*. The scores produced by the evaluation assessment would obviously affect the identification of configuration options; but that does not undermine or qualify the clear and unequivocal representation that the information supplied in the assessment stage would not have a direct bearing on the scoring of the configuration evaluation process.

157. As to the question of whether the information provided by the RBH Trust had a direct bearing on the scoring of the Configuration Evaluation, the evidence is clear. As Professor Thomas explained in her witness statement:

> "*86. For the second sub criterion "innovation and research" the JCPCT used the Independent Panel's scores for centres which the panel scored in a meeting held in December 2010 using information from the completed submissions from their assessment, including self assessment forms which had been sent to the centres in March 2010.*"

158. Her evidence reflected that given by Professor Sir Ian Kennedy who said in terms that the assessment of each centre's research and innovation capacity and outlook was based both on the centre's submissions in the self-assessment form and on the site visits carried out by the independent panel. His explanation of the scoring is in the following terms:

> "*41. The Panel gave the Royal Brompton a consensus score of two out of five. This score was based on the written evidence given to the panel by the Royal Brompton. It was the Royal Brompton's responsibility (as with every other centre) to provide us with all the relevant information with regard to research into paediatric cardiac surgical services, and any plans that they had for development. The reason why some of the centres had higher scores than others was because, on the basis of their submission, they provided evidence which better demonstrated that they met the Standards. Based on the Royal Brompton's written submissions, the panel felt that not all of the research undertaken and referred to by the Royal Brompton during the assessment visit applied to paediatric cardiac surgery and was not, therefore, as relevant in meeting Standards. The Royal Brompton's responses did not contain sufficient reference to or contain sufficient*

> *plans to develop research in the area of paediatric cardiac surgery. RBHT's Research Strategy made insufficient reference to research into paediatric cardiac surgical services.*
>
> *42. The Independent Panel appreciated that the Royal Brompton has a good record in clinical research; however, the panel felt that the research undertaken by the two Bio Medical Research Units ("BRUs ") at the Royal Brompton was not specifically relevant to paediatric cardiac surgical services.*
>
> *43. The independent panel's score in December 2010 reflected its previous findings from the assessment in June 2010, as published in the independent panel report published in January 2011: this recorded that RBHT has a good track record with clinical research, however, the panel felt that this standing has recently slipped, and the research undertaken by the two BRU's was not relevant to paediatric cardiac surgery. This was because the panel did not feel that there were explicit plans for research undertaken by the BRU's to include research relevant to paediatric cardiac surgical services."*

159. I therefore reject the submission that the information supplied in the assessment stage did not have any direct bearing on the scoring of the configuration evaluation process.

160. Secondly Mr Garnham submitted that if the process adopted deviated from that communicated by the template, the RBH Trust did not suffer any unfairness in consequence. There were two strands to the argument, first that had the RBH Trust been given the opportunity further to respond on the issue of research and innovation, its case would not have been any stronger.

161. To assess the validity of that submission it is necessary to consider the relevant parts of the self-assessment form submitted by the RBH Trust. At section 1.11 the form invited a response to the following:

> "*Please describe the way the Paediatric Team works to learn, develop and grow, taking into account learning from practice, national and international research evidence, best practice and multi-disciplinary working. Please include any example of innovative working that you have undertaken and how these have proven benefit to clinical care.*"

162. Section two of the self-assessment form was directed to '*Achievement of Core Requirements'*. The third bullet point under core requirement 7, '*Ensuring Excellent Care,'* was:

> "*Each Tertiary Centre must have, and regularly update, a research strategy and programme that documents current and*

> *planned research activity, the resource needs to support the activity and objectives for development. The research strategy must include a commitment to working in partnership with other centres in research activity which aims to address research issues that are important for the further development and improvement of clinical practice, for the benefit of children and their families.*"

The form also asked those responding to attach their '*Research Strategy and Programme'*.

163. In its response the Trust said:

> "*Research strategy: The Trust has a clear and accountable research strategy and infrastructure (Appendix 20e). Our willingness to work with other centres is evidenced by several of our recent studies including several national epidemiological studies in congenital heart disease and the national multi-centre NIHR-funded 'CHiP' trial, which is run from the Royal Brompton.*
>
> …
>
> *The Trust has recently restructured it's research and development arrangements including the recruitment of a new Associate Director of Research. A key aim of these changes is to improve the alignment of the Trust research activity with the objects of the NHS at large.*"

164. The Independent Panel's assessment of the information provided by the RBH Trust is set out in the evidence given by Professor Sir Ian Kennedy (see paragraph 158 above). His evidence is addressed in witness statements from Dr Duncan Macrae, a consultant paediatric intensivist and Director of Paediatric Intensive Care at the Royal Brompton, and by Professor Timothy Evans, who was the medical director and director of research and development at the RBH Trust.

165. In addition to his role within the RBH Trust, Dr Macrae is currently the President of the International Paediatric Cardiac Intensive Care Society, the paediatric editor for the European Journal 'Intensive Care Medicine' and an associate editor of 'Paediatric Critical Care Medicine' based in the United States. In his second witness statement he addresses the assessment of 'research and innovation' by the Independent Panel. The following paragraphs are of particular relevance:

> *"6. Professor Kennedy says at paragraph 41 that the consensus score of 2 out of 5 was reached at a meeting held the following day, on 14 December 2010, based on our written material supplied to his Assessment Panel. He makes a series of assertions with which I disagree. He says that it was our responsibility to provide he and his colleagues with the written information with regard to surgical services, and that they thought that not all research undertaken and referred to by us applied to paediatric cardiac surgery and was therefore not relevant in meeting the Standards. He says that our*

responses did not contain specific plans to develop research in paediatric cardiac surgery and contained insufficient reference to research into paediatric cardiac surgical services. The short answer is that we never thought that any of these were relevant to the process that Prof Kennedy and his Panel had been represented to us as undertaking. We thought that we were being asked not about the content of our research, but about the application and the governance of research.

7. Research is not described as a component of excellence in the Template questions we were sent in advance of the visit of Professor Kennedy's Panel. The Template invited us (at section 10 ...) to describe the opportunities for innovative working and new ways of working across the network with improvements in screening diagnostics and telemedicine. That is what we did in our response, when we dealt with how we utilise new discoveries to improve the way in which we treat patients.

8. Similarly, at section 11 ..., we are asked to describe how the cardiac team works to learn, develop and grow, taking into account learning from national and international research. Once again, this was a question about how we were able to exploit and apply research advances (made here and elsewhere alike), and we answered it accordingly. The question is simply not about the very different matter of how we were going to contribute to the advancement of knowledge through research by clinicians and others from the Royal Brompton.

9. The governance questions arose ... in Excellent Care, where we were told that we must have and regularly update a research strategy and a program that documents current and planned research. We were asked to explain how we supported the activity and objectives for development and it was stressed that we must have a commitment to working in partnership with other activities in research activities that seeks to address research issues that are important for the further development and improvement of clinical practice. All this is about the governance of research and the shaping of research on how we support our researchers. That is why we provided the research strategy of the Trust in our response. Nothing in the questions put to us indicated that we were to be assessed on the content of our research, still less that the (illfounded) conclusions reached as to the nature and quality of our research were to prove to have such an important role in the process.

…

11. Anyone interested in this sort of issue would have looked at the results of the spadework in this field done by the professionals. I would have expected them to ask how we had fared in the Higher Education Funding Council for England (HEFCE) Research Assessment Exercise (RAE). I would understand if they did not want to rely on this Exercise unquestioningly, for the reasons given by Prof Kennedy, but anyone interested in the issue would have sought to probe how many of the highest scoring people submitted by Imperial College worked in the relevant fields. No one asked us any questions about that at any stage of the process.

> *12. The Rand Analysis referred to by Professor Evans was an assessment produced for the NHS. It did not look at grants, but it did look at the citation of individual papers. It collected all the papers together and look at the institutes from which they came. Again it was a careful, ambitious piece of work which is highly respected. Anyone interested in the research output of this hospital would have been fascinated by this because it shows that this hospital eclipses every university in the country except our own partner, Imperial, and that we do so handsomely. Again, we were never asked about this and it is plain that it was not considered by Professor Kennedy or the Safe & Sustainable process more generally.*
>
> *13. Prof Kennedy and his colleagues could have asked to see the papers and we would have produced a list. Looking at Professor Kennedy's statement I see that there is some suggestion that a lot of our research may have nothing to do with children. With respect to Prof Kennedy, who is an academic lawyer, any such suggestion is entirely misplaced. I have caused an analysis to be prepared ... listing all of the cardiological publications emanating from this hospital from 2008 to the end of 2010. Not only does it indicate the volume of work (498 discrete publication plainly supports the inference to be drawn from the Rand Analysis) but 227 or 44% of them deal with paediatric cardiac disease."*

166. Dr Macrae goes on to say that when Professor Kennedy and his team visited the Royal Brompton on 9 June 2010, he cannot remember anyone asking significant questions about research, nor suggesting that their research was not relevant to paediatric cardiac surgery.

167. Dr Macrae's understanding of the issues at which the Template was directed appears to me to be fully justified. Secondly his evidence clearly demonstrates that the assessment of 'research and innovation' based on the RBH Trust's response to the Template did not reflect the true position.

168. Professor Evans is a consultant in Intensive Care and Thoracic medicine at the RBH Trust, and Professor of intensive care medicine at Imperial College London within the National Heart and Lung Institute. He pointed out that it is a feature of the RBH Trust that its hospitals are specialist heart and lung hospitals treating patients of all ages, the only such hospitals in the UK. Thus, the research conducted by the RBH Trust is *"… on an enormously wide spectrum"*, and *"it may be that paediatric services will actually benefit most from techniques being pioneered more aggressively in adults."* He argued that that illustrates the value of a speciality-based hospital as opposed to a multi-speciality children's hospital. Whilst research undertaken in a children's hospital will obviously be focussed on paediatric services, it does not follow from the fact that research undertaken at the RBH Trust, or by the Trust in conjunction with Imperial College, is not limited in that manner, that such research may not be of direct relevance to the paediatric services that it provides.

169. It is not for this court to make an assessment of the research undertaken at the RBH Trust, either alone, or in conjunction with Imperial College, nor is it necessary to undertake a detailed analysis of the different measures of research activity to which Dr Macrae and Professor Evans referred in their evidence. But in the light of their evidence I reject the argument that to have informed the RBH Trust that its capacity

for research and innovation was being assessed by reference to the self-assessment form, and to have invited further submissions, would not have made any difference to the assessment made by the Independent Panel.

170. But the second strand to the argument advanced by Mr Garnham is directed to the scoring of the London centres, see paragraphs 68 – 70 above. He submitted that a different assessment of 'research and innovation' would not have made any difference to the preference for GOSH and the Evelina at which the JCPCT arrived. He substantiated the argument by reference to the table at pages 95/96 of the Consultation Document, from which it can be seen that the RBH Trust scored lower than GOSH and the Evelina on two criteria, 'Quality' and 'Deliverability'.

171. GOSH scored highest on 'Deliverability' because it provides three highly specialised nationally commissioned services, children's heart transplantation, ECMO services and complex tracheal surgery. The Evelina scored higher than the RBH Trust by virtue of the assessment of the negative impact for the provision of paediatric intensive care.

172. As to 'Quality' the weighted scoring for GOSH, the Evelina and the RBH Trust was 117, 156 and 78 respectively. The Evelina was given a higher score than GOSH under 'quality' by reference to the original assessment by the independent panel, see paragraph 54 above. As for the difference in scoring between GOSH and the RBH Trust, the explanatory note above the table says under the heading 'Quality':

> "*Similarly Great Ormond Street Hospital and the Royal Brompton Hospital were ranked equally by the panel, but the higher score for Great Ormond Street is due to its capacity for 'research and innovation'.*"

They had been ranked equal in the assessment made by the Independent panel, see paragraph 54 above. But if at this stage the RBH Trust had been scored the same as GOSH for 'research and innovation', its total score on the inter London centre scoring would have been 303, as against 347 for GOSH and 364 for the Evelina.

173. Mr Garnham therefore argued that had the RBH Trust been given an opportunity to make further submissions as to its capacity for 'research and innovation', and had such submissions persuaded the JCPCT that it should be scored equally with GOSH in that regard, it would still have been ranked third in the comparative assessment, and that in consequence there was no unfairness to the RBH Trust.

174. I do not agree. It was of course open to the RBH Trust to respond to the Consultation Document advancing the arguments as to its capacity for research and innovation summarised by Dr Macrae and Professor Evans in their witness statements, arguments that the JCPCT would be obliged to take fully into account in arriving at its final decision as to the reconfiguration of PCCS services. But in my judgement the consequence of the failure to meet the RBH Trust's legitimate expectation was seriously to distort the consultation process. Those responding to the Consultation Document would inevitably have proceeded on the premise that the RBH Trust's capacity for research and innovation was poor, a point made graphically in the colour coding on the diagram at page 102.

175. I recognise that when addressing the issue of which the London centres are to be preferred, the Consultation Document identified reasons for preferring GOSH and the Evelina. But from the viewpoint of a consultee, the question of which two London centres should be included in the proposed reconfiguration cannot be viewed in isolation from the question of whether there should be two or three London centres. Bearing in mind that each of the centres scored equally under 'Sustainability', had the RBH Trust been scored equally with GOSH in relation to research and innovation, it would have been a legitimate line of thought for a consultee, weighing the relevant considerations, to have arrived at the conclusion that notwithstanding the analysis of the projected case load (see paragraph 126 above), a three London centre configuration was to be preferred, a configuration that would have the advantage of preserving the unique features of a specialist heart and lung hospital. But such a conclusion was in effect precluded by the assessment of research and innovation at the RBH Trust as 'poor'.

176. As Sullivan J observed in *R(Greenpeace Ltd) v Secretary of State for Trade and Industry* [2007] EWHC 311 (Admin),

> *"63. In reality, a conclusion that a consultation exercise was unlawful on the ground of unfairness will be based upon a finding by the court, not merely that something went wrong, but that something went "clearly and radically" wrong".*

But I have come to the conclusion that that is the case. The assessment of the quality of the service provided by the RBH Trust would plainly be regarded as of central importance by a consultee when considering the options for reconfiguration of PCCS; and it seems to me that the low scoring of the RBH Trust on 'quality' in the weighted scoring of the London centres, must inevitably have affected the responses to the Consultation Document in a manner seriously adverse to the Trust.

177. I therefore consider that the failure to meet the RBH Trust's legitimate expectation as to the use to which the information provided in response to the self-assessment Template, and the likely consequential effect upon the assessment of 'Quality' in the inter London centre scoring, rendered the consultation process unfair to the Trust, the unfairness being of such a magnitude as to lead to the conclusion that the process went radically wrong.

178. <u>Conclusion</u>

It follows that in my judgment the consultation exercise was unlawful, and must therefore be quashed.