Neutral Citation Number: [2016] EWHC 17 (Admin)

Case No: CO/4920/2015

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

Manchester Civil Justice Centre,
1 Bridge Street West, Manchester,
M60 9DJ

Date: 07/01/2016

Before :

MR JUSTICE DOVE

- -

Between :

KEEP WYTHENSHAWE SPECIAL LIMITED — **Claimant**

- and -

NHS CENTRAL MANCHESTER CCG (1)

- and -

NHS NORTH MANCHESTER CCG (2)

- and -

NHS SOUTH MANCHESTER CCG (3)

- and -

NHS STOCKPORT CCG (4)

- and -

NHS TAMESIDE AND GLOSSOP CCG (5)

- and -

NHS BOLTON CCG (6)

- and -

NHS BURY CCG (7)

- and -

NHS SALFORD CCG (8)

- and -

NHS WIGAN CCG (9)

- and -

NHS HEYWOOD MIDDLETON AND ROCHDALE CCG (10)

- and -

NHS TRAFFORD CCG (11)

- and -

NHS OLDHAM CCG (12)

Defendants

- and -

UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST (1)
- and -
NHS NORTH DERBYSHIRE CCG (2)
- and -
DERBYSHIRE COUNTY COUNCIL (3)
- and -
STOCKPORT NHS FOUNDATION TRUST (4)
- and -
NHS COMMISSIONING BOARD (NHS ENGLAND) (5)
- and -
HIGH PEAK BOROUGH COUNCIL (6)

Interested Parties

- - - - - - - - - - - - - - - - - - - -

Fenella Morris QC and Annabel Lee (instructed by **Irwin Mitchell LLP**) for the **Claimant**
Philip Havers QC, Jeremy Hyam and Kate Beattie (instructed by **Hempsons**) for the **Defendant**
David Lock QC and Robert Walton(instructed by **Hill Dickinson**) for the **First Interested Party**
Jason Coppel QC and Hannah Slarks (instructed by **Bevan Brittan**) for the **Fourth Interested Party**
Daniel Stilitz QC (instructed by **NHS Commissioning Board**) for the **Fifth Interested Party**

Hearing dates: 9th & 10th December 2015

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Approved Judgment

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

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MR JUSTICE DOVE

MR JUSTICE DOVE :

Introduction

1. The Healthier Together ("HT") initiative is a programme of reform for the provision of healthcare services within Greater Manchester which was launched by the defendants in February 2012. As a consequence of successive legislative reforms, the provision of healthcare under the auspices of the National Health Service ("NHS") in England is a complex web of organisations with separate roles to play in the provision of services to patients. It is unnecessary for the purposes of this judgment to set out these arrangements in detail; what follows is a broad account of the various roles of the parties in this case in meeting patients' needs.

2. The defendants are the organisations charged with the responsibility of commissioning healthcare services from the providers of such services for patients in Greater Manchester. The first interested party ("1st IP") and fourth interested party ("4th IP") are responsible, respectively, for the Wythenshawe Hospital ("Wythenshawe") and the Stepping Hill Hospital ("Stepping Hill") and are therefore providers of largely acute healthcare through the operations of their hospitals. The fifth interested party ("5th IP") is, amongst other functions, the commissioner of various specialised services at Wythenshawe. The second interested party ("2nd IP") is responsible for commissioning healthcare services in Derbyshire, adjacent to Greater Manchester. The third interested party ("3rd IP") and the sixth interested party ("6th IP") are local authorities also in Derbyshire.

3. The claimant is a company which has been formed and deployed for the purpose of representing the interests of, in particular, consultants at Wythenshawe in these proceedings. Whilst questions have been raised by the defendants in relation to the standing of the claimant to bring this case, by the time of the hearing the issue of standing was only raised as a factor to be taken into account in the question of whether or not to grant relief. There is, therefore, no longer any outstanding issue as to whether, as a matter of principle, the claimant is entitled to bring this matter before the court.

4. Whilst HT was far more wide-ranging, the focus of the attack upon it in these proceedings relates solely to its proposals in relation to changes to acute hospital care, and in particular the proposal to identify Stepping Hill, as opposed to Wythenshawe, as one of the four Specialist Hospitals in the proposed redesign of hospital services. The claimant contends that the process whereby Stepping Hill came to be preferred was procedurally flawed and unfair and that it was substantively illegal as being a perverse decision which was unreasonable in the Wednesbury sense.

5. There are two further preliminary observations which it is necessary to make. Firstly, during the course of their evidence and in their initial pleaded cases the parties have raised and refuted a very large number of concerns and allegations. As the case has evolved, and in particular in the final stages of producing skeleton arguments and addressing the hearing, the cases have become far more focussed and less diffuse. This judgment therefore addresses the points which were raised at the hearing and which remained after this distillation process. It assumes, as the court must, that points raised earlier but not pursued in the context of the hearing are no longer relied upon and certainly are not at the heart of a party's case.

6. Secondly, I wish to place on record, as I did at the hearing, my thanks to all of the parties' representatives (both lay and legal) for the conspicuous hard work put into preparing for the hearing and then ensuring that it was completed following full submissions on all sides within the two days allowed. Demanding case management directions were made, and all parties rose to the challenge. This preliminary work, and the care and diligence with which it was undertaken, was instrumental in ensuring an effective hearing. All counsel also played their part in adhering to our timetable and using court time extremely efficiently with their careful, helpful and concise submissions.

The facts

7. It appears, in particular from the consultation material which will be examined below, that the motivation for the HT reform programme was both clinical as well as financial. For patients who had life-threatening injuries or illnesses the provision of specialist care spread across a large number of hospitals meant that in some hospitals staff did not see and regularly treat sufficient numbers of particularly ill patients to maintain and hone their skills in treating them. As an example, undertaking emergency surgery in nine acute hospitals led to treatment taking place in some instances without a consultant present and without a guaranteed admission to a critical care bed. The consolidation of these services into a more limited number of Specialist Hospitals was considered to assist in improving consistency in the quality of care and of outcomes, in particular at evenings and weekends. The financial case was based on the financial challenge being faced in respect of the provision of both healthcare and adult social care which, it was estimated, would exceed £1 billion if nothing was done to address and change the model of care.

8. The new model of care proposed in particular in relation to hospital care was described as the formation of "Single Services", and affected the provision of A&E, acute medicine and general surgery. Whilst every hospital, both those designated as a local General Hospital and also those designated as a Specialist Hospital, would have an A&E department, the sickest patients would go to a Specialist Hospital which would be the location for the provision of high-risk and emergency surgery. The Single Service would be provided by one team of doctors and nurses who would work across both a Specialist and also one or two of the General Hospitals. The General Hospitals would still provide surgery, but it would be elective or planned surgery. General Hospitals would also provide screening and diagnostic testing and services as well as out-patient appointments.

9. The work of examining the issues and developing a case for change, as well as the potential shape of the changes, occupied the defendants from February 2012 to December 2013. In the first half of 2014 they then proceeded to develop a business case for the proposals, described as the Pre-Consultation Business Case ("PCBC"). The future model of care was identified in the PCBC in the following terms:

> "In summary, the proposed model of care for [hospital services] includes:
>
> **Deliver care locally for the majority of patients**-local services;

> **Upgrade Local Services** so that all sites achieve Greater Manchester Quality and Safety standards;
>
> Care for the small number of patients with "once in a lifetime" life threatening illnesses and injuries in a **smaller number of Specialist Services** delivered in line with best practice standards;
>
> To achieve this, **create Single Services**-multi-disciplinary teams responsible for the delivery of Specialist and Local Services across a sector of Greater Manchester;
>
> **Consultant led services delivered to best practice standards**
>
> **Standardise and improve children's community care** to treat as many children as is safe and appropriate to do so in the community;
>
> Work with the **Ambulance Service to direct patients to the right place at the right time**, including to Community and Primary Care if appropriate as well as to Local and Specialist services, and;
>
> **Effective clinical leadership and decision making** to ensure high quality, efficient care."

10. At this stage of the process the defendants formulated proposals for the criteria with which to assess the effectiveness of the various combinations of hospitals designated General and Specialist for the purpose of configuring the potential Single Services. The criteria were grouped into themes. In relation to "Quality and Safety" two criteria were identified: "Clinical Effectiveness and Outcomes" and "Patient Experience". With respect to "Clinical Effectiveness and Outcomes" the PCBC noted that all of the options to be examined "will achieve the GM Quality and Safety standards - the cost of achieving this has been factored in to the VfM [value for money] analysis". The criteria of "Patient Experience" was to be scored using results from the NHS Friends and Family Test (in essence, the expression by patients of how likely they would be to recommend the service which they had received to their friends and family).

11. The PCBC also included a theme of "Access", which included two criteria: the first related to the distance and time to be travelled to access facilities both by car or ambulance and also by public transport; the second was a consideration of "Patient Choice". The distance and time criteria were settled into three standards: firstly, 20 minute emergency access to any hospital (General or Specialist) by ambulance; secondly, 45 minute emergency access to a Specialist Hospital; thirdly, 75 minute access to a specialist site by public transport. Other criteria which are uncontroversial in these proceedings were identified under the themes of "Affordability and VfM" and "Transition".

12. In order to make collective decisions the defendants set up the HT Committees in Common ("HTCiC") to make decisions on behalf of the defendants in the HT process. To further assist in the process, HT created various groups in relation to areas of

expertise involved in the decision-making process. One of these was the Clinical Reference Group, which made recommendations to the HTCiC. On 26th February 2014, acting on the recommendation of the Clinical Reference Group, the HTCiC determined that Manchester Royal Infirmary and Salford General Hospital should be designated as Specialist Hospitals in any of the options for reform which were to be adopted. At this stage the Clinical Reference Group also recommended that Wythenshawe should be designated as a specialist hospital in any of the options. On 16th April 2014, the HTCiC decided to designate Royal Oldham Hospital as the third Specialist Hospital within all the options. These decisions formed the backdrop to the consultation with the wider public which then occurred.

13. The public consultation ran from 8th July 2014 until 24th October 2014 (the period having been extended to a total of 15 weeks). The consultation was supported, in particular for the purposes of the documentation before the court, by literature in the form of two documents. The first was a leaflet entitled "Healthcare in Greater Manchester is changing" and it stated that:

> "We need help to shape our plans and we are specifically asking you about proposed changes to how we look after the (small number of) sickest people in hospital…
>
> For hospital services, we are proposing changes to A&E, acute medicine, and general surgery. These changes are supported by the principle that everyone in Greater Manchester should have access to the highest standards of care wherever they live, whatever the time of day or night, or whether it is a weekday or the weekend…
>
> In acute medicine, the Greater Manchester quality and safety standards will **raise the standard of care for our patients across all hospitals in Greater Manchester**, both General and Specialist…
>
> For a small number of patients (those who are the most unwell) a smaller number of hospitals will provide the most specialised care. These Specialist Hospitals will provide emergency and high-risk surgery as well as the services a local General Hospital provides. The 12 clinical commissioning groups will be making a decision on the way these hospital services are organised depending on what you tell us during this consultation."

14. The leaflet went on to present eight options for the designation of hospitals: four of the options identified four hospitals as Specialist Hospitals and four of them identified five hospitals as Specialist Hospitals. As set out above three hospitals were, in effect, fixed as Specialist Hospitals from earlier decisions which had been reached by the HTCiC. In the options for four Specialist Hospitals identified as 4.3 and 4.4 Wythenshawe and Stepping Hill were identified as alternatives with the three fixed hospitals. They were also alternatives in the four potential combinations of five Specialist Hospitals.

15. The leaflet set out the criteria for the assessment and, in a table, suggested scoring against the criteria using a relatively coarse scoring system on a five-point scale ranging from "++" to "- -". For the purposes of the arguments in this case it suffices to note that the only distinctions in the scoring between option 4.3 (containing Wythenshawe) and option 4.4 (containing Stepping Hill) was that option 4.4 scored slightly lower for "Patient Experience". In particular, the score for "Clinical effectiveness and outcomes" was the same for both (on the basis of the PCBC approach that all the options would be the subject of investment to ensure that they were all equally good when measured against this criterion), and "Travel and Access" was scored the same. The leaflet stated that HT were "asking for your views on eight options for the proposed changes to hospital services".

16. The leaflet concluded, in addition to inviting recipients to attend consultation events to express their views on all aspects of the proposals, with the following invitation:

> "Healthier Together is a review of health and care in Greater Manchester, we are looking at how to provide the best care for you and your family. Please tell us what you think by filling in the form opposite. Please remember that this is a consultation and not a 'vote'. We will be taking into account your responses along with a wide range of other information, including the views of staff, professional groups and key organisations."

It went on to provide contact details for HT including a telephone number, email address and the location of social media presences.

17. A lengthier document, "A Guide to Best Care, Greater Manchester Health and Social Care Reform" was produced as part of the consultation. It contained, obviously, the same information as the leaflet, but in addition provided greater detail. The emphasis of the document was on the provision of healthcare to the residents of Greater Manchester and, in relation to hospitals, the services provided by Greater Manchester hospitals. An example of the way in which this was expressed in the document is as follows:

> "**There is unacceptable variation in the quality of care and outcomes for patients across Greater Manchester.** Evidence suggests that the best results are seen when hospital care is delivered under the direction of the most senior and experienced doctor. We know that there is variation in the number of consultant doctors across Greater Manchester and this may be contributing to a corresponding variation in the quality of care and patient's experience in hospitals in Greater Manchester."

18. The document went on to describe the reconfiguration of hospital services, reflecting the approach to General and Specialist Hospitals that has been set out above. In respect of what the document described as specialist services (which it should be noted are not the same as the specialised services which are commissioned by the 5th IP and which are set out further in the analysis of the facts below) the document provided as follows:

> "Specialist services provided locally
>
> Whilst emergency and high risk General Surgery operations will not be provided at General Hospitals anymore, **the other parts of hospital care will still be provided locally**. For example, there will be rapid access clinics for patients arriving at A&E who need an urgent surgical assessment. Similarly, following an emergency operation, patients can see their surgeon in an **outpatient clinic** at their local general hospital- for example specific cancer or chemotherapy treatments, and diagnostic tests…
>
> As described earlier, Specialist Hospitals will work in a single service with general hospitals. Across Greater Manchester a smaller number of specialist hospitals will provide specialist services for the small number of very sick patients. **Therefore, these hospitals delivering specialist services will provide care for patients from both the immediate locality of the hospital but also those in the surrounding localities.**
>
> This means that Specialist Hospitals will see a larger number of patients each year from across a larger geography of Greater Manchester, enabling them to become centres of excellence in caring for seriously ill patients."

19. The document went on to consider the topic of travel and transport. It set out the access standards which have been rehearsed above and noted that these standards had already been used in a previous reconfiguration of major trauma services within Greater Manchester.

20. The consultation process comprised a number of different techniques and events. A questionnaire was deployed for consultees to complete. There was also the opportunity for individuals and organisations to make written submissions to the consultation. Petitions were received and public meetings organised for discussion about the proposals. Articles and advertisements were placed in the media and a dedicated website was created for the publication of HT documentation. On 24th October 2014 the 1st IP provided a written submission in relation to the HT proposals. In that document they observed as follows:

> "Wythenshawe Hospital has an existing portfolio of high quality specialist services. Whilst some of the services are not directly within the scope of the Healthier Together consultation, they remain of critical importance to the overall service for the people of Greater Manchester and the Southern Sector in particular. Due to the interdependencies of these specialist services it is important that these services are maintained...
>
> While the consultation is not about our highly specialist services we feel the longer term unintended consequences of not being recognised as a specialist site would inevitably mean

> our ability to maintain and enhance our specialist services could be compromised.
>
> **Conclusion**
>
> UHSM supports the ambition of Healthier Together and looks forward to working collaboratively with colleagues in health and social care to support the much needed changes to primary care, joined up care and how hospitals work across Greater Manchester.
>
> UHSM recommends, based on clinical evidence and strategic vision for the Greater Manchester health care economy, Wythenshawe Hospital should be confirmed as a specialist site under consultation options for 4.3 or 5.2/5.3."

21. At this time the 1st and 4th IPs were both participants in an initiative called the Southern Sector Partnership. That Partnership provided its own consultation response in the form of a document dated October 2014. The principal message of their joint response was that it was essential for there to be a Specialist Hospital within the Southern Sector. Part of the reasoning for reaching that conclusion was expressed in the document in the following terms:

> "The principal of a single service model in the Southern Sector, applies across a range of specialised services including "specialist" services as described in Healthier Together. We believe teams of clinicians working across the Southern Sector will provide high quality, specialist and specialised care for the population of the Southern Sector. We recognise that the exact solution may differ for different services. It is envisaged that this model of care will address the volume and complexity of emergency surgery and high-risk elective general surgery for the local Southern Sector population. We also believe that this will need to be developed in a phased manner…
>
> We are also concerned that if "specialist" services were not available in the Southern Sector people living in the High Peak area of Derbyshire and Cheshire (catchment areas of the Southern Sector) will have to travel further, both by ambulance and public transport.
>
> It is very clear that if there were only to be four "specialist" sites within Greater Manchester, there must be one in the Southern Sector."

22. For the purposes of decision making the responses to the consultation were themed and reported along with the responses to the points made. This analysis became Appendix 11 to the Decision Making Management Report ("DMMR") which was produced finally on 8th July 2015 to inform the HTCiC at the time of making the decision which is the subject of this judicial review. There remains an issue as to the extent to which this document was in the public domain. The defendants contended,

and I am prepared to accept, that this document was publicly accessible when published for the purposes of a meeting of the HTCiC on 15th April 2015. At references TA4 and TA10 some consultees (including the 4th IP) had raised the question of whether the transport analysis had included populations of patients outside the Greater Manchester area who used Greater Manchester hospital facilities. The response noted to this point was dealt with as follows:

> "The group agreed that the transport analysis will be refreshed for the decision making phase to include those areas outside of the Greater Manchester CCG boundary where the closest hospital is a Greater Manchester hospital. This will incorporate those patient groups that currently use Greater Manchester hospitals, and are affected by the proposals, into the transport analysis."

23. Other consultees, and in particular the 1st IP, raised the question of whether new and proposed changes to the transport network had been taken into account. This point was identified under reference TA8. The response provided was as follows:

> "The Transport Group discussed and considered this feedback at the meeting on the 17th December 2014. The group agreed that the analysis used to support the pre-consultation phase of the programme should now be updated for the decision making phase to take account of current road network and public transport systems.
>
> This updated analysis reflects the latest available public transport data (July 2014) and includes the Manchester Airport Metrolink line which has been recently added to the network."

24. Following the close of the consultation, on the 19th November 2014 the HTCiC agreed a decision-making approach which identified six decisions that needed to be made, the first five of which are essentially uncontroversial in these proceedings. The decisions were as follows. Firstly, the HTCiC had to confirm the case for change. They did so on 21st January 2015. The second question was whether the model of care was supported: again on the 21st January 2015 the HTCiC endorsed it. Thirdly, the HTCiC had to identify whether there were any alternative options. On 21st January 2015 the HTCiC determined that they would support options with four or more single services and options with no more than five single services. They agreed that the configuration of one site specialising in general surgery for patients with life threatening illness teamed with three others would be assessed under the configurations to be considered as part of the options appraisal.

25. The fourth decision was the identification of the criteria to be used in the decision-making process. On 18th February 2015 the HTCiC agreed the four criteria of quality and safety, travel and access, affordability and value for money and transition (which included a consideration of which specialised services required co-location with other services within the scope of the reorganisation). They further determined on that date that "no weighting should be applied to the criteria" in the decision making process.

26. The fifth question was how many single services, or Specialist Hospitals, there should be. On the 17th June 2015 the HTCiC concluded unanimously that there should be four Specialist Hospitals, leaving as the final decision (and the one which is controversial in these proceedings) which of the four options incorporating four Specialist Hospitals should be chosen. Given that, as set out above, three of the Specialist Hospitals had already been selected the decision was in effect whether the fourth should be Wythenshawe or Stepping Hill.

27. Clearly in preparing for the making of this final decision a vast amount of data and analysis was compiled and presented to the HTCiC in the DMMR. The concerns of the claimant are focussed upon particular aspects of that material and the manner in which certain issues were dealt with. It is convenient for the structure of this judgment to now trace through the evolution of the consideration of the particular issues in the decision making process which are the subject of criticism by the claimant in this case. This examination will start with travel and access considerations in the decision making process, before returning to other aspects of the factual background relating to clinical considerations.

28. Throughout the analysis the travel time standards set out above remained fixed, with Standards 2 and 3 which related to Specialist Hospitals being particularly significant in the selection of any future site as a Specialist Hospital. The testing of the options and the prediction of journey times was undertaken using two transportation models developed by Transport for Greater Manchester ("TfGM"). In relation to car travel the Transport Advisory Group ("TAG"), which had been established to explore these issues, used the TfGM SATURN model of all of the roads in the Greater Manchester area, which also incorporated all roads of traffic significance up to 40 miles from the boundary of the Greater Manchester area. The model was built with SATURN computer modelling software and would have been calibrated with actual journey time data. In relation to public transport the TAG obtained information from the TfGM TRACC model in relation to relevant journey time data.

29. In response to the concern raised in relation to changes in the road network the following conclusion from the TAG is noted in the DMMR:

> "It is clear that on-going transport and infrastructure projects may also be completed during implementation, for example the SEMMS link road is due to be completed in the autumn of 2017. Such developments will need to be kept under review during the implementation to understand any changes in impacts for affected residents."

As a result the modelling took no account of any effects on journey time which might arise as a consequence of the completion of the SEMMS road in the decision making process.

30. Further work was also undertaken in order to respond to the consultation queries about the impact on residents outside Greater Manchester who might use healthcare facilities in Greater Manchester and, in particular, its hospitals. The analysis is described in the following terms in the DMMR:

> "A number of responses indicated that patients who live outside the GM CCG boundary, but use GM hospitals, had not been considered in the travel analysis used in the pre consultation phase. As a result, the boundary for the analysis has been expanded to cover all addresses that are currently closest to a GM hospital (e.g. North Derbyshire, Eastern Cheshire, Chorley and South Ribble). This allows a fuller understanding of the potential impact of patients going to hospitals outside of Greater Manchester if, in future, these hospitals are now their 'nearest'. This wider catchment area is called the "GM hospital catchment area".
>
> The result of expanding this analysis is that for car off peak travel, the total catchment population within the analysis has been expanded from a total GM CCG population of 2.7m to 2.8m under the wider GM hospital catchment area. When analysing the origin of relevant inpatient activity provided in GM hospitals, this wider catchment area covered 97% of GM hospital activity."

31. In light of the conclusion in respect of the fifth decision that there should be four Specialist Hospitals the TAG went on to examine whether there were implications for the travel and access standards which depended on which options were selected. The first question which they posed was in the following terms: "If we model where patients would go if they attended their 'nearest' hospital providing specialist care do the options meet the transport standards? Is there anything to differentiate between the options?" Predicating the modelling on the use of the nearest hospital to residents of the wider GM hospital catchment meant that it proceeded on the basis that some patients would be attending hospitals outside the Greater Manchester area, in particular where they lived in the parts of the catchment more remote from Greater Manchester such as the northern parts of Derbyshire. The analysis showed that in response to this question travel standards 1 and 2 would be met in all cases. Whilst travel standard 3 was not met, the overall conclusion of the TAG was that there was "very little evidence to differentiate between the four remaining options based on patients travelling to their nearest hospital providing specialist care".

32. That was not an end of the travel and access analysis and the TAG went on to pose and answer a second question that was expressed in the following terms: "What if the people currently served by GM hospitals continue to travel in to Greater Manchester for specialist care? Where are the longest travelling times? Would this meet the standards?" The reasons for posing the question in relation to the most appropriate option in this second formulation were especially related to the outlying parts of the catchment. In particular, by way of example, deploying the first formulation of the question and looking at the nearest hospital for a patient in North Derbyshire his or her destination would be assumed to be Macclesfield or Chesterfield hospitals. However, concerns had been raised that in reality these patients would be conveyed by ambulance to Stepping Hill in preference as the roads to Macclesfield or Chesterfield were slower and more difficult. These concerns were corroborated by the TAG's work: this is explained in further detail in the evidence of Dr Whiting (an officer of the second defendant and the chair of the TAG) as follows:

> "We also discussed, and made a priority for further analysis in the data, that during the public consultation the HTCiC received data from North Derbyshire CCG which showed that consistently for the last 3 years residents of those postcodes within the catchment area use Greater Manchester hospitals ~60% of the time (and indeed Stepping Hill ~57% of the time). This was confirmed to be due to the weather conditions affecting the roads over the Pennines to Sheffield and Chesterfield."

33. Further information on the analysis of this second question can be obtained from a presentation made to a Data Familiarisation Workshop which was held on 8th July 2015. Six of these Workshops were held to present the findings of the research which was to underpin the decision making process. This was the final one, and included an update in relation to the work on travel and access. Within the presentation the population with a greater than 45 minute journey by ambulance or car when travelling to a Greater Manchester Specialist Hospital in the future is quantified as being 17,647 within option 4.3 (Wythenshawe) and 0 under option 4.4 (Stepping Hill). All 17,647 of those identified were residents of North Derbyshire. The presentation went on to provide the data in relation to the proportions of patients in Greater Manchester hospitals whose origin was North Derbyshire. Based on a catchment population of 29,968 the number of patients predicted to come from North Derbyshire to a Greater Manchester hospital was identified as 1.7 per day. As was pointed out by Ms Fenella Morris QC, who appeared on behalf of the claimant, based on a population of 17,647 it could be calculated the potential number of patients exceeding the 45 minute standard for emergency trips to Wythenshawe if it were selected as the fourth Specialist Hospital would be around one per day.

34. More detail on the modelling exercise is provided by Dr Whiting in his witness statement in the following terms:

> "To assess if this catchment based on travel times provided an accurate reflection of actual patient usage of Greater Manchester hospital, Hospital Episode Statistic (HES) data from 2013/4 was analysed. As reported to the TAG the catchment area of transport analysis covered 98% of the in scope activity in Greater Manchester Hospitals. Our analysis found that for 97.3% of Lower Super Output Areas (LSOA) that were included in the newly drawn catchment area, >75% of actual hospital attendances from that LSOA used a Greater Manchester hospital in the time period analysed. The group therefore concluded that the newly drawn catchment area strongly reflected historic patient use and as such provides an accurate reflection of the true Greater Manchester hospital catchment area."

35. As a consequence of this analysis, the advice from the TAG was that whilst measured against the first question for the sixth decision (namely, measuring the journey times to the nearest available hospital to the catchment population) all of the options would meet travel standard 2, by contrast when the options were measured against the second question and account was taken of where the catchment population in fact

tended to be brought to hospital it was only the option involving Stepping Hill (option 4.4) which was found to meet that standard.

36. Turning to the criteria of Quality and Safety, it will be recalled that there were two identified elements to be assessed. In relation to "Clinical Effectiveness and Outcomes" the approach that had been taken at the time of the PCBC was that all options would achieve the required standards and therefore there was no basis to distinguish between them in the appraisal. They were all entitled to be awarded the maximum positive score in respect of this element of the evaluation. The justification for this was the same in the DMMR as it had been in the PCBC (see paragraph 10 above) and this approach was endorsed by the Clinical Advisory Group and the Clinical Patient and Safety Group. Part of the reasoning behind concluding that this was a sound basis for decision-making was the assumption that the necessary investment to achieve the standards had been costed into the affordability analysis, and therefore any differentials in existing infrastructure or other elements required to meet the standards had been ironed out in that part of the process.

37. The question which this approach begged was why existing data in relation to hospital patient outcomes were not used as a means of differentiating between the competing hospital facilities. In response to this issue being raised by the claimants in these proceedings, further explanation of the defendants justification was provided by Dr Bishop, an officer of the eighth defendant, in a witness statement in the proceedings as follows:

> "In practical terms, had an analysis of past quality and safety within the different hospitals been undertaken this would have been of limited practical use for the HTCiC in determining which option to choose. Whether a hospital has historically provided care with high quality and safety is not, unfortunately, always and necessarily a strong guide to the future of care. There have been rapid, and dramatic failings from previously well considered hospitals within the NHS noted in the national media.
>
> Such an analysis may provide a moment in time analysis (limited to the moment the data was extracted) however, extrapolating into the future based on the past would be, in my view, highly speculative. This would also require a broader examination in the reliability of such data for the purpose to which it was put. I have seen nothing that suggests that such reliability can be extrapolated from historic findings."

38. The second element of the Quality and Safety theme was Patient Experience and at the PCBC stage it will be recalled that the evaluation proceeded using the NHS Friends and Family Test data. Some consultees including the 1st IP had raised the question over the time period covered by the data that had been used. It was noted that the Friends and Family Test data in the PCBC was a snapshot of a single month (March 2014) and the 1st IP pointed out that they had achieved a higher Friend and Family Test score over the 12 months to July 2014. The suggestion that was examined in the DMMR was whether a longer time-frame for the data should be deployed.

Having scrutinised Friends and Family Test data over a longer time frame the DMMR adopted the following advice from the Clinical and Patient Safety Group:

> "C&PSG notes that FTT data has changed since the PCBC with some Trusts improving and others worsening. CPSG therefore advise that as current quality and safety standard will be improved in **all sites**, this should not be used as a criteria to determine the number of single services."

39. Thus as a result of these conclusions the theme of Quality and Safety was deemed to be equally good across all options, on the basis that the reconfiguration had been designed to meet the required service quality standards in all cases.

40. The final feature of HT's work that needs to be set out for the purposes of this judgment is that concerned with co-dependent services. Co-dependent services are those that depend upon, or provide assistance to, other services. It was necessary for the defendants to be satisfied that as a consequence of the reconfiguration of the provision of services, where services were rendered less available or unavailable this would not have a knock-on adverse consequence for services which were not within the scope of the reorganisation. In the particular context of the decision to be reached in respect of Wythenshawe the relevant service which was within the scope of the reorganisation was emergency and high-risk surgery, and the co-dependent services outside it relevant to the arguments in the case were cardiothoracic surgery, vascular surgery, specialised burns treatment and the treatment of cystic fibrosis.

41. As set out above in paragraph 18, the premise of the consultation exercise was that, in effect, apart from the provision of emergency and high-risk surgery which was to be reconfigured within the proposals, "the other parts of hospital care will still be provided locally". At the Pre-Consultation stage consideration was given to the question of co-dependencies. In a report entitled "In Hospital Future Model of Care" issued in April 2014 there was an examination of co-dependencies between emergency general surgery and various services and specialities, placing them in a framework rating the dependency between "Not Dependent" and "Absolutely Dependent". Vascular surgery was identified as "Highly Dependent" and cardiothoracic surgery was identified as "Moderately Dependent". The work in relation to the future model of care was reviewed at the Pre-Consultation stage by the National Clinical Advisory Team ("NCAT") and also by the Greater Manchester, Lancashire and South Cumbria Senate.

42. As part of the assessment of feedback following the public consultation HT prepared a report addressing the issues that had been raised. This was presented as Appendix 45 to the DMMR. Amongst the themes that it addressed was the question of co-dependencies upon emergency and high-risk elective surgery. In summary, the report identified all four of the areas of work which potentially had a co-dependency with emergency or high-risk elective surgery and which are in issue in this part of the case as requiring support "via a robust pathway or on-call arrangement" and as being "moderately" or "minimally" dependent. The detail of the assessment in the report in relation to each of the areas of clinical work was as follows.

43. Dealing firstly with cardiothoracic surgery the report set out a number of documents and references to which regard had been had in reaching its conclusion. These

included a document entitled "The Cardiovascular Project Co-dependencies Framework" of August 2010, and standard contracts issued by the 5th IP for the provision of certain specialised services which they commissioned such as heart and lung transplant. In the summary of the evidence the report noted:

> "The Cardiovascular Project Co-dependencies framework lists General Surgery as "*vital but does not necessarily require collocation in the same hospital*"

In the light of this and the other evidence noted the report's assessment was that:

> "No co-location requirement was identified through the literature review."

44. In respect of vascular surgery it was noted that in particular complex and emergency vascular surgery was commissioned at (amongst other hospitals) Wythenshawe by the 5th IP. A number of documentary references were noted as having been reviewed for the purposes of considering the question of co-dependency including "The Clinical Co-dependencies of Acute Hospitals" by the South East Coast Clinical Senate 2014, and the NHS Standard Contract for Specialised Vascular Services produced by the 5th IP. The conclusion that was reached was that "Robust pathways for prompt access to vascular surgery were required" and that "Sites designated as a 'specialist site' that do not have on-site vascular surgery will need clear and robust pathways to access this service".

45. Turning to Specialised Burns, the report addressed the requirements of the specialised burns service that was provided at Wythenshawe and commissioned by the 5th IP. Amongst the references referred to in the report was the "Co-dependencies framework for Specialised Burns Services" prepared by the Burns Clinical Expert Panel of October 2011, as well as the 5th IP's standard contract for the commissioning of this service. Within the recording of the available evidence, the assessment and the conclusion following analysis, the following was noted:

> "Evidence summary
>
> The above co-dependency framework reviewed recommends that "The framework recommends the onsite co-location of all specialised burn services with the following…general surgery (adult services only)." No requirement for 24/7 access is identified.
>
> A similar recommendation is made in the specialised commissioning specification; "Burn Centres will be co-located with or have on-site access to…General Surgery…"
>
> Assessment
>
> …
>
> The specification requires access to general surgery which will be available whether or not UHSM is a 'local' or a 'specialist'

> site as all sites will continue to operate elective, day case and outpatient care in the day seven days per week and a dedicated on-call consultant out of hours.
>
> There is already a robust pathway in place for the transfer of acutely unwell burns patients from Emergency Departments across Greater Manchester.
>
> UHSM will need to maintain 24/7 radiology, pathology and transfusion services. Should UHSM be designated a 'local' site this provision would be over and above the 'local'.
>
> Conclusion: 24/7 radiology, pathology and transfusion services should be maintained at UHSM"

46. Finally, in relation to cystic fibrosis it was noted within the report that concerns had been expressed by the Cystic Fibrosis Trust about the future of the service commissioned by the 5th IP and provided at Wythenshawe for patients with this disease. On this occasion a single document was referenced: the 5th IP's Commissioning Specification "A01/S/b Cystic Fibrosis". Having considered the requirements which were identified for the specification of the service in that document it was concluded:

> "There is no requirement for co-location with other services".

In the light of this evidence the report concluded that no action was required in respect of this co-dependency.

47. In May 2015 the NHS Midlands and Lancashire Commissioning Support Unit provided an independent review of published evidence and literature on clinical co-dependencies as part of the evidence base for the decision making process. Whilst the review identified literature in relation to co-dependencies associated with vascular surgery, it did not directly touch upon the other three areas of work that are of concern in this case.

48. Mr Andrew Bibby is the Assistant Regional Director of Specialised Commissioning (North) of the 5th IP following appointment to that post in January 2015. As will have been noted from the material set out above, the 5th IP are responsible for commissioning as specialised services much if not all of the clinical work undertaken at Wythenshawe in relation to the four areas which are particularly in point in this case. As might be imagined, the 5th IP also commissioned other specialised services in hospitals affected by the HT initiative. In order to provide an understanding of the impact of the proposals on the interests of the 5th IP, Mr Bibby produced the "Headline Impact Assessment of *Healthier Together* Options on the provision of Prescribed Specialised Services in Manchester" in May 2015. Having identified the four areas of work set out above (amongst many others) as clinical services commissioned by the 5th IP the report went on to identify "critical interdependencies" and reach the following conclusion:

> "To summarise, five services at UHSM have a critical interdependency with Specialist and/or Interventional

> Radiology and assurance is required that any change proposed would not undermine this provision. A number of services within the Trust have a critical interdependency with ICU. The Trust currently has two ICU facilities (one in the Cardiothoracic centre and a general ICU). We anticipate that the Cardiac ICU would remain, however assurance is required that this could be sustained in the context of changes affecting the wider hospital, further there are a number of non-Cardiothoracic services (4) currently dependent on the general ICU which requires consideration. The ability to sustain ECMO services against the context of the significantly reduced ICU bed-base across the Trust also needs consideration.
>
> Of particular concern, which requires further exploration, is the potential impact of a change to services at UHSM on the Specialised Burns service. There are a number of 24 hour interdependencies for this service (in addition to ICU) which include 24/7 Radiology; 24/7 Pathology; and 24/7 Blood Transfusion Laboratory services and round-the-clock anaesthetic services. Specific assurances are required that any change to the role of UHSM would not impact the sustainability of the Burns service."

49. After the promulgation of this report discussions ensued between Mr Bibby and representatives of HT, in particular at meetings on 29th May 2015 and 9th July 2015. As a result of these discussions and the assurances which Mr Bibby received he became satisfied that the proposals were satisfactory from the point of view of the interests of the 5th IP, in the event that Wythenshawe was not selected as a Specialist Hospital. This position was confirmed by the 5th IP in an email dated 14th July 2015, the day before the decision which is challenged in these proceedings.

50. The final piece of work that is relevant to this part of the case was commissioned by the defendants in May 2015 from the four Clinical Senates of the North of England. The review, which was chaired by Professor Andrew Cant was entitled "North of England Clinical Senates-Independent Clinical Review to Support Decision Making by the Committee in Common for the Greater Manchester Healthier Together Programme". Amongst the specific questions posed was whether HT had "properly addressed the potential co-dependency issues raised in consultation feedback comments?" A further question was addressed to the potential impact of the proposed service changes on vascular surgery. At Section 3.4 of the Review the Panel endorsed the conclusions that had been reached in relation to the co-dependencies associated with acute medicine with the exception of cardiothoracic surgery which they considered should be classed as "minimally dependent" with acute medicine within a specialist emergency department. The conclusions of the Review Panel were expressed as follows:

> "The North of England Clinical Senate Review Panel concludes that:
>
> The Healthier Together programme has gone to great lengths to ensure that at this stage in their work, the clinical co-

> dependencies of the in-scope specialities have been considered and understood;
>
> There is good evidence of a robust and wide-ranging consultation process;
>
> The conclusions reached by the programme on the clinical co-dependencies of the in-scope services in the context of the proposed Single Service model-of-care are consistent with the views of the Review Panel and with other significant studies of clinical co-dependencies;
>
> The programme's Quality and Safety standards meet, and in some cases go further than, the most recent national clinical guidance;
>
> That detailed work needs to take place (particularly workforce modelling and capacity planning in all specialties) and significant consideration given to the Interventional Radiology model as a cross-cutting service once the programme progresses past the agreement on the Single Service model."

51. Information about co-dependencies was incorporated into the DMMR which was published on the 8th July 2015 with a view to a decision being taken on the 15th July 2015 by the HTCiC. In particular the Post Consultation Co-dependencies Review, and Professor Cant's Panel Review were appended to the DMMR. In the summary of the recommendations to the HTCiC vascular surgery was identified as one of the "Co-dependent services with implications for the safe implementation of Healthier Together - Greater Manchester design required". The implication identified was that standard clinical protocols were to be considered as part of the implementation process following decision-making. The specialised burns unit at Wythenshawe was identified as one of the "Co-dependent services with implications for the safe implementation of Healthier Together - Single Service design required with Greater Manchester oversight and assurance". Cystic fibrosis and cardiothoracic services at Wythenshawe were identified as services "with no action required". In short no co-dependency issue was identified as marking out a preference for any particular hospital to be identified as the final remaining Specialist Hospital. Any outstanding issues could be addressed and accommodated after the selection had been made and as implementation occurred.

52. In the run up to the decision which is the subject matter of this case further representations were received by the defendants. On 1st June 2015 the Southern Sector Partnership, of which the 1st IP was a member at this time, provided an update of their position. They reinforced the need to have regard to the population of East Cheshire, notwithstanding that they fell "outside the direct scope of Healthier Together". The update included information about a detailed review that in particular the 1st and 4th IP's had commissioned to examine the potential impact of the various options for the future siting of Specialist and General Hospitals in the Southern Sector. The update provided a position statement in the following terms:

> "Within the Southern Sector Partnership there is consensus on the following:
>
> That for the benefit of residents, the full range of low and high risk general surgery services must be retained in the Southern Sector. In Healthier Together terminology that there must be a "Specialist" Hospital in the Southern Sector.
>
> There is a jointly agreed clinical description of a future service model which could be implemented.
>
> The achievement of the "Healthier Together" clinical standards, and the capacity implications, appear to be manageable at both locations and, based on the clinical work and activity modelling, the "specialist" hospital could be sited at either Stockport Foundation or UHSM Foundation Trust."

53. On 10th June 2015 the 1st IP made a joint submission to the defendants with Central Manchester University Hospitals NHS Foundation Trust ("CMFT") with whom they were forging an alliance in relation to the provision of future hospital healthcare. The discussions at the time of making the representations had focussed on the provision of general surgery services. The submission recorded as follows:

> "For general surgery, the intention would be to establish a single shared service for emergency and complex elective general surgery delivered jointly across CMFT and UHSM, recognising the importance of general surgery in supporting the extensive range of tertiary services provided by both Trusts."

54. On 30th June 2015 the 1st IP wrote again to the defendants on their own behalf expressing the following view:

> "We firmly believe that Wythenshawe Hospital should be the fourth Healthier Together specialist hospital in Greater Manchester and continue to receive all emergency acute surgery patients. Wythenshawe hospital has a strong general surgery service, a unique portfolio of tertiary services, major investments in facilities and infrastructure and excellent access to the hospital which make it a strong choice for patients in Manchester and the Southern Sector, as well as across Greater Manchester and, indeed, the North West."

In an Appendix attached to the letter the 1st IP emphasised the potential impact on the specialised services set out above were it to be made a General rather than a Specialist Hospital in the reorganisation.

55. This letter was followed by an update from the 1st IP to the defendants dated 3rd July 2015. This was in effect the expression of their final position prior to the decision being taken in relation to the identity of the fourth Specialist Hospital. The position was described in the following terms:

> "We wish to clarify, on behalf of the Board and our clinicians, the Trust's ambition to be a Healthier Together specialist hospital. This is clearly different to the position set out in the update we provided with CMFT dated 10th June 2015, which this update supercedes.
>
> UHSM's position is that we firmly believe that Wythenshawe Hospital should be the fourth Healthier Together specialist hospital in Greater Manchester and continue to receive all emergency acute surgery patients…
>
> If commissioners designate Wythenshawe Hospital as a Specialist Hospital, UHSM would be an emergency receiving site and could not be in a Healthier Together single service with CMFT. As a Specialist Hospital, UHSM would expect to work in a single service with one or more of the other Southern Sector Trusts, as described in the Southern Sector proposal which was previously submitted.
>
> If commissioners choose not to designate UHSM as a Specialist Hospital, our preference would be to work with CMFT to implement a single service model. As justified below, Wythenshawe Hospital would need additional general surgery support above that provided by the Healthier Together local hospital model in order to maintain the quality of our secondary and tertiary services. Wythenshawe Hospital would need to be more than a "local hospital" within the Healthier Together model."

56. On 15th July 2015 the HTCiC met to take the decision as to which of the options to select in relation to the fourth Specialist Hospital in the reconfigured service. The HTCiC had the compendious information in the DMMR before them and received oral presentations from officers of the defendants in relation to the criteria for decision-making. They were told that in relation to Quality and Safety "no quality and safety points were raised that would allow for differentiating between the options". The evidence in relation to Travel and Access that has been set out in detail above was presented to the members of HTCiC, in particular in relation to the expanded catchment population and the extent to which the options complied with the travel and access standards. Turning to the criteria of "Transition", which included the question of co-dependencies, the officers advised, according to the minutes of the meeting, that the time to deliver was the same for all options and that:

> "In relation to the independent report from the North of England Senate regarding the clinical co-dependencies, there was no significant impact for decision making described."

57. The final criterion to be examined was Affordability and Value for Money. Having explained the findings in relation to each of the criteria the individual representatives of the defendants on the HTCiC were called upon to comment on the proposals. The minutes of the debate record the various contributions verbatim. It is not necessary to quote from them all to capture sufficient for the purposes of the submissions which

are set out below. Examples from the debate are as follows. Firstly, Dr Guest on behalf of the eleventh defendant stated:

> "Looking in more detail from the evidence we have seen today and the extensive work that has been done up until now, it is absolutely clear, from my point of view that the 4.4 group is certainly the only group that satisfies all parts of the transport requirements and within that group I have made consideration of the finances and also the provider configurations and so my decision when we take that vote shortly will be based on those particular aspects."

Dr Bishop, representing the eighth defendant, observed as follows:

> "The only criteria that allows in my mind material difference between any of the options is travel and access and as such the only configuration which achieves the standards is a 4.4 with Stepping Hill Stockport as a specialist site for general surgery would achieve it. Certainly the 4.3 option would lead to 17,500 people unable to achieve that standard."

Dr Whiting on behalf of the second defendant agreed that the only significant difference between the options was travel and access and that this favoured the selection of Stepping Hill. In a similar fashion Dr Dalton representing the ninth defendant stated:

> "As others have said, on balance the only real difference I can see is the travel and access and therefore for me to choose the 4.4 options is to make sure the 17,000 people of High Peak are suitably cared for."

Dr Burns for the third defendant contended:

> "Today it has become very clear that the key piece of evidence, as others have mentioned is the accessibility and we cannot make a decision today that will deny access to a portion of the population that Greater Manchester serves and we do not have to make that decision, so my decision today is based on the criteria and standards on which we have consulted…"

Dr Dow speaking for the fifth defendant stated:

> "I was reminded of the clinical beginnings of the programme which was to reduce variation and in that regard and in the humanity of the situation I feel we have to consider those who are outside Greater Manchester in considering the humanitarian situation and actually taking the impact of the changes into account, particularly that of the people that will be most affected in the High Peak. Stepping Hill Hospital working to the Greater Manchester Healthier Together Standards could be

> a key piece of the jigsaw in reducing clinical variation both within and beyond Greater Manchester."

58. Following the discussion one of the officers, Mr Williamson, summarised the comments and formulated a proposal for the HTCiC to vote on. He is recorded in the minutes as stating:

> "So, the main criteria over which decisions will be made. I will particularly focus on those and whether the information clearly differentiates between the options as described by colleagues in the last few minutes. In terms of quality and safety, we expect standards of care that will be the best in the country and that none of our hospitals currently meet in total. In terms of transition we have considered issues of workforce, time to deliver and independent advice on co-dependencies. Our hospital providers have made clear that we will implement the changes best by focussing the new single services on the North West part of Greater Manchester, the North East part of Greater Manchester, the Central South part of Greater Manchester and South East part of Greater Manchester. That configuration will give us four single services of approximately the same population size. In terms of affordability and value for money we know that the configurations in the South of Greater Manchester offer the best value for money for the tax payer in overall financial terms and generally the lowest capital costs. In travel and access we know that the populations of North Derbyshire and East Cheshire who currently use our hospitals will only be able to reach the 45 minute emergency travel standard if they are served by Stepping Hill Hospital in Stockport. So on the basis of the evidence and of what has been said today I propose that we move to a vote on options 4.4A, which identifies Stepping Hill Hospital in Stockport as the fourth site providing high risk general surgery and creates four single services throughout Greater Manchester…"

59. When the vote came to be taken this option, selecting Stepping Hill as the fourth Specialist Hospital, was carried unanimously.

60. In the course of the production of the evidence, attention was drawn to factual material relating to the period following the decision and in particular meetings between various parties, further statements by the 1st IP and the establishment of elements of the implementation process. In my view these aspects of the case have at best a very indirect bearing on the legal questions that need to be determined and therefore I do not see much purpose to be served by setting them out in detail in this judgment. Suffice to say that since the decision was taken preliminary discussions have occurred in relation to implementation and representatives of HT have corresponded with the 1st IP with a view to seeking to resolve the continuing concerns which the 1st IP has in relation to the impact of the reorganisation upon its specialised services. Discussions have occurred in an endeavour to establish a Clinical Leadership Group with a view to working through these issues, although in the evidence before the court there are divergent views expressed as to the prospects of success for this

Group. The claimant takes the view that its potential efficacy has been greatly overstated, and that the concerns which have brought the claimant to court remain unresolved.

61. Notwithstanding this evidence, the key focus for the court's decision must be circumstances as they existed and were known at the time when the decision not to designate Wythenshawe as the Specialist Hospital was made. It is against the factual situation as it existed on 15th July 2015 that the legality of the decision must principally be evaluated.

The law

62. The various grounds that are raised by the claimant in this case and discussed below are framed within the relevant law relating to consultation, legitimate expectation and, lastly, rationality or perversity. Each of these principles will be examined before embarking on a consideration of how they apply to the facts of this case.

63. Under s3(1A) of the National Health Service Act 2006 the defendants, as Clinical Commissioning Groups, have responsibility for arranging the provision of clinical services, which include hospital accommodation and medical services, to those who are provided with primary medical services by one of their members, or persons who usually reside in their area. The 2006 Act places them under a variety of duties, which include under s14U the duty to involve patients, their carers and representatives in decisions relating, amongst other matters, to the patient's care and treatment.

64. In some circumstances a public body can voluntarily assume a duty to consult or alternatively one can arise as a consequence of them giving rise to a legitimate expectation that there will be consultation. In other situations, like here, the duty to consult can arise as a result of a statutory obligation. The obligation in the present case is derived from s14Z2 (2) of the National Health Service Act 2006 which provides as follows:

> "14Z2 Public involvement and consultation by clinical commissioning groups
>
> ...
>
> (2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways)-
>
> in the planning of the commissioning arrangements by the group,
>
> in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

> in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact."

65. The basic requirements of a lawful consultation have now been settled for some considerable time and are derived from the decision of Hodgson J in *R v Brent London Borough Council ex p Gunning* (1985) 84 LGR 168. They are, firstly, that the consultation should be undertaken at a time when the proposals are still at a formative stage. Secondly, the body undertaking the consultation should provide sufficient reasons and explanation for the decision about which it is consulting to enable the consultees to provide a considered and informed response. Thirdly, adequate time to allow for consideration and response must be provided. Fourthly, the responses to the consultation must be conscientiously taken into account in reaching the decision about which the public body is consulting. These principles, known as the Sedley criteria as a result of the author of the submissions upon which they were based, have recently been endorsed by the Supreme Court in *R(Moseley) v Haringey London Borough Council* [2014] UKSC 56; [2014] 1 WLR 3947 at paragraph 26.

66. In his judgment in *Moseley* Lord Wilson JSC emphasised that however the duty to consult arises, the manner in which it is conducted will be informed by the common law requirements of fairness. He observed at paragraph 24 as follows:

> "Fairness is a protean concept, not susceptible of much generalised enlargement. But its requirements in this context must be linked to the purposes of consultation. In *R(Osborn) v Parole Board* [2014] AC 1115, this court addressed the common law duty of procedural fairness in the determination of the person's legal rights. Nevertheless the first two of the purposes of procedural fairness in that somewhat different context, identified by Lord Reed JSC in paras 67 and 68 of his judgment, equally underlie the requirement that a consultation should be fair. First, that requirement "is liable to result in better decisions, by ensuring that the decision-maker receives all relevant information and that it is properly tested": para 67. Second, it avoids "the sense of injustice which the person who is the subject of the decision will otherwise feel": para 68. Such are two valuable practical consequences of fair consultation. But underlying it is also a third purpose, reflective of the democratic principle at the heart of our society. This third purpose is particularly relevant in a case like the present, in which the question was not: 'yes or no, should we close this particular care home, this particular school etc?' It was: 'Required as we are, to make a taxation-related scheme for application to all the inhabitants of our borough, should we make one in the terms which we here propose?'"

67. In his judgment Lord Reed JSC placed greater emphasis upon the statutory context and the purpose of the particular statutory duty to consult and less on the common law duty to act fairly. In paragraph 36 of his judgment, having noted that the case under consideration was not one where the duty to consult arose as a result of a legitimate expectation he stated:

> "This case is not concerned with a situation of that kind. It is concerned with a statutory duty of consultation. Such duties vary greatly depending on the particular provisions in question, the particular context, and the purpose for which the consultation is to be carried out. The duty may, for example, arise before or after a proposal has been decided upon; it may be obligatory or may be at the discretion of the public authority; it may be restricted to particular consultees or may involve the general public; the identity of the consultees may be prescribed or may be left to the discretion of the public authority; the consultation may take the form of seeking views in writing, or holding public meetings; and so on and so forth…"

Having noted that in that case the local authority was discharging an important function in relation to local government finance which affected its residents generally (the case centred on the authority's decision in relation to a revised scheme for council tax benefits) Lord Reed concluded that the purpose of the statutory duty to consult in that case was "to ensure public participation in the local authority's decision-making process". He went on to observe in paragraph 39:

> "In order for the consultation to achieve that objective, it must fulfil certain minimum requirements. Meaningful public participation in this particular decision-making process, in a context with which the general public cannot be expected to be familiar, requires that the consultees should be provided not only with information about the draft scheme, but also with an outline of the realistic alternatives, and an indication of the main reasons for the authority's adoption of the draft scheme."

He concluded that in the particular circumstances of that case the second of the Sedley criteria (the provision of adequate and appropriate information) had been breached.

68. The differences in emphasis between Lord Wilson JSC and Lord Reed JSC were resolved in the joint judgment of Baroness Hale JSC and Lord Clarke JSC in the following terms:

> "We agree with Lord Reed JSC that the court must have regard to the statutory context and that, as he puts it, in the particular statutory context the duty of the local authority was to ensure public participation in the decision-making process. It seems to us that in order to do so it must act fairly by taking the specific steps set out by Lord Reed JSC, in para 39. In these circumstances we can we think safely agree with both judgments."

69. Applying this approach, the starting point in the present case must be the purpose of the statutory duty, which is expressly stated to be involvement of individuals who are or may be recipients of the services about which decisions are being taken. No specific requirements or steps are specified in relation to how involvement is to be achieved, and indeed consultation is only one option as to the way in which the

commissioning group may proceed to accomplish the involvement of those individuals. There is therefore a broad discretion as to the means of involvement, and in the present case there is no dispute that the use of consultation (rather than, for instance, simply the provision of information) was fit for the purpose of involvement given the radical nature of the reconfiguration of services that was being contemplated.

70. The specific steps that it was necessary to take in respect of the consultation to ensure that the defendants acted fairly must also be measured bearing in mind the purpose and the context of the consultation and the decision that it is intended to inform. A clear framework for the consideration of the requirements of fairness is provided by the Sedley criteria. Influences on the requirements of fairness may include the following.

71. Firstly, the role that the consultation is playing in the decision-making process must be considered. At one end of the spectrum a consultation could perform the function of a referendum, or an exercise in direct democracy, determining the decision for the public body through a popular vote. At the other end of the spectrum the purpose of the consultation may be simply to elicit views about a proposal to which regard will be had as an influence on the decision but which (even if it produced an overwhelming majority of opinion opposed to the authority's proposal) could not be binding upon the authority. Another dimension is that in some circumstances the consultation may be taking place in the context of a staged decision-making process and may be part of a sequence of consultations to be undertaken during that process. The requirements of fairness will be shaped by the needs of the stage that the decision-taking has reached and the recognition that there will be further consultation and further decisions to be made later in the process. The role that the consultation will play in the decision-making process will be an influence upon the requirements of fairness in terms, for instance, of the nature and extent of the information necessary for the consultation to be considered fair, and also the manner in which the outcome of the consultation is considered when the decision is reached.

72. Secondly, the extent of the detail which fairness requires that the public body provides can in some circumstances be influenced by the identity of those that are being consulted: see *Fletcher v Minister of Town and Country Planning* [1947] 2 All ER 496, 501 and *Moseley* paragraph 26. Thirdly, the demands of fairness are likely to be higher when a public body is deciding whether to deprive a person of an existing benefit, as distinct from circumstances when the person is applying for a future benefit: see *R v Devon County Council ex p Baker* [1995] 1 All ER 73, 91. There will no doubt be other detailed considerations which have an influence over the requirements of fairness in any particular case: fair consultation must be shaped to its purpose and from its context.

73. One of the particular questions which arises in this case is when fairness determines that there should be re-consultation by the decision-maker. When do circumstances exist which give rise to a legal requirement that there should be a further round of consultation? This issue arose before Silber J in the case of *Smith v East Kent Hospital NHS Trust* [2002*]* EWHC 2640 (Admin). From paragraph 43 onwards he reached the following conclusions:

"43 A matter of crucial importance in determining whether the defendants in this case should have re-consulted on the proposals under challenge was the nature and extent of the difference between what was consulted on in the consultation paper and the proposal accepted in the March 2002 decision. Clearly, if all the fundamental aspects of the decision under challenge had not been consulted on but ought to have been, that would indicate a breach of the duty to consult, whilst at the other extreme, trivial changes do not require further consideration. In approaching this issue, it is necessary to bear in mind not only the strong obligation of the defendants to consult, but also the dangers and consequences of too readily requiring re-consultation, as those dangers also flow from the underlying concept of fairness, which underpins the duty to consult.

44 As Schiemann J, as he then was, (with whom Lloyd LJ agreed) pointed out in explaining these dangers in *R v Shropshire Health Authority ex p Duffus* [1990] 1 Med LR 119 at p223:

"A consultation procedure, if it is to be as full and fair as it ought to be, takes considerable time and meanwhile the underlying facts and projections are changing all the time. It is not just a question of an iterative process which can speedily be run through a computer. Each consultation process if it produces any changes has the potential to give rise to an expectation in others, that they will be consulted about any changes. If the courts are to be too liberal in the use of their power of judicial review to compel consultation on any change, there is a danger that the process will prevent any change-either in the sense that the authority will be disinclined to make any change because of the repeated consultation process which this might engender, or in the sense that no decision gets taken because consultation never comes to an end. One must not forget there are those with legitimate expectations that decisions will be taken."

45 So I approach the issue of whether there should have been re-consultation by the defendants in this case, on the proposals now under challenge on the basis that the defendants had a strong obligation to consult with all parts of the community. The concept of fairness should determine whether there is a need to re-consult if the decision-maker wishes to accept a fresh proposal but the courts should not be too liberal in the use of its power of judicial review to compel further consultation on any change. In determining whether there should be further re-consultation, a proper balance has to be struck between the strong obligation to consult on the part of the health authority and the need for decisions to be taken that affect the running of

> the health service. This means that there should only be re-consultation if there is a fundamental difference between the proposals consulted on and those which the consulting party subsequently wishes to adopt."

74. During the course of the argument on this point both parties, and in particular the defendants and those defending the decision, emphasised the phrase "fundamental difference" in their submissions. As the argument developed, it appeared to me that this phrase was in danger of having more rhetorical force than substantive content, and in and of itself providing limited assistance in determining when re-consultation might be required. In my view that phrase cannot be detached from the clear and undoubtedly accurate conclusion reached by Silber J that any consideration of the need to re-consult will be determined by the concept of fairness.

75. The requirements of fairness in considering whether or not to re-consult must start from an understanding of any differences between the proposal and material consulted upon and the decision that the public body in fact intends to proceed to make. This is because there will have already been consultation. The issue is, then, whether it is fair to proceed to make the decision without consultation on the differences, which will therefore be heavily influenced in this particular context by the nature and extent of the differences. Whilst it is not possible to produce any exhaustive list of the kind of matters that would need to be considered (alongside all the other legal principles set out above) to determine whether re-consultation is required, some illustrations may assist. Examples would include where it has been determined that it is necessary to re-open key decisions in a staged decision-making process which had already been settled prior to consultation occurring; or where the key criteria set out for determining the decision and against which the consultation occurred have been changed; or where a central or vital evidential premise of the proposed decision on which the consultation was based has been completely falsified. These examples serve to illustrate the very high order of the significance of any difference which would warrant re-consultation.

76. It is also important to point out that the question of a change's significance is not to be determined with the benefit of hindsight: it is significance at the point in time when the question of re-consultation is to be determined that counts. Finally, the fact that a change arises so as to reflect views produced by the consultation process does not itself require re-consultation. Once again, it is the extent of the change or difference which is the starting point. If the change arose from the original consultation that is simply evidence of the fourth Sedley criterion in operation and not in and of itself a reason for re-consultation. It is the extent of the change which requires examination.

77. Having observed all of the above in relation to the legal principles governing consultation it is important to recognise, as the courts have on several occasions, that a decision-maker will have a broad discretion as to how a consultation exercise may be structured and carried out. As Sullivan J (as he then was) observed in *R(on the application of Greenpeace Limited) v Secretary of State for Trade and Industry* [2007] EWHC 311 at paragraphs 62 and 63:

> "A consultation exercise which is flawed in one, or even in a number of respects, is not necessarily so procedurally unfair as to be unlawful. With the benefit of hindsight it will almost

> invariably be possible to suggest ways in which a consultation exercise might have been improved upon. That is most emphatically not the test. It must also be recognised that a decision-maker will usually have a broad discretion as to how a consultation exercise should be carried out…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'."

Subsequently in the case of *R(JL and AT Beard) v The Environment Agency* [2011] EWHC 939 Sullivan LJ confirmed that the "test is whether the process was so unfair as to be unlawful".

78. The question of legitimate expectation arises where a public body issues a promise or adopts a practice which represents how it proposes to act in a given area of its responsibilities: where it does so the law will require the promise or practice to be honoured unless there is a good reason not to do so. To give rise to legitimate expectation the representation must be "clear, unambiguous and devoid of relevant qualification" (see *R v Inland Revenue Commissioners ex p MFK Underwriting Agents Limited* [1990] 1 WLR 1545 per Bingham LJ at 1569C). The essential approach was spelled out by Schiemann LJ (giving the judgment of the court) in *R(Bibi) v Newham London Borough Council* [2001] EWCA Civ 607; [2002] 1 WLR 237 at paragraph 19:

> "In all legitimate expectation cases, whether substantive or procedural, three practical questions arise. The first question is to what has the public authority, whether by practice or by promise, committed itself; the second is whether the authority has acted or proposes to act unlawfully in relation to its commitment; the third is what the court should do."

79. The basis for the court's jurisdiction was explained by Laws LJ in *Abdi v Secretary of State for the Home Department* [2005] EWCA Civ 1363 in the following terms:

> "68 The search for principle surely starts with the theme that is current through the legitimate expectation cases. It may be expressed thus. 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. What is the principle behind this proposition? It is not far to seek. It is said to be grounded in fairness, and no doubt in general terms that is so. I would prefer to express it rather more broadly as a requirement of good administration, by which public bodies ought to deal straightforwardly and consistently with the public. In my judgment this is a legal standard which, although not found in terms in the European Convention on Human Rights, takes its place alongside such rights as fair trial, and no punishment without law. That being so there is every good reason to articulate the limits of this requirement-to describe

> what may count as good reason to depart from it-as we have come to articulate the limits of other constitutional principles overtly found in the European Convention. Accordingly a public body's promise or practice as to future conduct may only be denied, and thus the standard I have expressed may only be departed from, in circumstances where to do so is the public body's legal duty, or is otherwise, to use a now familiar vocabulary, a proportionate response (of which the court is the judge, or the last judge) having regard to a legitimate aim pursued by the public body in the public interest. The principle that good administration requires public authorities to be held to their promises would be undermined if the law did not insist that any failure or refusal to comply is objectively justified as a proportionate measure in the circumstances.
>
> 69 This approach makes no distinction between procedural and substantive expectations. Nor should it. The dichotomy between procedure and substance has nothing to say about the reach of the duty of good administration. Of course there will be cases where the public body in question justifiably concludes that its statutory duty (it will be statutory in nearly every case) requires it to override an expectation of substantive benefit which it has itself generated. So also there will be cases where a procedural benefit may justifiably be overridden. The difference between the two is not a difference of principle. Statutory duty may perhaps more often dictate the frustration of a substantive expectation. Otherwise the question in either case will be whether denial of the expectation is in the circumstances proportionate to a legitimate aim pursued. Proportionality will be judged, as it is generally judged, by the respective force of the competing interests in the case."

80. Turning finally to the legal principles governing the investigation of whether the defendants acted unreasonably in an unlawful sense in reaching the decision they did the principle, as is well-known, was summarised by Lord Greene MR in *Associated Provincial Picture Houses Limited v Wednesbury Corporation* [1948] 1 KB 223 in the following terms at p233:

> "The court is entitled to investigate the action of the local authority with a view to seeing whether they have taken into account matters which they ought to have take into account, or, conversely, have refused to take into account or neglected to take into account matters which they ought to take into account. Once that question is answered in favour of the local authority, it may be still possible to say that, although the local authority have kept within the four corners of the matters which they ought to consider, they have nevertheless come to a conclusion so unreasonable that no reasonable authority could ever have come to it. In such a case, again, I think the court can interfere."

81. Having set out the legal principles it is now necessary to turn to examine each of the grounds raised by the claimant and reach conclusions in relation to them. I have used the enumeration which was used at the hearing; it will be apparent that Ground 4 was not pursued.

Ground 1

82. This ground centres on the inclusion within the travel and access analysis of populations outside the Greater Manchester area and the application of a travel standard to them which differed from that which had been applied to the population within the original catchment. As set out above, after the public consultation had been completed the travel and access analysis was revisited to take account of trips to hospital from outside the Greater Manchester area, in particular for the purposes of this argument East Cheshire and North Derbyshire. It was contended by the claimant that in posing the second question (based upon where people from outside the Greater Manchester area actually travelled, as opposed to how far they were from their nearest hospital) the defendants had applied an approach to those outside the Greater Manchester area that they had never applied to those within it.

83. Allied to this point it was contended that in arriving at their conclusions the members of the HTCiC had failed to appreciate that the populations outside the Greater Manchester area would still be able to reach a hospital within the 45 minute travel standard for emergencies: their contributions to the debate betrayed a misconception that under option 4.3 (including Wythenshawe) those populations would not be able to have their needs met within the travel standard when in truth they would, by travelling to their nearest hospital. It was also submitted that this was particularly unreasonable given that these patients were not patients for whom the defendants were "responsible" under s3(1A) of the National Health Service Act.

84. These submissions were pursued both as legal flaws in the consultation, and also in the context of legitimate expectation as well as by way of a Wednesbury challenge. It was contended that the new information in relation to the travel and access analysis should have been made the subject of a re-consultation exercise. The change to the catchment area being examined and the asking of the new questions in relation to it were, it was submitted, changes of such moment that there should have been further consultation about them. This was so in particular in the context that the consultation documentation had focussed exclusively on the interests of the residents of Greater Manchester: the reference to the "surrounding localities" in the lengthier consultation document when read in context was not in any way a departure from the consultation's clear intention to be confined to the interests of the population of Greater Manchester. When that changed, and the catchment being assessed changed, then there should have been a re-consultation exercise based upon that new approach.

85. As part of the backdrop to these submissions, and the submissions in relation to consultation within the other grounds, reference was made to a document entitled "Planning and delivering service changes for patients" published by the 5th IP and intended as a guide to good practice for commissioners when developing proposals for major service changes and reconfigurations. The document emphasises that change must be clinically led and underpinned by a clear clinical evidence base. It has a "key message" in relation to consultation expressed in the following terms:

> "**Patients, the public and staff should be engaged throughout** the development of proposals from their very early initiation through to implementation. Engagement should seek to build an on-going dialogue with the public, where they have an opportunity to shape and contribute to proposals, in addition to any formal consultation on options."

The document records four key tests which should be used to measure proposed service changes. They are: strong public and patient engagement; consistency with current and prospective need for patient choice; a clear clinical evidence base and support for proposals from clinical commissioners. The document identifies some key questions to be addressed in preparing for an assessment against the four tests. Ms Morris drew attention to the following question as being relevant to the claimant's arguments in relation to the Travel and Access criterion:

> "12 Have I considered issues of patient access and transport, particularly if the location where services are provided may change? Is a potential increase in travel times for any groups of patients outweighed by the clinical benefits?"

I have taken this good practice guidance into account when assessing the merits of the claimant's arguments in relation to consultation under this and also under subsequent grounds.

86. It is appropriate to, firstly, address the arguments related to consultation, and in particular re-consultation. As set out above, whilst in the final analysis the travel and access criteria proved to be the decisive factor between options 4.3 and 4.4, the significance of the difference between the position at the time of the consultation and the position following the further work by the TAG is not to be gauged by the fact that this further work proved to be the matter on which the decision turned in the final analysis. That outcome could not have been predicted at the time when the further work on travel and access was completed. The question of whether or not there should be re-consultation could not be determined solely on the basis that this issue became decisive: an examination of the nature of the differences and the other aspects of the requirements of fairness set out above is required.

87. Having considered the claimant's submissions I am not satisfied that it was unfair not to re-consult in relation to the change to the catchment and revised travel and access analysis, including the second question relating to the hospitals that were actually used by those accessing Greater Manchester hospitals from beyond the Greater Manchester area. Ultimately, I am not satisfied that the new material was so significant that re-consultation was legally required. My reasons for so concluding are as follows.

88. As identified above an important part of the context when considering the requirements of fairness in relation to consultation is the purpose of the consultation and the role which it is playing in the decision making process. As is clear, for example, from the extracts set out at paragraph 13 and 16 above, the consultation literature set out that it was seeking help in shaping HT's plans and that views were being sought from the wider public to be taken into account in the decision making

process. The role of the consultation is further clarified within the DMMR itself in the following terms:

> "The purpose of the Healthier Together consultation was for commissioners to listen to the views of the public and stakeholders about the proposed changes to primary care, integrated care and the in scope hospital services (A&E, Acute Medicine, and General Surgery). In particular, our opportunity to listen to feedback in relation to options for the configuration of in scope hospital services."

Thus, as is most often the case in circumstances of this sort where public services are being reconfigured, the consultation was an important source of wider opinion on the changes that were proposed. It was not close to being decisive or determinative. It was rather designed, as stated in the consultation literature, to mould and inform the ultimate decisions to be made.

89. It must, of course, be observed that the further work and the changes to the catchment arose directly from the observations of consultees. Applying the Sedley criteria the defendants were obliged to take those observations into account conscientiously, and having decided that they had made a good point, seek to address it as part of the decision-making process. Whilst the claimant is entitled to draw attention to the emphasis in the consultation documentation upon the population of Greater Manchester, once attention had been drawn to the use of Greater Manchester's hospitals by a wider population beyond, the interests of this population needed to be addressed. This new analysis did not abandon Travel and Access as a criterion upon which the selection decision would be based, nor were the travel standards against which it was to be judged changed. In reality, what occurred was a refinement of the understanding of travel and access effects within the framework of the criteria and standards set out in the consultation.

90. This extension of the catchment was a difference from the consultation stage, but the expansion of the catchment to capture populations which resided beyond the Greater Manchester area was in my view an unsurprising development of the modelling of travel and access consequences, bearing in mind that it is fairly obvious that hospitals in a large regional centre such as Greater Manchester will be serving patients from a wider hinterland beyond its administrative boundaries. The fact that the defendants were not under the relevant legislation responsible for these individuals did not render them irrelevant to the process and it was not unreasonable for their interests to be taken into account in the evaluation of the proposals. The enlargement of the catchment was neither a paradigm shift in the approach to this criterion, nor was it a falsification of the original analysis. It was, rather, a development of it.

91. Turning from the enlargement of the catchment area to the issue related to the second question, in my view similar considerations apply. This was an entirely understandable development of the analysis seeking to examine where in fact the patients accessing hospitals in the Greater Manchester area came from. It was a refinement of the examination of the issue, not a significant shift from the consultation material: the criteria and the standards remained the same and what was undertaken was a different interrogation of the issue within that framework. The

requirements of fairness did not demand that there be further re-consultation in respect of this elaboration of the examination of travel and access effects.

92. There is still the point raised by the claimant that posing this second question applied a different approach to the patients outside Greater Manchester to that within it, and that therefore, illegitimately, patients outside Greater Manchester were subject to preferential treatment as their choice of hospital was taken into account. There is an air of artificiality to this point since the patients in question are generally speaking being conveyed to hospital by ambulance as emergencies and therefore the choice, if choice there be, is being exercised for them by the operators and operatives of the ambulance service.

93. The claimant addresses this by observing that any preference in this respect for Stepping Hill could be simply countermanded by instructions to the ambulance drivers. However, there is a more fundamental point which undermines the claimant's contention and this is that I am not satisfied that the question was posed differentially in the way the claimant suggests. As set out above in paragraph 34, the evidence of Dr Whiting demonstrates that this further stage of the analysis was supported, not simply by an examination of the origin and destination of patients outside Greater Manchester, but also of patients within Greater Manchester so as to satisfy the TAG that the larger catchment area they had drawn accurately reflected patient usage across its area. Thus the choice or selection of hospitals by or for patients was reflected in the work produced.

94. I am equally not persuaded that the record of the debate demonstrates that the members of the HTCiC did not appreciate that the 17,647 residents of North Derbyshire would have emergency access within 45 minutes travel if they travelled to their nearest hospital rather than a hospital in Greater Manchester. Their contributions to the debate must be read in context. The claimant is entitled to say that read literally the observation, for example, of Dr Bishop that "the 4.3 option would lead to 17,500 people unable to meet the standard" is only true if their ability to go to their nearest hospital is ignored. That literal reading is, however, one undertaken out of context. The statement is also consistent with an acceptance that the decision in relation to travel and access should be based on the reality of where patients are actually taken for treatment at present on the basis that this pattern is likely to continue. When read in context, which in my view more fairly and accurately reflects the understanding and perspective of Dr Bishop, I am not persuaded there is any error or misunderstanding in his, or others, contribution to the discussion. In the context of the evidence which was presented to the HTCiC, and the difference between options 4.3 and 4.4 which it identified, I am unable to accept that the record of the debate demonstrates a failure to understand properly the content of the TAG's work. What the debate shows is that the members of the HTCiC accepted the differential that they had identified as a suitable basis for decision-making.

95. Turning to the claimant's arguments which are framed in relation to the legal principles pertaining to legitimate expectation, Ms Morris identified in the course of argument five propositions that she submitted amounted to legitimate expectations. Firstly, that all options would meet the 45 minute travel standard. Secondly, that the decision which would be reached would depend on the responses of the consultees. Thirdly, that the HT initiative was aimed at meeting the needs of Greater Manchester residents and only Greater Manchester residents. Fourthly, that Wythenshawe rated

better than Stepping Hill in the charts which were produced in respect of patient care. Fifthly, that the decision would be based only on the application of the four criteria. It was submitted that the interests of the 17,647 residents referred to above from North Derbyshire could not, legally, be permitted to override these legitimate expectations in the way in which they had been allowed to in the final decision to prefer Stepping Hill. Notwithstanding the conspicuous care and precision with which Ms Morris made these submissions, I am unable to accept them for the following reasons.

96. Having set out the consultation material above I am unable to discern within it any clear and unambiguous promise in relation to any of the five propositions referred to. In relation to the first proposition, the 45 minute standard for emergency access was applied, albeit that in response to representations made during the consultation it was applied in a nuanced fashion in the final analysis based upon actual usage of hospitals rather than simply their physical proximity. No promise or undertaking was made as to how the standard was to be applied in detail in the modelling. As a parameter it remained unchanged.

97. So far as the second proposition is concerned, whilst it is true to say that the consultation leaflet stated that the defendants would make their decision "depending on what you tell us during this consultation" when read in context it is quite clear that this is an undertaking that the fruits of the consultation will be carefully considered and taken into account, not that the decisions would be determined by the consultation. Again, in my view the third proposition results from over-reading of the consultation material. As set out above, whilst it is correct that the literature focussed on residents of Greater Manchester, it did not suggest that the interests of those outside Greater Manchester who might have need of its hospital facilities were irrelevant to the process. Indeed, in my view such a suggestion would have been surprising and unrealistic. Turning to the fourth proposition I can find nothing in the consultation material or elsewhere which amounts to an unequivocal assurance in relation to Wythenshawe being preferable with respect to the data on patient care. As Mr Havers QC (who appeared on behalf of the defendants) pointed out, it was clear from the consultation material that such a representation was not being made. Finally, I again accept the submission made by Mr Havers that whilst the consultation proceeded on the basis of seeking views founded on the four criteria which the defendants had identified that did not rule out a consultee establishing a sound basis for departing from them or establishing an additional criterion. There was, therefore, no legitimate expectation created in the respect claimed.

98. The final way in which this ground is presented legally is the claimant's contention that it was irrational to reach a decision based on the revised catchment and asking the second question based on the usage of hospitals in Greater Manchester rather than using the answer derived from the first question, namely measuring the journey time to the hospital nearest to the potential patient.

99. I have already dealt with the suggestion that those outside Greater Manchester in the catchment were afforded preferential treatment and concluded that this was not in fact the case. I have also rejected the contention that there ought to have been re-consultation over this issue, which is another argument raised under the rationality heading, along with the submission that members of the HTCiC did not understand that the North Derbyshire patients would be within 45 minutes of their nearest hospital. The reasons for dismissing these arguments apply equally in the context of

the rationality challenge. It will be clear from the reasons I have set out above that I am satisfied in the light of the evidence that it was entirely reasonable to extend the travel and access analysis to embrace the effects upon potential patients beyond the Greater Manchester area and expand and test an enlarged catchment accordingly. Further it was in my view reasonable to explore those effects on the basis of existing trends in usage by patients from beyond the Greater Manchester area and the assumption that they would continue as a means of understanding the travel and access effects of the alternative options.

100. The further point raised in the light of the factual material is that it was irrational to allow the interests of a very small group of potential patients, for whom the defendants did not have legal responsibility, to have disproportionate and, in reality, overriding weight in the making of the decision. As noted above, on the basis of past trends the methodology established that it would be likely that this would be no more than around one patient per day. In my view it is beyond argument that the margin upon which the decision to choose between Wythenshawe and Stepping Hill in this case was exceedingly narrow. It was very finely balanced, but I am unprepared to accept that it was not open to a reasonable decision maker to conclude that, all other things being equal, the interests of one emergency patient per day could carry the day. A decision had to be reached as to which hospital was to be the fourth Specialist Hospital and differentiating on this basis was not in my view irrational.

101. It follows that in the light of the reasons that have been set out above the claimant's arguments in relation to this ground must be dismissed.

Ground 2

102. This ground has an affinity to both Ground 1 and also Ground 3. It is the contention that it was unlawful for the defendant to discriminate between the options solely upon the Travel and Access criteria and to fail to deploy the other three criteria in reaching their decision. Once again the claimant's arguments were developed in the form of contentions relating to the legality of the consultation, the creation of legitimate expectations, and in particular the fifth proposition set out above, and irrationality.

103. In my view the central difficulty with this ground is that there is simply no evidence to support the view that the HTCiC reached its decision on behalf of the defendants solely on the basis of the Travel and Access criterion and not on the basis of a consideration of all of the criteria (albeit, as set out above, without weighting the criteria as against each other). The documentation throughout the chronology of the case demonstrates that each criterion was the subject of detailed scrutiny and examination as part of building the evidence in support of the decision-making process. Whilst I am unconvinced that there was a legitimate expectation based on the consultation material that only the criteria identified would be used to make the decision, since that documentation did not contain any unequivocal promise to that effect, it is in my view perfectly clear that all four criteria as they finally emerged in the DMMR were in reality the basis of the decision. It was simply that the decision turned on the Travel and Access criterion in the absence of the HTCiC concluding that there was any other material distinction to be drawn between option 4.3 and 4.4 based on the other criteria.

104. Some of the issues raised by the claimant under this ground have already been addressed under Ground 1. I have already provided conclusions in relation to the failure to re-consult about the revisions to the catchment and the investigation of the second question related to usage of Greater Manchester hospitals by those living outside Greater Manchester; the suggestion that irrationally disproportionate or overriding weight was given to the Travel and Access criterion; and the allegation that the fifth proposition set out above amounted to a legitimate expectation, all of which surface as arguments under this ground. For the reasons given above I cannot accept that they amount to a basis for concluding that the decision was unlawful.

105. There is a further point raised by the claimant arising under this ground which is that the results of important elements of the consultation, in the form of the Household Survey and the Consultation Questionnaire, demonstrated that all elements of the community consulted in this way and who responded identified that Quality and Safety was the most important of the four criteria. It is submitted that this supports the argument for re-consultation about the potentially decisive importance which would be assumed by the Travel and Access criterion, and also the unfairness and perversity of this criterion becoming decisive. I am not persuaded by these contentions. Firstly, it is important to recall that the HTCiC determined that they would not weight the criteria and this decision was reached in the light of the responses to the consultation. The reasons for this decision are reflected in the DMMR in the following terms:

> "This feedback suggests that the four criteria themes…are appropriate and recognised by the public and as such the CIC supported their use in decision making. In addition, very few qualitative comments were received requesting that the criteria should be weighted…In the light of the average score for any one criteria being no less than 7 [out of 10] CIC determined not to apply a weighting to the criteria for decision making."

106. Secondly, and in the light of this material, in my view there was no legal error in the decision of the HTCiC not to weight the criteria in the final decision. It was reasonable for the HTCiC to treat each criterion as being, in effect, of equal importance in arriving at the final decision.

107. Further, I do not consider that there was a need for there to be any re-consultation about the conclusion that the criteria would not be weighted. That approach was, for the reasons set out in the DMMR, in reality supported by the outcome of the consultation in which consultees gave a high score to each of the criteria. There was, thus, no justification for re-consultation upon the issue. In the circumstances this additional point does not add to the substance of the claimant's case under this ground, which for the reasons given I reject.

Ground 3

108. Under this ground the claimant criticises the failure to discriminate between the options on the basis of Quality and Safety and to treat all of the options as being equally beneficial in this respect. The claimant commences by noting, as set out above, that the responses to the consultation rated Quality and Safety as the most important criterion. The claimant disputes the assumption adopted by the HTCiC that the planned investment in services would ensure that all of the options achieved the

specified quality standards and contends that this was without evidential basis. Furthermore, it is contended that there were in reality clinical differences between Wythenshawe and Stepping Hill and that in terms of co-dependent services the current arrangements at Wythenshawe are more clinically desirable than those which would arise as a result of adopting the HT proposals. The failure to re-consult in relation to the decision not to discriminate against the options on the basis of Quality and Safety was, the claimant submits, unfair. Further the claimant submits that reaching the decision on the basis of this assumption was irrational.

109. It will be evident from the factual summary that has been set out above that there is a preliminary evidential difficulty faced by the claimant. In fact, so far as Clinical Effectiveness and Outcomes were concerned the assumption set in the PCBC was that in the light of the required investment there was no distinction to be drawn between any of the options and that in fact they would all achieve the quality standards which had been adopted. It was on this basis that the consultation proceeded and that all the options were scored equally positively in the consultation documentation. Thus there was consultation that was predicated on the basis that all the options were identical in relation to Clinical Effectiveness and Outcomes.

110. The position was different in relation to the other element of this criterion, namely Patient Experience. The consultation documentation, relying upon NHS Friends and Family test data from a single month, differentially scored the options with only option 4.4 scoring marginally less than full marks for this element. For the reasons set out above at paragraph 38, and in response to observations made in the consultation, by the time of the DMMR it had been concluded that "as current quality and safety standards will be improved in **all sites**, this should not be used as a criteria to determine the number of single services".

111. In the light of this very marginal difference between the basis upon which the original consultation was carried out and the final basis for decision-making I am not satisfied that there was any need for further consultation on this point.

112. Turning to the arguments raised in relation to rationality whilst the claimant contends that there are grounds for believing that Wythenshawe is, clinically, a superior hospital to Stepping Hill and this should have been decisive or at least a strong basis for preferring it in the selection process, in my view there are clear difficulties with this argument. The first is that the approach of the defendants was avowedly not to proceed on the basis of historic data as to clinical outcomes for the reasons set out above in paragraph 37. The reasons which are given provide in my view a rational basis for approaching the issue without reliance on historic statistics and therefore this aspect of the decision-making process was legally defensible.

113. Secondly, the claimant's submission is contentious on the evidence, and in particular Dr Wasson on behalf of the 4th IP suggests in his witness statement that there is reason to believe that care standards at Stepping Hill are in fact higher than those at Wythenshawe. The court is ill-equipped to seek to resolve issues of this sort and in any event since I am satisfied that in principle it was rational for the defendant to put to one side existing data on clinical outcomes, on the basis that they are not necessarily a reliable basis for predicting clinical performance in the future, there is no need for that issue to be resolved. Even if the claimant were to be correct, in the

light of my conclusion that it was rational not to base the decision on prior clinical statistics, this would not amount to a reason to quash the decision.

114. In my view the claimant's case obtains greater traction when the consequences of the assumption for the decision-making process are examined. As explored in the course of argument the assumption, in effect, casts a form of invisibility cloak over the question of Quality and Safety and has the effect of excluding it exerting any form of influence over the final selection of the fourth Specialist Hospital. Far from being a potentially decisive criterion it becomes, in effect, a neutral factor in the decision. This is superficially surprising, given the obvious importance of this criterion both self-evidently given the purpose of the HT initiative, and also in the light of the outcome of the consultation. There is an argument that the neutrality of this criterion should have been more clearly advertised by the consultation documentation, or potentially that it should have been excluded as a criterion altogether as a consequence of its inability to exercise any influence over the outcome of the decision.

115. In the event, and not without some hesitation, I have concluded that the defendant's approach in this respect was not unlawful. Whilst Mr Havers was keen to impress upon the court the extent of the independent verification of the proposals by various bodies and reports, such as the National Clinical Advisory Team, the 5th IP and the Department of Health "Health Gateway Review" that occurred at various stages of the process, the existence of this independent scrutiny is not a complete answer to the point. In my view there is greater substance in the contention at the heart of this issue, namely that it was reasonable for the defendant to rely on the levels of investment in services determined through the examination of the Value for Money case as delivering within each option the specified and adopted quality standards. In other words the assumption was justified by the work that had been done in an associated part of the evaluation under a different criterion.

116. Whilst the consultation material could have been more explicit about the essentially neutral role played by Clinical Effectiveness and Outcomes, I am unconvinced that the failure to emphasise this was unfair. It was expressly open to consultees to express a view about the importance of this criterion and the role that it should play. The feedback from the consultation process in this respect was considered by the defendants but it did not cause them to change their mind. Ultimately, I am persuaded that the approach that they took was reasonably open to them and not unlawful, and therefore that this ground must be dismissed.

Ground 5

117. This ground explores flaws in the transport analysis. In the claimant's pleaded case points were pursued in relation to failure to take into account properly the population of travellers passing through Manchester Airport, which is in relatively close proximity to Wythenshawe, and the existence at Wythenshawe of a helipad. These were not specifically raised at the hearing and in my view correctly so. The question of the Airport population was examined in response to the matter being raised during the consultation, and on analysis a legally defensible conclusion reached that the extent of the travelling population was not so significant as to influence the decision. The existence of the helipad also did not, to my mind, materially advance the claimant's case.

118. The key point under this ground is the claimant's complaint that the SEMMS road was left out of account in undertaking the modelling of travel times by the TAG. In circumstances where the Travel and Access criterion was assuming a great significance and the time differences were relatively small (approximately 10 minutes on the journey time in option 4.3 for patients in North Derbyshire according to Table 14.7 in the DMMR) it was vital for the influence of this new piece of transport infrastructure to be taken into account, bearing in mind that it is likely to be open to traffic in 2017. It was incumbent on the defendant, through the TAG, to enquire into this, and the failure to take the SEMMS road into account within the analysis was irrational.

119. The explanation for not taking the SEMMS road into account is set out in the evidence of Dr Whiting and it is essentially that the advice of TfGM was that it should not be included, and that the TAG considered that including any data in relation to it would be speculative and inconsistent with the approach of the methodology to use actual data. In truth, of course, the travel times which were used from the TfGM SATURN model were modelled times, albeit that no doubt the model was itself calibrated using actual journey times. However, the journey times were, if necessary, capable of objective verification by actually driving them.

120. In my view, the approach taken to the analysis, namely to confine it to an understanding of journey times derived from actual infrastructure on the ground, rather than infrastructure in the pipeline, was not irrational. It meant that the data used was transparent and could be checked, rather than being journey times which could only ever be the product of computer modelling. Journey times derived from competently produced traffic models, using industry-standard computer models like SATURN, are not speculation and can and are used as a sound basis for decision making in other contexts. However, in this case it is unclear on the evidence whether modelled journey time data for the introduction of the SEMMS road could have been obtained. Even if it could, the existence of this alternative approach does not render unlawful or irrational the approach that the TAG and the HTCiC adopted namely to rely exclusively on data based on the existing highway network. I am not satisfied that there is substance in this ground.

Ground 6

121. Within this ground the claimant alleges that the decision reached that there was a satisfactory impact from the proposals upon co-dependent services was irrational. It is also submitted that the consultation which occurred was flawed in that it suggested that there would be no impact upon specialised services outside the scope of the reorganisation. These submissions are based on the contention that, on the evidence that was available, there plainly would be adverse effects upon co-dependent services. The public were therefore deprived of important information that they needed to respond intelligently to the consultation, namely the knowledge of the impact upon co-dependent services which would arise from the reconfiguration related in particular to emergency and high-risk surgery.

122. The 1st IP has a further point which it raises concerning consultation in respect of co-dependent services. Attention is drawn to the fact that there needs to be agreement between the commissioner of the specialised services provided at Wythenshawe, namely the 5th IP, and the 1st IP such that the 1st IP is willing to continue to provide

those service at Wythenshawe. The 1st IP remains to be convinced that it will be able to continue to provide the specialised services commissioned by the 5th IP following the implementation of the HT changes to a standard that reflects the duty of care which it owes to the patients which it would treat pursuant to the commission. The 1st IP complains that this point, namely the continuing provision of specialised services being unaffected by the HT proposals being contingent upon the willingness of the 1st IP (and other hospital providers) to continue to provide them, was not pointed out within the consultation material and therefore the information available to consultees was incomplete and misleading.

123. I propose to deal firstly with the points raised by the claimant, and then subsequently to the submissions of the 1st IP. In relation to the claimant's submissions it is convenient to deal with the arguments in relation to each of the specialised services (in relation to which it is contended that the defendants' conclusions were irrational) and then turn to the argument raised in relation to consultation.

124. The generality of the claimant's case is that the conclusions which were reached in relation to each of the specialised services, namely that they were not co-dependent upon the services within the scope of the HT initiative to the extent that their provision would be unharmed by the proposals, was one which was unsupported by the evidence and that much of the material produced on this topic and referred to above did not address the particular issue of the four services in point.

125. It will be obvious from the legal principles which have been set out above that in this part of the case the question is not whether there are differences of clinical opinion as to the likely or possible consequences of the HT initiative's proposals. The legal question is whether in reaching their conclusions about co-dependencies the defendants, in the course of their analysis of the issue, failed to take account of relevant material considerations (or took account of immaterial ones) or reached a conclusion which no reasonable decision-maker could have made in the circumstances.

126. The first area of concern is cardiothoracic surgery. In this respect the claimant relies upon the material contained within the document entitled "Cardiovascular Project Co-dependencies Framework" produced by the NHS Commissioning Support for London on behalf of Primary Care Trusts in London in August 2010. Within that document co-dependencies related to cardiothoracic surgery are considered. In particular the document advises:

> "Thoracic aortic surgery has:…
>
> A high dependency on, and collocation is strongly recommended with:
>
> …
>
> -general surgery"

The claimant contends that it was irrational not to follow this recommendation.

127. The defendant's response to this point in detail is to draw attention to the contents of Appendix 45 of the DMMR referred to in paragraph 43 above. As noted this document's assessment of the "Cardiovascular Project Co-dependencies Framework" was that it found that the co-dependency of cardiothoracic surgery with general surgery was "vital but does not necessarily require collocation in the same hospital" and that therefore there was not a collocation requirement identified in the literature that was reviewed.

128. In my view, having considered the document relied upon by the claimant, that was a reasonable assessment and certainly one that was open to the defendants. First and foremost, the "Cardiovascular Project Co-dependencies Framework" document does not suggest that co-dependency in this case is essential. There is a category of co-dependency which the document identifies described as "an absolute dependency…and collocation is recommended as essential" and general surgery does not fall into that category, but the lesser dependent category set out above. Secondly, as Mr Havers, on behalf of the defendants, points out, the dependency the claimant relies upon is in respect of "general surgery" and not on the regular provision of the emergency and high-risk surgery that will be removed from Wythenshawe as a result of the HT proposals. Thus, without engaging with the defendants' suggestion that in fact there will still be access to emergency and high-risk surgery at Wythenshawe when required provided through the operation of the single service of which it will be part, I am satisfied that the defendant's interpretation of the document and its application to the HT proposals for cardiothoracic surgery was rational and lawful.

129. The second area of controversial specialised services are those related to vascular surgery. As has been noted above, the examination of the available documentation and evidence within Appendix 45 of the DMMR led to the conclusion that there was a need for a robust pathway to access vascular surgery to be established, but nothing further. This conclusion is challenged by the claimant on the basis that it failed to understand or have regard to the recommendation of one of the key documents referred to in the literature review prepared within Appendix 45, namely "The Clinical Co-dependencies of Acute Hospitals" produced by the South East Coast Clinical Senate in 2014. Within that document there is a grid summarising its conclusions in respect of the co-dependencies of eleven acute services and other clinical specialities and functions. In relation to vascular surgery, a relationship characterised as "Service should be co-located (based) in same hospital" with "general surgery (upper GI and lower GI)" is identified in the grid. Thus, it is said by the claimant, the conclusion that a "robust pathway" to access vascular surgery suffices is irrational and fails to understand properly the conclusion of the document.

130. The defendants' response to this is firstly, that the assessment which was made both by the authors of Appendix 45 and the subsequently produced reports addressing issues associated with co-dependencies which are set above considered questions of co-dependency comprehensively and robustly. Secondly, and in detail, the defendants contend that the claimant has failed to fully understand the conclusion of the document upon which reliance is placed. That document does not identify a requirement for co-location with emergency and high-risk general surgery, but rather simply with general surgery. General surgery will remain at Wythenshawe as a consequence of the HT proposals and therefore the defendants' approach is consistent with the findings of the document.

131. Having considered the arguments I am satisfied that there is no substance in the claimant's contentions. The defendants were entitled to conclude, as set out above, that the document was in fact identifying a relationship with general surgery and not the somewhat more demanding provision of emergency and high-risk surgery. As such, the conclusions of the document do not disturb the assessment made within Appendix 45 of the DMMR which was relied upon by the defendants in reaching their decision. The decision in respect of this co-dependency was not therefore irrational.

132. The next area of specialised work is that of the regional Specialist Burns Centre at Wythenshawe. The essence of the assessment of this co-dependency in Appendix 45 of the DMMR is set out in paragraph 45 above, and the thrust of the claimant's case is that this document failed to understand and apply the co-dependency which is established by one of the documents identified in Appendix 45, namely the "Co-dependencies framework for Specialised Burns Service". In particular, in the case of what the document characterises as an "Adult Burns Centre" (which is the nature of the facility at Wythenshawe) there is a relationship described as "co-located on site" with "general surgery". It is submitted that the analysis in Appendix 45 fails to give effect to this identified relationship and therefore either fails to understand it, or alternatively, was irrational on the basis that its conclusion was flat contrary to this clear expert recommendation.

133. The defendants' answer to this allegation is similar to that provided in relation to vascular surgery, namely that the relationship with general surgery will be preserved in the HT proposals and that the recommendation of this report does not identify a need for co-location with emergency or high-risk general surgery, or indeed access to general surgery 24 hours per day. In my view this is a reasonable interpretation of the document: certainly there is nothing in the document which suggests that the reference to general surgery includes within it the requirement for emergency and high-risk surgery to be co-located. As such, therefore, I am not persuaded that the analysis within Appendix 45, and the defendants' reliance upon it, was irrational.

134. The final area of specialised service involved in these arguments is cystic fibrosis. It will be recalled that on the basis of the 5th IP's Commissioning Specification Appendix 45 of the DMMR concluded that there was no requirement for co-location in respect of this service. Both the claimant and the 1st IP noted that the reference contained in Appendix 45 was to the Specification for the care of children ("A01/S/b") rather than the care of adults ("A/01/S/a"). Notwithstanding this, I noted during the course of argument that I had not been able to identify from my own reading of the documents any material distinction between the two specifications as far as co-dependent services were concerned, and invited the parties to point any material distinction out to me. By the close of the argument no such distinction had been drawn to my attention. The paragraphs from the adult specification reproduced by Dr Attila Vegh (the Chief Executive of the 1st IP) in his witness statement on behalf of the 1st IP in relation to both "Specialist Centre Responsibilities" and also "Surgery" are identical in each of the adult and the child Specifications. I am unable to conclude that this error in relation to referencing had any relevant bearing on the outcome of the analysis. Furthermore, I have been unable to identify anything in the Specification which is inconsistent with the conclusions reached in relation to cystic fibrosis in Appendix 45. There is, therefore, in my view no substance in the complaints raised by the claimant and the 1st IP in this respect.

135. Turning to the claimant's submissions in relation to consultation, these were predicated on the basis that the consultation literature was misleading when it assured consultees that there would be no impact upon specialised services as a result of the reorganisation of services within the scope of the HT proposals. It was submitted that either the question of co-dependencies had not been properly thought about, or they had been and there had been a failure to appreciate the need for further work in that regard. The conclusion that there would be no impact was wrong, and had been formulated without regard (or properly informed regard) to the independent literature on the co-dependencies set out above. Furthermore, this assurance effectively excluded the public from involvement in the impact which the decisions would have on the con-dependent services, in particular at Wythenshawe. It was submitted that if specialised services would be less effective as a result of the reforms (and the claimant submitted that they would), then the public should have been consulted about this. The on-going discussions at the start of the implementation stage demonstrated that the assertion that the effects on co-dependent services would be neutral was not the case and that there would be impacts on co-dependent services which need to be consulted upon and then taken into account.

136. The preliminary difficulty for the claimant in making this submission is that, for the reasons which I have set above, I am unable to accept that the conclusions reached by the defendants that there would no material adverse effects upon co-dependencies was either irrational or grounded upon a failure to understand properly or take account of material considerations in the form of the reported literature upon which the claimant relied.

137. That is not, however, a complete answer to the point in relation to consultation, since it is clear to me that it was obviously within the range of reasonable clinical judgment to form the view that there could be adverse impacts upon co-dependent services, and this was an issue under active consideration by the defendants. Having scrutinised the consultation material, whilst it is clear that the position taken by the defendants at the time of the consultation was that aspects of hospital care outwith the HT initiative would be unaffected (see paragraph 18), I am unable to accept that this expression of HT's intention excluded any impacts in this respect being the subject of representations by consultees. The consultation was expressly seeking views (in addition to the completion of the questionnaire) on all of the features of the reorganisation including the wider impacts of the proposals, and there was nothing in the material that suggested that views would not be welcome on the potential effect of the changes on co-dependencies. Indeed it is clear from, for instance, the observations which the 1st IP made in response to the consultation in October 2014 set out above, that they did indeed make representations in relation to the impact on the specialised services they provided potentially being harmed by the possible loss of emergency and high-risk surgery. Both therefore as a matter of examining the documents, and also in practice, I am entirely satisfied that there was no error in the consultation of the kind alleged.

138. Turning to the detailed submissions of the 1st IP their central thesis as set out above is that as a healthcare provider within the NHS they cannot be compelled to provide healthcare services which they are not under contract to provide, and that equally unless the 1st IP agrees to provide certain healthcare services, for instance the specialised services commissioned by the 5th IP, then they will not provide them. The

1st IP is a licensed provider of healthcare under s.81 of the Health and Social Care Act 2012. Their licence is granted by a regulatory organisation, Monitor, and is subject to conditions pursuant to s.97 of the 2012 Act and they are obliged by those conditions imposed to continue to provide existing services, including emergency and high-risk general surgery, unless and until the contract comes to an end. The contracts are negotiated annually and expire at present on 30th March each year. Thus, it is submitted, notwithstanding the HT proposals, the provision of emergency and high-risk surgery will continue at Wythenshawe. Perhaps more significantly, unless and until the 1st IP conclude that it is safe and consistent with their duty of care to their patients for them to do so under the HT reconfiguration, the 1st IP may in future decline to contract to undertake the specialised services it currently provides, thereby falsifying the assumption of the consultation that there would be no effect on the provision of these services.

139. It is pointed out that this position underpins the thrust of the 1st IP's concerns expressed in the run-up to the decision that are set out above. Further the 1st IP draws attention to the 5th IP's guidance in "Planning and delivering service changes for patients" which emphasises the need for collaborative working and the integral involvement of providers in the development of any proposals for change. Typical of the guidance in this respect is the following extract:

> "Developing, explaining and implementing proposals takes time, collective effort and energy. It is not something that single organisations can, or should, do in isolation. The strongest proposals are those developed collaboratively by commissioners, providers, local authorities, patients and the public. This will ensure that proposals are sound and evidence-based, in the best interests of patients, will improve the quality and sustainability of care, and that people affected will be involved and their feedback will be listened to, and acted upon."

By contrast with this guidance the 1st IP contends that the HT proposals were developed by the defendants alone and that, for example, the reports prepared on co-dependencies by Professor Cant's panel and Mr Bibby had no input from the 1st IP.

140. On the basis of these contentions the 1st IP submits that the consultation was legally flawed in that the information with which it was provided did not draw attention to the fact that the continuing provision of specialised services could not be guaranteed under the HT proposals for the reasons set out above. If emergency and high-risk surgery were to be removed from Wythenshawe as contemplated by some of the options then it should have been pointed out to consultees that it would be open to the 1st IP to conclude that it was no longer possible for them to continue to provide safely the specialised services for the 5th IP. This impact on specialised services was not drawn to the attention of consultees: in fact they were misled by the assertion that the provision of hospital services outside the scope of the reorganisation would be unaffected by the changes in all options.

141. The defendants dispute the legal accuracy of the 1st IP's analysis, and suggest that, by virtue of the standard conditions of the 1st IP's provider licence imposed under s.97 of the 2012 Act, Monitor would be entitled to require them to continue to provide

"commissioner requested services" which are the specialised services. This in turn is disputed by the 1st IP in two respects: firstly, they point out that Monitor is merely another organisation outside the control of the defendants and as a matter of fact therefore they could not rely upon them to require the continued provision of the specialised services; secondly, they contend that the powers which Monitor has are, in particular, designed for use in circumstances where providers are in special administration. Be all this as it may, for the reasons I am about to give it is unnecessary to resolve this dispute, since I take the view that even taking the 1st IP's submissions at face value I am not satisfied that the consultation was unlawful as they allege.

142. The key question is whether or not it was unfair and unlawful for the consultation literature to fail to advise consultees that it could not be guaranteed that specialised services might continue at hospitals designated General Hospitals as at present and that there may be circumstances in which the location of the provision of specialised services would change following the reorganisation. I am satisfied that this failure was not a legal flaw in the consultation process for the following reasons.

143. Firstly, in order to be appropriately informed so as to provide a constructive response to the consultation it was not necessary for the consultees to be informed about every potential contingency which might arise. Certainly, if there were clear or obvious disadvantages for consultees to consider as a consequence of the changes, then it might very well be appropriate to draw attention to them for their comment. Whether or not that is required would depend upon the circumstances of the case and the nature of the disbenefit. The key question would be whether the consultees would be misled by a failure to include it, leading to a breach of the second of the Sedley criteria. However, secondly, on the facts of this case there was in my view no reason to oblige the defendants to incorporate this risk in their consultation documents in the particular circumstances set out below.

144. The 1st IP had been involved throughout in helping shape the HT proposals and indeed their representatives had participated in the Clinical Advisory Group and Patient Safety Group as well as contributing to the consultation through the Southern Sector Partnership and in their own capacity. From these responses, and from their own work, the defendants were entitled to form the view that whilst the impact upon specialised services was clearly material to their decision it was not likely that there would be a deleterious impact upon specialised services and that the consultation could properly proceed on the basis that services outside the scope of the reorganisation would be unaffected. There was no need, to provide for a fair consultation, for this potential contingency that on the evidence at the time was relatively remote as a possibility to be included within the consultation information and the participants were not misled.

145. Thirdly, and far less significantly bearing in mind the way in which the 1st IP puts its case, notwithstanding that it was legitimate on the evidence for the consultation to proceed on the basis that specialised services would be unaffected, it was entirely open for consultees to express the view that this premise of the proposals was incorrect. The consultation had an open structure, as set out above. Thus not only was the documentation not misleading in the manner suggested by the 1st IP, but also it was not unfair in that it did not in any way exclude parties from disputing in their response that specialised services would be unaffected. As we have seen, this was an

opportunity that was taken up in their response by the 1st IP. I have therefore formed the view that there is no substance in the 1st IP's complaints about the consultation.

146. For all of the above reasons there is in my view no substance in the complaints raised under this ground.

Conclusions

147. For the reasons which I have set out above I have concluded that each of the claimant's grounds must be dismissed. It is therefore unnecessary for me to consider the issues which were raised by, in particular, the defendants and the 4th IP in relation to whether or not relief should be granted. It should be noted, for the sake of completeness, that the 1st IP did not urge that the defendants' decision be quashed even if the court were satisfied that the consultation were unlawful. This was on the basis that the 1st IP considered that there was the opportunity for its concerns to be addressed and solutions designed to accommodate them during the development of the implementation stage of the project. It has been conspicuous throughout that these proceedings have been brought before the court and defended out of a passionate concern on all sides for the health and wellbeing of all those who depend on healthcare provision in Greater Manchester, whether or not they reside there. No doubt the matters with which this case has been concerned, and many other details of the HT initiative, will remain under close and conscientious consideration during the implementation stage of the project. I am satisfied, however, that there was no legal error in the decision reached by the HTCiC on the 15th July 2015.