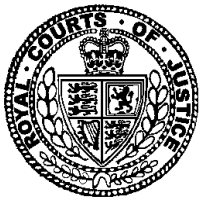

Neutral Citation Number: [2021] EWHC 12 (Admin)

Case No: CO/3383/2019

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 06/01/2021

Before:

MR JUSTICE KERR

- -

Between:

RON GLATTER	**Claimant**
- and -	
NHS HERTS VALLEYS CLINICAL COMMISSIONING GROUP	**Defendant**
-and-	
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	**Interested Party**

David Wolfe QC and Emma Foubister (instructed by **Leigh Day**) for the **Claimant**
Jeremy Hyam QC (instructed by **Hempsons**) for the **Defendant**
Fenella Morris QC and Peter Mant (instructed by **Capsticks Solicitors LLP**) for the **Interested Party**

Hearing dates: 27 and 28 October 2020

- -

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 KERR

Covid-19 Protocol: This judgment was handed down by the judge remotely by circulation to the parties' representatives by email and release to Bailii. The date and time for hand-down is **10am** on **6 January 2021**

Mr Justice Kerr:

Introduction

1. In this judicial review application, the claimant seeks to establish that decisions made by the defendant (**the CCG**) in May and July 2019 with the support of the interested party (**the Trust**) about reorganising National Health Service (**NHS**) hospital provision in Hertfordshire, were unlawful. The essence of the claim is that the CCG was obliged to conduct a public consultation before making the decisions and did not do so.

2. The claimant coordinates the New Hospital Campaign Group (**NHCG**) which favours the building of a new emergency and specialist hospital on a clear site in Hertfordshire (a **new build**). The first decision challenged, made on 30 May 2019 (**the first decision**) was to select four of eight options for further consideration and rule out the other four. The four ruled out options included two versions of the new build option, which was considered too expensive.

3. The **second decision** challenged, made on 11 July 2019, was to choose one of the four remaining options: to spend money on improvements to services at three existing hospitals, Watford General Hospital (**Watford General**), St Albans City Hospital (**St Albans City**) and Hemel Hempstead Hospital (**Hemel Hempstead**). The complaint is that the second decision too was taken without public consultation which could have led to a new build being approved instead.

4. The CCG and the Trust say they were under no statutory or common law duty to consult publicly. Their obligation, fully performed, was to "involve" service users in "development and consideration of proposals …. for change" (National Health Service Act 2006, as amended (**the 2006 Act**), sections 14Z2(2)(b) and 242(1B)(b)). They were not required to consult on the proposals for change, especially those they rationally considered unaffordable.

5. They also submit that even if the CCG should have undertaken a public consultation, relief should be refused because it is highly likely the outcome would have been substantially the same (section 31(2A) of the Senior Courts Act 1981) and because granting relief now would serve no useful purpose and would be contrary to good administration. The new build options were indeed too expensive; not enough money was available to make them viable.

The Facts

6. In 2003, the then Bedfordshire and Hertfordshire Strategic Health Authority consulted on proposals that led to a decision by a joint committee with delegated powers, not at the time implemented, to construct (among other changes) a new build hospital at Hatfield. In November 2006, the Trust decided to reorganise its services, following a public consultation exercise. The new hospital at Hatfield has not been built.

7. The decisions in 2003 and 2006 are not directly relevant but are part of the background. Decisions made in 2006 by the Trust led to a judicial review challenge by the chair of a different campaign group concerned to preserve the presence and quality of certain services at Hemel Hempstead which were intended to be moved to

Watford General. That challenge failed: see Walker J's judgment of 9 July 2007 in *R (Bullmore) v. West Hertfordshire Hospitals NHS Trust* [2007] EWHC 1636 (Admin).

8. During the following nine years or so, various proposals were debated and publicly discussed. It is not necessary to go through the detail. The need to reorganise NHS hospital services in west Hertfordshire continued to be recognised. Parts of the Trust's hospital estate were deteriorating and investment was needed, as everyone agrees. The process became protracted. There was a public involvement exercise in 2014 and 2015.

9. In February 2017, the Trust published a Strategic Outline Case (**SOC**) on stating its proposals for reconfiguring acute services. In the decision making process leading to investment in changes to NHS provision, the SOC is the first stage for securing funding provision; next comes the Outline Business Case (**OBC**) and, finally, the Full Business Case (**FBC**). There are detailed definitions of these terms in documents issued by the Treasury. I do not need to set them out because the titles indicate what they should contain.

10. The Trust's 2017 SOC lamented the poor state of its hospital estate: 80 per cent of it was assessed as in poor condition and "no longer fit for purpose". A list of 14 options was set out. They included several versions of a new build option on a clear site. There were cost estimates, supported by external consultants. The estimates for the new build options ranged from £789 million to £812 million. The preferred option, at £565 million, was redevelopment of emergency care at Watford General and planned care at St Albans.

11. The CCG approved the Trust's 2017 SOC, but it did not find favour with the regulator of the NHS, formerly called Monitor but by 2017 called NHS Improvement. The SOC, the regulator explained, was unlikely to succeed in securing funding because of the amount of capital expenditure required. It was necessary to reconsider the proposals and make recommendations that were containable within a capital expenditure limit of £350 million, a threshold linked to the Trust's annual turnover.

12. The reconsideration was described in the contemporary documents as a "refresh" of the 2017 SOC. Refresh is civil service jargon for reconsideration. NHS Improvement recommended to the Trust in a letter of 13 June 2018 that it:

> "reconsiders its SOC assumptions and financial projections for each of the eight shortlisted options and seeks expert advice regarding blended and phased funding options potentially including land sale proceeds, Section 106 contributions and the potential for private finance …. where elements of the project relate to new build and can be progressed as discrete and separable elements of the overall project."

13. The CCG and the Trust issued a joint statement on 4 October 2018 explaining the need to revisit the proposals in view of the capital expenditure constraint and consequent need for a "phased approach". The preference continued to be "retaining emergency services at Watford" rather than "at a new location". That view was based on the "guiding principles" of "deliverability"; "[q]uality"; and "[s]ustainability". The revised SOC was to be ready in early 2019; there would be "continued engagement with all stakeholders as plans are developed further".

14. Public meetings explaining the process were held with interested parties in October and November 2018. Mr Robert Scott, an articulate supporter of the NHCG with experience of conducting financial appraisals and of the construction industry, contributed an "interim appraisal" document in November 2018. It was not his first such contribution.

15. In early December 2018, the CCG and the Trust met NHS Improvement and NHS England. They were told that their bid in the next spending review settlement must be constructed so as to be sufficient to cover their requirements for the following ten years and should be submitted in the period from April to July 2019. The funding would be long term public dividend capital, serviced by payment of a charge representing the notional cost of servicing the debt. The maximum capital available would be the amount of the Trust's annual turnover.

16. From December 2018 to February 2019, extensive discussions took place between the CCG and the Trust to work up the bid for funding. The NHCG wished to be involved in the process and made this clear in a series of emails in January 2019 making various enquiries about what was going on internally within the CCG and the Trust and in contacts between the two bodies. The claimant and the NHCG sought access to documents generated in these discussions which were not made public.

17. At a public meeting on 29 January 2019, representatives of the CCG and the Trust stated that some of the options previously under consideration were likely to be ruled out because of the affordability cap of £350 million imposed at national level. Mr Scott questioned the approach of the CCG and the Trust to the issue of affordability. He submitted in correspondence in February 2019 that the cost of a new build option was overstated while other aspects of the costing were understated. He sought a meeting but that request was not granted.

18. In addition to public meetings, provision of information on the websites of the CCG and the Trust, correspondence and social media discussion, a body called the "stakeholder evaluation panel" was established. Its membership was confirmed at a public meeting on 27 February 2019 and included the claimant's wife. It was described thus in a later report in July 2019:

> "A stakeholder evaluation panel was formed to support the development of and consider the options shortlist. This was an advisory group, made up of public and patient representatives, clinicians and managers, local authority partners, and Hertfordshire Healthwatch, together with representatives from the voluntary sector and the sustainability and transformation partnership (STP). The panel members, presented with detailed information and a set of agreed criteria, evaluated the shortlist, thereby informing the qualitative assessment of the options."

19. Those present at the meeting on 27 February 2019 were treated to a slide presentation which included a depiction of eight possible options, five of which (costed at about £700 to £750 million) were considered by the CCG and the Trust to exceed by far the affordability limit of £350 million. These headline figures were derived from an affordability analysis carried out by the CCG and the Trust with external consultants.

20. The minutes of the CCG board meeting held in private the next day record that at the public meeting on 27 February, "the panel agreed the shortlist", although "one individual patient representative [*this was the claimant's wife*] said we ought to

include building a new major hospital on a greenfield site on the shortlist to be evaluated"; but "[i]t was pointed out that this was not feasible within the funding available."

21. The minutes went on to record that the four proposed shortlisted options were:

> "1. Three sites: Watford General Hospital (WGH) as emergency and specialist with St Albans (surgery) and Hemel Hempstead (HH) (medicine).
>
> 2. Two sites: WGH as emergency and specialist with St Albans doing planned.
>
> 3. Two sites: WGH as emergency and specialist with HH doing planned.
>
> 4. Two sites: WGH as emergency and specialist with planned care at new planned care centre on fresh site."

22. The CCG's board approved the four shortlisted options at that private board meeting, held on 28 February 2019. A further public meeting and two further stakeholder evaluation panel meetings were held in March 2019. The various options were discussed and scored. The same shortlist, which did not include any new build option, was approved by the board of the Trust on 7 March 2019.

23. The claimant continued probing for information and access to internal documents in April 2019. His requests were considered under the Freedom of Information Act 2000 and eventually he learned on 23 April 2019 that the CCG's board had approved the four shortlisted options on 28 February 2019. There was one further stakeholder evaluation panel meeting on 15 May 2019, held in public; it included feedback from regulators. Documents from the meeting were published on the websites of the CCG and the Trust.

24. A public meeting of the CCG's board was held on 30 May 2019. Mr David Evans, the director of commissioning, presented the shortlist of options agenda item. Affordability was a "red line", he explained. The £350 million was a cap set by the regulator. The capital expenditure had to be within the Trust's annual turnover for the Trust to be considered able to make the required repayments. The four shortlisted preferred options were discussed.

25. The claimant was among three members of the public present. He disputed the inevitability of the cap of £350 million, asserting that (as stated in the minutes later) "the annual turnover was a good metric of affordability only and it was a gross misunderstanding that this was a mandated constraint". He asserted that a different NHS trust with a lower annual turnover was submitting a higher bid.

26. Mr Evans responded that the other trust "still had work to do" on its figures. The claimant then had a disagreement with the CCG's chief executive officer, Ms Kathryn Magson, over whether a new build at £750 million could be affordable. After further discussion, the board again decided to approve the four options for shortlisting, which meant excluding other options including a new build. That is the first decision challenged.

27. Approval of the SOC was scheduled to be on the agenda at board meetings of the CCG and Trust in July 2019. The claimant and his wife continued to make written

representations through June 2019, claiming that the estimated £700 million cost of a new build was grossly overstated and a "frankly preposterous figure". The CCG's project team responded with detailed accounts of costings from earlier stages of the process, explaining the basis of its cost estimates for new build options. The options were further discussed at a joint meeting of the two boards on 6 June 2019 and at a public event on 13 June 2019.

28. At the CCG's board meeting held in public on 11 July 2019, Ms Helen Brown, the Trust's deputy chief executive officer, together with officers of the CCG, presented the draft SOC to the board. The documents included the draft SOC itself, an equalities analysis, a quality impact assessment and a "[p]ublic and stakeholder engagement report", with "frequently asked questions" and written representations from stakeholders and members of the public.

29. The draft SOC, despite its title, was 138 pages long. It continued to rule out any new build options on the ground that their cost would far exceed the £350 million limit. The proposal in the draft SOC was to approve option 1 which, it will be recalled, was that there should be three sites, Watford General for emergency and specialist care, St Albans City for surgery and Hemel Hempstead for planned medical care. The cost was put at £350 million.

30. The draft SOC stated that in view of extensive public involvement, a formal consultation exercise was not thought necessary for the proposed estate redevelopment at Watford General, nor for the service reconfigurations at Hemel Hempstead and St Albans. The proposals would be subjected to detailed analysis and further public engagement at the stage of developing the OBC.

31. The claimant submitted that the CCG was influenced by the proposition that option 1 alone among the four options would not require public consultation. The claimant relied on an extracted diagram in a slide presentation from both bodies dating from 31 May 2019, headed "[s]ummary of pros and cons of each shortlisted option". It indicated as "cons" in the case of each of options 2, 3 and 4 (but not option 1) that they "[w]ill require public consultation as involves significant consolidation of services, delaying implementation".

32. The CCG maintained that this was erroneous because none of the four options would have required public consultation and that the decision to select option 1 was not influenced by that consideration; though public consultation has still not been ruled out. No request was received from the Health Scrutiny Committee of the relevant local authority, which has statutory standing in the matter and, the CCG maintained, had been kept fully informed.

33. The boards of both bodies approved option 1 at public board meetings on 11 July 2019. The CCG's decision that day is the second decision challenged. After that, the SOC was submitted as a funding bid to NHS England and NHS Improvement. After engaging in pre-action correspondence, the claimant brought this claim as a permission application on 28 August 2019.

34. In September 2019, the Department of Health asked for certain review work to be done and informed that formal review of the SOC could not take place until sources of funding had been identified. The CCG served summary grounds of resistance on

24 September seeking a stay for the purpose of considering other options. On 30 September, the Secretary of State for Health announced a fresh funding initiative for six large new hospital builds, to be funded imminently and delivered by 2025. The Trust's scheme was one of these six projects.

35. On 2 October 2019, Johnson J granted permission to apply for judicial review of the first and second decisions. He also granted a costs capping order and a stay pending the Trust's response to the government's request that it should consider other options, following the release of further capital. He considered there was a real possibility that the claim would become academic in view of the release of further funding.

36. The project's continued eligibility for further funding was confirmed by the Trust in January 2020, following the general election in December 2019. The stay was then lifted and the present application moved towards a substantive hearing, while at the same time the arguments over affordability of option 1 continued. A consultancy called AA Projects was commissioned by NHS Improvement to consider the SOC, together with a stern critique of it by Mr Scott dating from September 2019.

37. After initially expressing reservations, AA Projects eventually endorsed the costing of option 1 at around £350 million, in a report finalised (though still marked "draft") in March 2020. Meanwhile, the Trust's thinking had moved on and it had prepared a detailed paper of its own in February 2020 setting out potential options should the indicated further funding become available.

38. From June to September 2020, there was correspondence between the parties in which the claimant attempted to discern whether the present judicial review had indeed become academic, as Johnson J had thought it might. During that period, public discussion took place in correspondence and at monthly meetings with interested parties, a newsletter was distributed and, in September 2020, a survey carried out to canvass views on the way forward.

39. The CCG and the Trust produced a fresh report in September 2020 entitled "[b]ringing new hospital facilities to west Hertfordshire". Four possible "greenfield" new build sites had been identified. However, the report stated:

> "… [a]n independent site feasibility study concluded that the most acceptable of the several options is to use the Watford site and adjacent land for emergency and specialist care. This is because it will take longer and be higher risk to try to develop a new hospital on a new site."

40. The CCG in a letter of 21 September 2020 explained that there was a new shortlist of options forming part of what was now the OBC stage. Options not considered in the 2019 SOC could now be candidates for a more detailed appraisal at the OBC stage as "the Regulators have now confirmed that additional funding may be available." The claimant concluded from these developments that the new build options remained off the table and that the issues in the present judicial review therefore remained live.

41. On 1 October 2020, a few weeks before the substantive hearing before me and shortly before the claimant's skeleton argument was due, the boards of the CCG and the Trust met to consider a proposed shortlist of options and to decide on a preferred option for the OBC stage of the exercise. They specifically considered whether to include

within the shortlist a new build option on a clear, greenfield site and decided not to do so.

42. I was shown a tabulated depiction of the current list of six options discussed at the joint board meeting on 1 October 2020. They are described respectively as: "business as usual"; "do minimum"; "smaller scope"; "intermediate scope"; "preferred way forward"; and "larger scope".

43. These descriptions suggest the penultimate, "preferred way forward", is the current favourite, or was as at 1 October 2020. It is costed at about £540 million and appears to be an enhanced version of the "option 1" (called "SOC 1") endorsed on 11 July 2019, with the greater capital investment reflecting the hoped for availability of increased funding.

The Parties' Contentions

44. The essence of the claim is that the CCG and Trust were obliged to conduct a public consultation exercise in the case of both the first and second decisions; that they misdirected themselves by deciding that they were not obliged to do so; and that they deliberately selected option 1 influenced by the misconception that it, alone among the four options considered on 11 July 2019, did not require a public consultation exercise to be carried out.

45. The response of the CCG and the Trust, in summary, is that they discharged faithfully their statutory duties under the 2006 Act; that the duty was to make arrangements to secure the involvement of service users, whether by consultation or other means, in the planning, development and consideration of proposals or changes in commissioning arrangements; that they did exactly that and were entitled to rule out options they rationally considered unaffordable.

46. They also submit that the claim has been overtaken by the October 2020 decision not to include any new greenfield sites in the recommended shortlist; even if the claimant's case ever had merit, pointless delay and detriment to good administration would be caused by revisiting the first and second decisions now; the dispute about the expenditure limit of £350 million is no longer live but even if it were, relief should be refused because it is highly likely the outcome would have been no different, had public consultation been carried out.

47. The first ground of challenge is that the CCG failed to consult the public before deciding to eliminate the new build hospital option. Mr David Wolfe QC, for the claimant, relied on further provisions apart from sections 14Z2 and 242 of the 2006 Act. He pointed to the CCG's obligation to consult the relevant local authority (see the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013); and to the CCG's obligation to have regard to NHS England Guidance.

48. Mr Wolfe referred specifically to the passage in the NHS England guidance document dating from March 2018 entitled *Planning, assuring and delivering service change for patients*, stating that it is "critical that patients and the public are involved throughout the development, planning and decision making proposals for service change…".

49. He referred also to another document issued by NHS England in November 2015, *Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning*, and to the duty on NHS England under section 13Q of the 2006 Act to make its own arrangements for involving the public in commissioning services for NHS patients and to do so in a manner that is "fair and proportionate" (paragraph 3.2).

50. Mr Wolfe also relied on the high principle enshrined in the NHS constitution that patients must be at the heart of everything the NHS does. He argued that the common law imposed a duty to consult separate and distinct from the statutory duty to do so. This was based on a past promise to do so and a past practice of doing so, arising from the processes in 2003, 2006 and 2007. The failure to perform these duties lay, Mr Wolfe submitted, in the insufficiency of the financial information communicated to interested parties such as the NHCG.

51. Those parties, said Mr Wolfe, were thereby disabled from challenging the accuracy of the CCG's facts and the validity of its and the Trust's arguments (see *Bushell v. Secretary of State for the Environment* [1981] AC 75, per Lord Diplock at 96C-D). He also referred to the breach of the duty of fairness found in *Eisai Ltd v. National Institute for Health and Clinical Excellence* [2008] EWCA Civ 438 and to the Supreme Court's endorsement of the "Sedley" principles of consultation in *Moseley v. London Borough of Haringey* [2014] 1 WLR 3947 (per Lord Wilson JSC at [25]).

52. The CCG and the Trust had not permitted sufficient informed discussion to discharge its duty to consider the new build option conscientiously, while the proposals were at a formative stage. It was unlawful to rule out a new build peremptorily on the ground of cost. Only headline cost figures were provided to members of the public in documents and in public meetings; the detailed costings were not provided. As a result, the options were prematurely narrowed down to the four that survived the 30 May 2019 meeting, excluding a new build.

53. The absence of full consultation also meant that the process that did take place was unfair, according to Mr Wolfe's argument. It was wrong, he said, for the CCG and Trust to hide behind unaffordability, since whether the new build proposal was affordable was the very issue joined by proponents of a new build hospital on a clear site. There had to be a full debate in public about affordability, with full access to the NHS bodies' detailed calculations.

54. Mr Jeremy Hyam QC, for the CCG, said the claimant conveniently ignored that the statutory obligation is one of public involvement not public consultation. He submitted that there had been a high degree of public involvement throughout the process. There was no duty under section 14Z2(2)(b) of the 2006 Act to consult publicly on a new build option rationally considered unaffordable (see the judgment of Nicola Davies LJ in *R (Nettleship) v. NHS South Tyneside CCG* [2020] EWCA Civ 46, at [56] and [59]).

55. The claimant could not, said Mr Hyam, elevate the duty of public involvement to one of full consultation either by invoking the guidance or the common law. There was no past promise of consultation, nor any settled practice of engaging in it. Even where a duty to consult exists, it is open to a consulting party to select the options for discussion by reference to a shortlist of its making and to exclude options considered

inappropriate (e.g. *R (WX) v. Northamptonshire County Council* [2018] EWHC 2178 (Admin) per Yip J at [67]).

56. It was therefore for the CCG to decide whether to rule out a new build option as unaffordable by reason of the £350 million capital expenditure limit, Mr Hyam contended. The fact that the NHCG and Mr Scott were disputing the proposition that the £350 million limit was real and were arguing that the cost of a new build option was lower than the CCG and the Trust supposed, did not create a legal duty to open up the discussion to include a new build option and to include that option on the shortlist.

57. There was no basis, said Mr Hyam, for any legal obligation to disclose the costings supplied by the CCG's consultants for the purpose of determining the shortlist of four options decided upon at the meeting on 30 May 2019. It was enough to comply with the duty of public involvement that the CCG obtained cost forecasts from reputable consultants using Treasury methods and disclosed publicly the financial conclusions of that exercise.

58. Ms Fenella Morris QC, for the Trust, echoed the submissions of Mr Hyam for the CCG. She emphasised, further, that neither the CCG nor the Trust had ever consulted on the process of shortlisting or on options considered not financially viable. The public consultation in 2003 which included a preferred option of building a new hospital at Hatfield, was undertaken at a time when that option was considered viable.

59. Ms Morris contended that the claimant's accusations of unfairness proceeded from the wrong starting point because they focussed on the alleged unfairness of an exercise that was not required to be carried out and then argued that it had to be carried out because the unfairness of what happened meant that full consultation was needed to cure the unfairness. She also emphasised that the claimant's reliance on the *Eisai* case was striking because the facts of that case were very unusual and stark and far removed from the present case.

60. The second ground of the claim is that the CCG erroneously concluded that it was not required to have a formal public consultation about its own preferred option. Mr Wolfe submitted that the CCG drew what he called an arbitrary line between proposals requiring a new hospital to be built and those not requiring that. He argued that the decision that option 1 did not require a formal consultation exercise because no hospital would formally close, was both wrong in law in itself and a factor which influenced, and vitiated, the second decision.

61. Mr Wolfe advanced his argument that the detailed option 1 proposals amounted to a reconfiguration indistinguishable in substance from a hospital closure, since (as he put it in his skeleton argument) "[w]hat is planned is equivalent to closing [Hemel Hempstead] and replacing it with a local health and treatment centre", which "plainly amounts to service reconfiguration".

62. Mr Wolfe submitted that past public discussion and engagement dating back to 2003 and 2007 could not legitimately be relied on by the NHS bodies since they did not relate to the same proposals and opinions; concerns had moved on since then. The public discussions, in particular, did involve the building of a completely new hospital, while the 2019 proposals did not.

63. He also relied on those past consultation exercises as establishing the past practice necessary to generate a common law obligation to consult on this occasion, as he had already argued in his first ground of challenge, to the first decision. He dismissed as irrelevant the point that there had no formal public consultation exercise in 2015 and 2016; on that occasion, no reconfiguration of services resulted.

64. Mr Hyam, for the CCG, reiterated the points made in his response to the first ground of challenge. He emphasised that the decision not to engage in a public consultation exercise before taking the second decision had to be seen in its factual context, which included the detailed public engagement that had taken place leading to the proposals adopted in 2017 but rejected as too expensive by NHS England and NHS Improvement.

65. Ms Morris made submissions to the same effect and noted that the Health Scrutiny Committee of the local authority had not sought any consultation and its views were required under the relevant guidance to be taken into account. The majority of the clinical activity at the three hospitals would be provided within the existing configuration, with only limited changes to the provision at each hospital.

Reasoning and Conclusions

66. I will start with the background factual context. What is striking about the history is that no major decision on reconfiguring service provision has been implemented during the whole of the period from 2003 to the present. The process of appraisal, discussion both in public and private, evaluation of options, bidding for funding and then withdrawing or revisiting proposals, has been going on for nearly two decades without reaching any conclusion.

67. During that period, the wording of the applicable statutory provisions has changed, though I do not need to go through the detail of the changes. The hospital estate, especially at Watford General, has evidently deteriorated further. The amount of funding available was probably relatively generous in 2003, seems to have dipped sharply after 2010 and may now be going up again.

68. My impression is that each time a decision is close, the goalposts move and the decision is then revisited, with a new round of appraisals, business case documents, public and private discussions and budget changes. In the judicial review process too, we have difficulty keeping up with factual developments, as shown by the stay sensibly granted by Johnson J and subsequently lifted.

69. I do not think the nature of the discussions in 2003, 2006, 2007 and 2015 are of much assistance to the court, save that they serve to underline how difficult it is to make a decision about hospital provision, secure funding for it and implement it. The two 2019 decisions now challenged have also not proved capable of implementation, not because of this judicial review but, apparently, because of external political and economic forces.

70. In that factual context, I consider whether the legal duties of the CCG and the Trust were properly performed. The first question is the content of the duties. I agree with the CCG and the Trust that the duty is to ensure public involvement in the decision making process and that is not the same thing as an obligation to consult. The

statutory provisions themselves say that consultation is but one way of performing the duty. There are others, including providing information.

71. Mr Wolfe is correct to observe that guidance documents from NHS England are relevant to the content of the duty in each case. NHS England is empowered to publish such guidance under section 14Z2(4) of the 2006 Act. By subsection (5), the CCG must have regard to it; the Trust, likewise; see section 242(1G) and (1H)(a).

72. However, I do not agree that the passages from the two guidance documents Mr Wolfe relied on bear the weight he places upon them, elevating the duty of public involvement to a duty to carry out a formal consultation exercise. It would be inconsistent with the wording of the statutory duty for me to decide that the only way the CCG and the Trust could perform it is by full public consultation. If that conclusion could ever be properly reached, there would have to be no rational alternative, an unlikely proposition I roundly reject.

73. Nor, in any case, do the citations from the guidance mandate the use of a public consultation exercise. They replicate rather than enlarge the statutory duty of public involvement. That is what guidance documents often do. To say that the duty must be performed in a manner that is "fair and proportionate" is not a way of expanding it or changing its nature. Public functions ordinarily must be carried out in that way, with or without a guidance document saying so.

74. Nor does the history establish anything close to a common law obligation to engage in a public consultation exercise, over and above the statutory duty of public involvement and grafted onto it. The decision making processes adopted from 2003 to 2015, inconclusive as they were, appear to have been varied and conducted in accordance with prevailing statutory provisions (which, as I have said, were differently worded at different times) and with their own dynamics.

75. It is therefore not enough for the claimant to show, as he has done, that less than full and comprehensive information was provided to him, the NHCG and other interested parties. The approach of the CCG and the Trust was (subject always to obligations under the freedom of information legislation) to control the flow of information and to engage interested parties in the discussion through public meetings and the stakeholder evaluation group, without acceding to the demands of the claimant and others for unlimited access to information.

76. That method of proceeding is not necessarily inconsistent with performance of the duty of public involvement. It is true that the claimant and others were not given access to the detailed mathematical calculations and projections used to estimate the cost of the new build options. The contribution of Mr Scott and others to the debate could have been more fully informed than it was, had they had full access to the figures, or if his request for a meeting had been granted. But they were not thereby disabled from challenging the unaffordability of the new build options, nor the rigidity of the £350 million capital expenditure limit.

77. The provision of the headline figures enabled them to make their case and they were thereby involved in the decision making process. The statutory duty required no more than that on the facts here, in my judgment. The gulf between £350 million and some £700 million was very great. These NHS bodies were not obliged to do more than

note well the disparity and consider, with their consultants, whether Mr Scott's figures were realistic. That was done.

78. The rigidity of the £350 million limit was documented in a formal letter from the two national NHS bodies. There was a deadline of July 2019 for submitting the funding bid. The process had been going on for an inordinately long time and the hospital estate was in poor condition and getting worse. It was right for the CCG and the Trust to be concerned about avoidance of delay, as shown by the fact that even now a final decision and implementation is awaited.

79. In oral submissions, Mr Wolfe argued that the board of the CCG was not told in February and March 2019 what the £350 million would pay for and what it would not pay for. He submitted, in effect, that the board was deprived of the benefit of full financial information of the kind Mr Scott wished to place before it and would have been able to put before it if he and the claimant had been privy to the full documents informing the exercise carried out by the consultants appointed by the Trust, when they supplied their cost estimates.

80. Mr Wolfe contended that the case in favour of option 1 was thereby skewed; there was nothing to counterbalance the defective costings supplied by the consultants instructed by the Trust. The board was misled into believing that option 1 would deliver a site that was "NHS compliant", whereas in truth it would not. The defect could have been cured, he submitted, if the claimant had not been repeatedly "stonewalled" when he requested information and documents in the spring of 2019.

81. I do not accept these submissions for two reasons. The first is that they require a level of disclosure and engagement with advocacy of adversarial viewpoints beyond that required by the statutory obligation to involve the public in the decision making process. The obligation is not one to consult fully. Even in a case where there is a statutory or common law duty to consult fully, a consultation document usually need not contain every detail of the calculations and documents behind the calculations used to produce cost estimates.

82. Secondly, the logic of Mr Wolfe's submissions is either that there is only one right answer to the question what the correct cost estimate figures were, or that discussion on the subject must be untrammelled even if mired in controversy down to the detail of individually costed items of anticipated expenditure. Neither proposition is correct. The court is in no position to adjudicate between Mr Scott and the consultants; nor was the CCG obliged to prolong the already protracted considerations by engaging in a detailed and public comparative analysis of Mr Scott's figures and those it had commissioned.

83. Nor do I accept the submission that there was a duty by statute or at common law to consult in the case of the second decision because it involved a *de facto* closure of Hemel Hempstead. The slide presentation document expressing the view that option 1 would not require consultation, while options 2, 3 and 4 would, does not persuade me either that this was a correct statement of the law or that it exerted an improper influence on the decision to select option 1.

84. That option had plenty of other virtues to commend it. They are discussed at great length – perhaps too great length - in the appraisal documents. I think it is unrealistic

to submit that the wording of that particular slide is capable of creating or supporting the existence of a duty to consult publicly where one could not otherwise be extracted from the statutory provisions and on the facts.

85. Finally, I am conscious that when the second decision was taken on 11 July 2019, those involved in taking it and in seeking to influence it would, realistically, have recognised that it could not be regarded as necessarily set in stone. It was likely that, even after it, the claimant and those of like mind would remain able to press their case for a revision to the outcome, as they still can.

86. This point does not impact directly on whether the first or second decisions were lawful at the time they were made. It is of relevance mainly to the question of relief, to which I shall turn in a moment. But it does also lend some force to the proposition that too much procedural baggage can lead to the long delays and shifting of the scenery that has defeated attempts to decide upon and implement much needed changes to west Hertfordshire hospitals during this century.

Relief

87. It follows, for those short reasons, that the claim must fail and the question of what relief to grant, if any, does not arise. I will address the issue in case my decision on the merits turns out to be wrong and the case goes further. In his grounds and his skeleton argument, Mr Wolfe sought declarations that both decisions were unlawful and an order quashing each of them. In his oral submissions, he indicated that he might accept that quashing orders were now unnecessary; though he still pressed for at least an appropriate declaration.

88. If I were of the view that the CCG ought to have consulted publicly before making the two decisions and that they were taken unlawfully in consequence of its failure to do so, the CCG and the Trust argued that I must refuse relief anyway because it is highly likely that if the conduct complained of had not occurred, the outcome would not have been significantly different for the claimant: section 31(2A)(a) of the Senior Courts Act 1981.

89. Mr Hyam put it thus in his skeleton argument:

> "The Court can say with confidence that had there been a requirement for formal public consultation and had fairness required disclosure of the Arcadis costs information as part of that formal public consultation, (rather than the disclosure of a report outlining the costs estimates and how those figures had been arrived as was disclosed on 16th June 2019) then Robert Scott and/or the Claimant would have made the same, or substantially similar representations about the SOC and the options as they have in fact been able to make as part of the analysis by external consultants commissioned by NHS Improvement of alternatives and their costs. Had the same representations been made to the decision maker (WHHT [the Trust] and CCG) then in the light of the NHS Improvement's externally commissioned draft independent analysis, Option 1 would have remained the preferred and only realistic and affordable option to pursue by reference to the cost constraint imposed by NHS Improvement."

90. Ms Morris, for the Trust, reminded me of the Court of Appeal's warning in *Gathercole v Suffolk CC* [2020] EWCA Civ 1179: "[i]t is important that a court faced with an application for judicial review does not shirk the obligation imposed by

Section 31 (2A)" (per Coulson LJ at [38]). She made detailed submissions to the effect that a consultation exercise along the lines advocated by the claimant would have made no difference to the outcome.

91. The gist of her argument was that "the options that were excluded had been costed at double the capital limit set by the regulators"; that "[t]his has now been verified by three different sets of independent consultants; and that "Robert Scott's own analysis also concluded that these options would cost significantly more than £350 million (albeit he thought that the preferred option would also cost more)."

92. Mr Wolfe made quite detailed arguments to the contrary effect. He pointed out that the decision maker would have had to consider conscientiously, with an open mind, at the formative stage before the shortlisting decisions were taken, the product of the public consultation that did not take place. He referred to the strength of feeling at the time. He submitted that after the event costings were no substitute for carrying out the exercise properly.

93. Mr Wolfe contended that refinements of the proposals would have emerged in consultation as a result of challenges to the rejection of a new build emergency and specialist hospital on a clear site, with elective care being provided on one of the existing sites; and that "blended or phased funding options" should have been considered and would have been had the consultation exercise taken place.

94. He submitted that the court could be in danger of being drawn into the forbidden territory of assessing the merits of the decisions challenged, which the Court of Appeal warned against in *R (on the application of Plan B Earth) v Secretary of State for Transport* [2020] EWCA Civ 214 at [273] (in the judgment of the court given by Lindblom, Singh and Haddon-Cave LJJ). He also cautioned against accepting *ex post facto* views about what the outcome would have been, expressed in the course of litigation.

95. To decide the issue, the court "must necessarily undertake its own objective assessment of the decision-making process, and what its result would have been if the decision-maker had not erred in law" (*R (Goring-on-Thames Parish Council) v. South Oxfordshire District Council* [2018] EWCA Civ 860, [2018] 1 WLR 5161, per Sir Terence Etherton MR at [55]).

96. I remind myself that "[t]he concept of "conduct" in section 31(2A) is a broad one, and apt to include both the making of substantive decisions and the procedural steps taken in the course of decision-making. It is not expressly limited to 'procedural' conduct" (*ibid.* at [47]).

97. By section 31(8) "… *'the conduct complained of'*, in relation to an application for judicial review, means the conduct (or alleged conduct) of the defendant that the applicant claims justifies the High Court in granting relief". It is therefore necessary to identify the conduct which, in this case, justifies the grant of relief. Here, the conduct complained of is the making of the two impugned decisions without having first engaged in public consultation on the subject.

98. I bear in mind these well made submissions on all sides. The "highly likely" test is not always easy to apply. It expresses a standard somewhere between the civil

standard (the balance of probabilities) and the criminal standard (beyond reasonable doubt); with the complication that the standard must be applied to a hypothetical or "counterfactual" situation that did not occur.

99. The court has the unenviable task of (i) assessing objectively the decision and the process leading to it, (ii) identifying and then stripping out the "conduct complained of" (iii) deciding what on that footing the outcome for the applicant is "highly likely" to have been and/or (iv) deciding whether, for the applicant, the "highly likely" outcome is "substantially different" from the actual outcome.

100. In the present case, even making every allowance for Mr Wolfe's argument to the effect that one can rarely ever know what would have happened, mindful of my obligation not to shirk the task of deciding (if the point arose) exactly that, applying the "highly likely" standard of proof, I am confident that the outcome would not have been different. I think the gulf between the claimant's proposals and the funding position in mid-2019 was too wide.

101. I do not think Mr Scott's financial analysis would have had any realistic prospect of carrying the day, if the CCG and the Trust had carried out a full blown public consultation. His account of the figures would have been highly likely to have had no impact on the reasoning and decisions of the CCG and the Trust, however strongly argued it would have been in a public consultation. The CCG and the Trust would have tested the figures with their consultants and the result would have been the same as those consultants have since found.

102. The fact that a new build emergency specialist hospital on a clear site may now seem less unaffordable than it did in the middle of 2019 does not alter that reasoning. The timing of the decisions challenged in this litigation would have been put back by only a few months at the most if full public consultation had taken place. The decisions would not have been postponed sufficiently for the funding position to have altered in the way it may now have altered.

103. For those reasons, it does appear to me highly likely that the outcome for the claimant would not have been substantially different if the conduct complained of had not occurred and I would therefore, if the point had arisen, have considered myself obliged to refuse relief under section 31(2A) of the 1981 Act.

104. The Trust, supported by the CCG, also took a further point: that relief should be refused because to grant it would be detrimental to good administration. I thought at first that this was a point taken by reference to section 31(6) of the Senior Courts Act 1981, which provides that the court may refuse relief where to grant it would be "detrimental to good administration"; but that sub-section only applies where "the High Court considers that there has been undue delay in making an application for judicial review"; which is not suggested here.

105. Rather, as Ms Morris explained, the submission is founded in the judgment of Lord Donaldson MR in *R. v. Monopolies and Mergers Commission ex p. Argyll Group plc* [1986] 1 WLR 763, at 774: the court should approach its duties with "proper awareness of the needs of public administration", which required it to consider substance rather than form, the speed of decisions, the public interest and the

legitimate interest of individual citizens and the need for decisiveness and finality, unless there are compelling contrary reasons.

106. Mr Wolfe pointed out the strong line of authority emphasising the importance of the proposition, central to the rule of law, that wrongs should be remedied; and that cases where relief is denied in the face of an unlawful decision should be wholly exceptional. He emphasised that the recent revisiting in September 2020 of the reconfiguration decisions and the funding that may now be available in support them, has not produced a clear superseding decision rendering the challenged decisions in mid-2019 academic.

107. The claimant had sought, in recent correspondence, clarity from the CCG and the Trust about what the current status of the earlier decisions was and had concluded from the responses that the present challenge was still necessary and had to be maintained and adjudicated upon in court; it was not accepted by the CCG and the Trust that those earlier decisions could be wholly ignored. They underpinned the SOC which was part of the government's decision about willingness to support and fund decisions about NHS provision.

108. The context of Lord Donaldson MR's reasoning in the *Argyll Group plc* case was very different; there had been a misdirection as to the powers of the chairman and a procedural irregularity in the course of determining a reference to the Monopolies Commission. Not only would the result clearly have been the same if the correct procedure had been followed; third parties needed to know if they could act in reliance on the decision; and relief was refused in the exercise of the court's discretion.

109. If I had found the two decisions to have been unlawfully taken for want of public consultation, I would not have refused relief, apart from section 31(2A) of the 1981 Act, applying the reasoning in *Argyll Group plc*. I accept that refusal of relief in the exercise of the court's discretion is not confined to cases where the "highly unlikely" test in section 31(2A) is met; the court always retains a residual discretion to refuse relief. However, aside from section 31(2A), specific justification is needed for a court to refuse relief where it has found the decision challenged to have been taken unlawfully.

110. Refusal of relief where the decision challenged is plainly unlawful is normally confined to recognised cases; where there is a suitable alternative remedy or the decision has become academic or for some other reason the grant of relief would be pointless or merely symbolic or tokenistic. Relief is not refused merely because granting it would be inconvenient to the decision maker or the public; it is also a matter of public importance that decision makers make decisions lawfully and are held to account by the court if they do not.

111. This is not a case falling within any of those exceptional categories. It is likely that the refusal of relief in the *Argyll Group plc* case would now be grounded in section 31(2A); the court would not have needed to have recourse to its residual discretion. I would not in this case have refused relief, had I found the decisions challenged to be unlawful, if it were not for the statutory requirement to do so applying the stringent test in section 31(2A) of the 1981 Act.

112. I have set out my reasoning on the question of relief in case it is of use to the parties. However, for reasons given earlier in this judgment, I do not accept that there was any legal flaw in the two decisions challenged and the claim for judicial review must therefore fail on its merits. I dismiss it.