Neutral Citation Number: [2020] EWHC 372 (Admin)

Case No: CO/1908/2019 & CO/1926/2019

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

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 21st February 2020

Before :

MRS JUSTICE FARBEY

- -

Between :

THE QUEEN ON APPLICATION OF A	**First Claimant**
-and-	
THE QUEEN ON APPLICATION OF MARION KEPPEL	**Second Claimant**

- and –

(1) SOUTH KENT COASTAL CCG **(2) WEST KENT CCG** **(3) MEDWAY CCG** **(4) BEXLEY CCG** **(5) CANTERBURY COASTAL CCG** **(6) SWALE CCG** **(7) ASHFORD CCG** **(8) DARTFORD GRAVESHAM & SWANLEY CCG** **(9) THANET CCG** **(10) HIGH WEALD LEWES HAVENS CCG**	**Defendants**
(1) KENT COUNTY COUNCIL **(2) MEDWAY COUNCIL**	**Interested Parties**

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David Blundell & Hannah Gibbs
(instructed by **Leigh Day**) for the **First Claimant**
Jenni Richards QC & Annabel Lee
(instructed by **Irwin Mitchell LLP**) for the **Second Claimant**
Fenella Morris QC & Benjamin Tankel
(instructed by **Capsticks**) for the **Defendant**
David Lock QC & James Neill
(instructed by **Medway Council**) for the **Second Interested Party**
The first Interested Party did not appear and was not represented

Hearing dates: 3, 4 and 5 December 2019
Written submissions: 30 January 2020

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Approved Judgment

Judgment Approved by the court for handing down.

MRS JUSTICE FARBEY :

Introduction

1. This is an application for judicial review of the decision of the defendants taken on 14 February 2019 to de-commission acute stroke services at Queen Elizabeth the Queen Mother Hospital (QEQM) in Thanet, Kent. Following a review of stroke services and a public consultation, the defendants have decided to establish three hyper-acute stroke units (HASUs) in Kent at Darent Valley Hospital, Maidstone Hospital and William Harvey Hospital respectively. The defendants have decided that the stroke unit at QEQM will not become a HASU and so it will close down.

2. The first claimant is a 59-year old man granted anonymity in these proceedings by order of Thornton J dated 31 May 2019. He has lived in Thanet for six years, currently residing in Westgate-on-Sea. He is a committee member of Save our NHS in Kent (SONiK) which has campaigned against the closure of the QEQM stroke unit. He was diagnosed with autism and Generalised Seizure Disorder three years ago. He has been told by doctors that he is at increased risk of stroke owing to a number of health conditions and lifestyle factors (for example, smoking from an early age).

3. The second claimant is a life-long resident of Ramsgate in Thanet. She has complex health needs and is at high risk of suffering a stroke. She regularly attends QEQM for hospital appointments. Her husband was successfully treated at QEQM for stroke in 2016. The claims are supported by SONiK. Ms Carly Jeffrey, a SONiK committee member, has provided a detailed witness statement.

4. The defendants are the Clinical Commissioning Groups (CCGs) responsible for commissioning healthcare services in Kent. In 2017, they formed a Joint Committee of Clinical Commissioning Groups (JCCCG) to consider how best to commission services in order to meet the needs of the people in their area for stroke treatment.

5. The interested parties are local authorities. The first interested party has taken no part in the proceedings. The second interested party - which represents the population in Medway in Kent - supports the claim and, like the claimants, invites the court to quash the decision. Its interest in the proceedings derives from its public health functions and duties under section 2B of the National Health Service Act 2006 which requires it to take such steps as it considers appropriate for improving the health of the people in its area. As a public health authority for an area affected by the defendants' decision, the second interested party was consulted and expressed its views to the defendants on the relevant issues prior to the decision.

6. By order of Sir Wyn Williams sitting as a Judge of the High Court, the claim was listed for a "rolled-up" hearing in order that the application for permission to apply for judicial review and the substantive claim be heard at the same time. I heard oral submissions over the course of three days. Mr David Blundell and Ms Hannah Gibbs appeared on behalf of the first claimant. Ms Jenni Richards QC and Ms Annabel Lee appeared on behalf of the second claimant. Ms Fenella Morris QC and Mr Benjamin Tankel appeared on behalf of the defendants. Mr David Lock QC and Mr James Neill appeared on behalf of the second interested party.

7. Following the hearing, the Court of Appeal handed down judgment in *R (Nettleship) v NHS South Tyneside CCG and anr* [2020] EWCA Civ 46 which touches on similar issues. I received written notes on *Nettleship* on behalf of the claimants and the defendants. No party requested a further oral hearing. I am grateful to counsel for their oral and written submissions.

Factual background

Social deprivation and risk of stroke

8. At the heart of this case are the concerns of the claimants and the second interested party about health inequalities for socially deprived people living in Thanet. I have received competing evidence about social deprivation in Thanet including a detailed witness statement from Dr David Whiting who is employed by the second interested party as a public health consultant. He gives evidence on the distribution of areas of deprivation within Kent and the relationship between deprivation and stroke incidence, challenging the defendants' analysis. Subject to limited exceptions which do not apply here, it is not the function of the court to make findings of fact in judicial review proceedings. In terms of what is relevant and material to the issues of law which I must decide, the following analysis suffices.

9. According to information published by Public Health England, Thanet is one of the 20% most deprived areas in England. The Indices of Deprivation 2015 show that it continued to rank as the most deprived part of Kent. There is a connection between social deprivation and poor health. Life expectancy for both men and women in Thanet is lower than the average in England. There is evidence before me, however, that Thanet is not the only deprived area in Kent. There are other pockets of deprivation in urban, coastal and estuarial areas.

10. In general, people from more deprived areas have an increased risk of stroke. People from the most economically deprived areas of the United Kingdom are around twice as likely to have a stroke and are three times more likely to die from a stroke than those from the least deprived areas. A number of lifestyle factors in deprived communities (such as obesity, physical inactivity and an unhealthy diet) contribute to that increased risk. Priorities in Thanet include reducing early death from a number of causes including stroke.

Access to emergency treatment for stroke

11. Thanet lies on the north-eastern edge of Kent. If the stroke unit at QEQM closes, stroke sufferers who live in Thanet will have to travel further to be treated for stroke. Their families and carers will have to travel further in order to visit them. The claimants and second interested party are concerned that the burden of increased journey times will be borne by a group of people more likely than others to suffer stroke and (save for patients conveyed by ambulance) less able to afford the travel costs.

12. It is not in dispute that stroke patients need timely treatment. The defendants' evidence shows that recovery from a stroke is significantly influenced by:

    i. Seeing a stroke consultant within 24 hours;

ii. Having a brain scan within 1 hour of arriving at a hospital;

iii. Being seen by a stroke-trained nurse and one therapist within 72 hours of admission; and

iv. Being admitted to a dedicated stroke unit.

13. As at April 2017, the Royal College of Physicians assessed that around 80% of people having a stroke in England arrived at hospital by ambulance. National, non-mandatory guidelines from NICE (1 May 2019) recommend the admission of everyone suspected of stroke "directly to a specialist stroke unit" and the administration of emergency thrombolysis (clot-busting treatment for which around 20% of patients are eligible) if "treatment is started as soon as possible within 4.5 hours of onset of stroke symptoms".

14. The Royal College of Physicians National Clinical Guideline for Stroke (2016) contains recommended clot-busting treatment times:

i. Patients with acute ischaemic stroke, regardless of age or stroke severity, in whom thrombolytic treatment can be started within 3 hours of known onset should be considered for such treatment.

ii. Patients with acute ischaemic stroke under the age of 80 years in whom thrombolytic treatment can be started between 3 and 4.5 hours of known onset should be considered for it.

iii. Patients with acute ischaemic stroke over 80 years in whom thrombolytic treatment can be started between 3 and 4.5 hours of known onset should be considered for it on an individual basis. In doing so, treating clinicians should recognise that the benefits of treatment are smaller than if treated earlier, but that the risks of a worse outcome, including death, will on average not be increased.

15. Local written standards in Kent stipulate that the care of people with suspected stroke should aim to minimise time between a call to emergency services and the administration of thrombolysis, for the proportion of patients who need it. This “call to needle” time should be less than 120 minutes. In practical terms, this means:

i. The time from a 999 call to the ambulance service to bringing a patient to the hospital door should be as short as possible and less than 60 minutes; and

ii. The time from arrival at the hospital door to thrombolysis should be as short as possible and less than 60 minutes.

16. The defendants have since at least July 2015 regarded both these 60-minute targets as "key clinical targets". Current standards of best practice indicate that, in cases where clot busting treatment is necessary, it should be administered within 4.5 hours from the onset of a patient's symptoms. The defendants' evidence is that its 120-minute "call to needle" timeframe is "well within the national 4.5 window and therefore optimises the clinical benefits available to patients."

17. Speed of treatment is not the only factor relevant to clinical outcomes in this field of medicine. The defendants' evidence makes plain that there is a connection between recovery from stroke and the kind of stroke service which CCGs provide. The 2016 Clinical Guideline says that thrombolytic treatment should only be administered within a well-organised stroke service with:

    i. Processes throughout the emergency pathway to minimise delays to treatment, to ensure that thrombolysis is administered as soon as possible after stroke onset;

    ii. Staff trained in the delivery of thrombolysis and monitoring for post-thrombolysis complications;

    iii. Specialist nursing staff. A minimum of six thrombolysis-trained staff should be available at any time of day or night;

    iv. Immediate access to imaging and re-imaging;

    v. Protocols in place for the management of post-thrombolysis complications.

18. National guidelines state that patients with a suspected transient ischaemic attack ("TIA"; also known as a mini-stroke) should be given aspirin and assessed urgently by a neurological specialist or at an ASU. I do not need to deal separately with TIA which did not form the subject of discrete submissions before me.

The pre-consultation decision-making process

19. On the current model in Kent and Medway, hospital stroke services are provided by four hospital trusts across six acute hospital sites. The average number of stroke patients treated across the catchment area is 3,010. East Kent Hospitals University NHS Foundation Trust (EKHUFT) provides stroke services in QEQM in Margate and William Harvey Hospital in Ashford.

20. As set out in the witness statement of Mr Glenn Douglas (the relevant Accountable Officer for the defendants and a member of the defendants' Joint Committee of CCGs), the decision to close QEQM's stroke unit has been years in the making. In 2014, the Kent and Medway Sustainability and Transformation Partnership (STP) launched a Stroke Services Review. The impetus for the Review was that poor Sentinel National Audit Programme (SSNAP) scores – indicating poor services- were recorded across all hospital sites in the area. In July 2015, the Review published a Case for Change. That document takes into consideration the National Stroke Strategy 2007 which says that the key to successful outcomes for stroke patients is treatment in a "high quality stroke unit with rapid access to diagnostics, specialist assessment and intervention."

21. The Review recognised the importance of effective primary prevention and rehabilitation but the 2015 Case for Change focused on improving treatment and care in the hyper-acute/acute phase. The aim of the Review was, therefore, to ensure the delivery of clinically sustainable, high quality, hyper-acute/acute stroke services for the next ten to fifteen years, that are accessible to Kent and Medway residents 24 hours a day, seven days a week.

22. The Review was not designed to prioritise the needs of socially deprived groups within Kent. The objective of designing a new service was to take into consideration the needs of all Kent and Medway residents who experience stroke as well as the needs of their families. For reasons that should not require elaboration, the Review proceeded on the basis that patients should be given the best possible chance of survival and the risk of disability should be minimised.

23. The 2015 Case for Change nevertheless considered the "stroke profiles" for the relevant CCGs based on data provided by Public Health England. East Kent (where Thanet is located) had the highest prevalence of risk factors. Stroke prevalence in Thanet was 2.7% compared with the 2.0% national average. Deprivation levels in Thanet were considered.

24. The Kent and Medway Stroke Programme Board was established in January 2015. It comprised NHS commissioners and service providers from across Kent and Medway as well as patient, local authority and Stroke Association representatives. The Programme Board provided an oversight function in relation to the Review. The Board was supported by (among other bodies) a Patient and Public Advisory Group. Public involvement was therefore engrained within the Review. NHS England also played its role in the work of the Review, providing oversight and assurance in relation to the defendants' statutory duties.

25. In November and December 2015, the defendants held three "People's Panels" aimed at patients and members of the public which considered the case for change in detail. The defendants' evidence is that the panels questioned and challenged the emerging proposals for improving future stroke care and voted on different aspects of stroke services, providing their view on what they, as patients and carers, valued most. There is no reason for this court to go behind that evidence.

26. The Review confirmed that the specialist HASU/ASU model based on national guidance was expected to bring a number of benefits to patients in Kent and Medway:

    i. Improved care and outcomes, ensuring that patients will be given the best possible chance of survival and minimising disability from stroke;

    ii. Access to 24-hour, 7-day specialist care, regardless of where in Kent and Medway the patient resides;

    iii. Sustainable stroke services for all residents;

    iv. High performance against national best practice, assisted by a minimum of 500 patients per annum to maintain workforce experience;

    v. A specialist workforce; and

    vi. Consistency of stroke care for Kent and Medway residents regardless of where they live.

27. Following the Review, the defendants started working on a plan to reconfigure stroke services and establish HASUs/ASUs. In March 2016, the defendants ran a "challenge session" with (among others) patient and public representatives to test the work to date

and the emerging options. In September and October 2016, there was a further series of events involving people who had suffered a stroke, their carers, and members of the public.

28. In 2017, "listening events" were held in every CCG area in Kent and Medway. Attendees included Stroke Association representatives, stroke survivors and carers. A further workshop was held in Ashford which was publicised to the wider public. There were a further 15 focus groups. Efforts were made to include those with protected characteristics under the Equality Act 2010 and other "seldom heard" groups.

29. In January 2018, the defendants received a pre-consultation Integrated Impact Assessment (IIA) compiled by independent consultants. This detailed report contained a health impact assessment, a travel and access impact assessment, and an equality impact assessment. The latter assessed the impact of change on groups with protected characteristics under section 149 of the Equality Act and on deprived communities. There is an express reference to the Equality Act 2010. There is no express reference to duties to socially deprived groups who fall outside the 2010 Act but it is plain that the purpose of considering deprived communities was to assist the defendants to meet those duties. The impact on journey times was assessed and was described in a manner that has not been challenged by the claimants or second interested party.

30. The IIA was reviewed by a bespoke Task and Finish Group which focused on the defendants' equality duties and its health inequalities duties. The Group comprised representatives from CCGs, local authorities and patient representatives.

31. In relation to stroke treatment, the defendants published a Pre-Consultation Business Case (PCBC) on 24 January 2018. The PCBC sets out in detail how the defendants developed their proposals for change to stroke services.

32. The PCBC shows that a decision was taken to develop stroke services at existing acute hospitals in Kent and Medway (of which there are seven) rather than to develop new sites. A theoretical long list of 127 options was reached. The next stage was to filter those options to a realistic and manageable medium list for detailed consideration. In order to achieve this, five criteria were deployed which were "hurdle criteria" in the sense that they each had to be surmounted before an option could progress to the medium list. Whether the services would be accessible to patients and carers was one of the hurdle criteria.

33. In relation to the accessibility criterion, the key question was whether the population would be able to access services within a window of 120 minutes from "call to needle." In applying that timeframe, clinicians developed a proxy measure for journey time, namely that 95% of the confirmed stroke population would have door-to-door access to a stroke unit (i.e. from arrival of an ambulance to reaching the unit) within 60 minutes at peak travel times. There is no challenge to the defendants' modelling of travel times.

34. Clinicians recommended that there should be three HASUs as it would not be possible to staff more than three units. An additional fourteen consultants would be needed to staff four or more units, which would be challenging against the background of national shortages in stroke consultants.

35. Application of the hurdle criteria led to a medium list of thirteen options, each containing three hospitals. QEQM featured in seven of the medium list options. A shortlist of five options was then drawn up for public consultation. All the medium list options were considered to be acceptable as having met the hurdle criteria. The evaluation of the remaining options therefore sought to weigh the advantages and disadvantages in accordance with specified evaluation criteria.

36. These evaluation criteria were developed by clinicians but with involvement from patients and the public. Draft criteria were developed and then tested in July and August 2017 with the involvement of: eight focus groups; support groups run by the Stroke Association; an online and paper survey; and a stakeholder event with an open invitation to members of the public. Quality, access and workforce were the top-rated criteria across all these forms of public involvement. Patient choice came last.

37. The finalised criteria were as follows:

    i. Quality of care for all;

    ii. Access to care for all;

    iii. Workforce;

    iv. Ability to deliver; and

    v. Affordability and value for money.

38. All seven of the medium list options which contained QEQM were ranked poorly or very poorly on quality of care. The five options that went forward to public consultation were ranked highest on quality. The claimants emphasise that options including QEQM failed to pass the evaluation criteria because QEQM cannot provide adequate co-dependent services, described in some of the documents as clinically "desirable" rather than as key to the viability of stroke services.

39. In March 2018, the STP published a general Case for Change, not limited to stroke services. It concluded that there was insufficient focus on ill-health prevention across the whole of the Kent and Medway health system. It identified those particular areas with a higher level of deprivation. It noted that higher levels of deprivation were linked to a number of health problems which could be reduced by a greater focus on prevention. It noted that stroke was "by far the worst performing service, failing to meet at least 67% of standards across…Kent and Medway."

Public consultation

40. The defendants' public consultation ran for 11 weeks from 2 February to 13 April 2018. The consultation document ("Improving Urgent Stroke Services in Kent and Medway") stated: "We are consulting on the proposal to establish hyper acute stroke units; whether 3 is the right number; and 5 potential options for their location." It set out the five shortlisted options but also said: "We would welcome your comments on all the options or other options you think we should consider". I shall return to the effect of this broader request for comments and to the details of the public consultation below.

41. The results of the public consultation were collated by an independent research consultancy in a report in summer 2018. SONiK's voice was expressly included in the report. It was noted that SONiK wanted stroke services to stay at QEQM. SONiK is referenced in the report as opposing the current proposals on the grounds that the defendants had failed to identify alternatives; failed to publicise the proposals adequately; failed to consult; and failed to provide adequate information.

42. The report set out residents' concerns over the reality of stated travel times: the key concern was whether the modelled travel times are realistic, in light of the risk of gridlock on the roads, increased traffic during summer months, increases in population, the poor state of roads and road closures. The impact of location on patients' families, who would be forced to travel long distances on hospital visits, was firmly raised.

43. The report sets out how members of the public expressed the view that residents of Thanet would live too far from any of the defendants' proposed options. Written responses to the consultation "centred around the desire for an option closer to Thanet." Many people "did not feel any option is suitable, and expressed a desire for…QEQM…to be reconsidered as one of the options." All options were "perceived to leave East Kent (particularly Thanet) at a disadvantage with little or no choice."

44. The report highlighted that all the proposed options were seen as leaving East Kent at a disadvantage:

> " one of the key areas of concern is that no options under consideration include an East Kent hospital, and in particular that Thanet is a long way from any hospitals under consideration."

45. The report states:

> "Across all strands of the consultation, the desire to maintain services at QEQM and consider the needs of the residents of Thanet has been made clear".

46. Key areas of concern regarding the decision-making process included the omission of QEQM from the shortlist. The report sets out how a significant proportion of people responded to the consultation by saying that Thanet should not have been excluded.

47. The report contains a section entitled: "Need: areas of deprivation and elderly populations will be least well served". It records:

> "Residents are particularly concerned East Kent has no HASU option yet has both higher proportions of elderly residents and some of the most deprived areas in the country - both of which are linked to higher incidences of stroke."

48. In summary, the report makes clear that respondents to the consultation raised questions as to why QEQM had not been prioritised and included in the options, given the levels of deprivation in Thanet and the distance that residents of Thanet would need to travel to any of the hospitals included in the proposed options.

49. The defendants were therefore aware from the public consultation that members of the public wanted a HASU in Thanet. Mr Douglas says in his second witness statement that an informal workshop discussed this issue on 28 June 2018. The workshop comprised members of the JCCCG and representatives from the consulting CCGs. The defendants further discussed the number of HASUs and the question of locating a HASU at QEQM at a formal meeting on 28 August 2018.

Post-consultation decision-making

50. Following the consultation, in September 2018, a further independent IIA was published, taking into account the findings of the public consultation. In support of the IIA, eight interviews were undertaken with "equality leads"; three interviews were undertaken with community groups; and five focus groups were undertaken with groups considered to have a disproportionate need for stroke services. A focus group in Margate covered the Thanet CCG and sought the views of those suffering social deprivation.

51. The defendants reviewed and updated the evaluation criteria and methodology. A "preferred option workshop" was held in September 2018. Attendees included local councils, expert advisors, clinical professionals and observers.

52. Mr Douglas in his witness statement sets out the careful methods adopted at the workshop to ensure evidence-based, robust and non-partisan decision-making. The unanimous view of participants was that "Option B" was the preferred option, i.e. Darent Valley Hospital, Maidstone General Hospital and William Harvey Hospital. Option B was the strongest option across metrics relating to quality, access, workforce, implementation and value for money.

53. On 22 January 2019, the decision-making business case (DMBC) for the review of urgent stroke services in Kent and Medway was published. This detailed and evidence-based document (which took account of groups protected by equality law and those from deprived communities) recommended Option B and concluded;

> "As part of the work to shortlist options, …EKHUFT… concluded that it would not be possible to run two Hyper Acute Stroke Units because it would be very difficult to deliver due to recruitment issues and the risks around staff relocation. Of the sites run by the trust, the William Harvey Hospital was identified as the best option for a hyper acute stroke unit. This was because of the existence of other services that are desirable to have located alongside a hyper acute stroke unit."

54. The claimants therefore emphasise that QEQM fell out of the equation because it cannot provide "desirable" as opposed to clinically necessary services.

The decision under challenge

55. The defendants' decision was taken at a committee meeting on 14 February 2019. The proposals were discussed including the evaluation criteria, increased travel times, workforce concerns, viability of four sites and the implementation process. The

committee agreed that Option B should be implemented. NHS England support the decision.

56. Under the proposed new configuration, the nearest HASU to the first claimant's home will be WHH, approximately 37.5 miles away whereas QEQM is approximately 3.6 miles away. The second claimant will have to travel 36.7 miles to WHH.

Legal framework

57. If a public authority withdraws a benefit previously afforded to the public, it will usually be under an obligation to consult the beneficiaries of that service before withdrawing it: *R (LH) v Shropshire Council* [2014] EWCA Civ 404, [2014] PTSR 1052, para 21.

58. In *R v Brent London Borough Council, Ex parte Gunning* (1985) 84 LGR 168, the court summarised the salient features of a fair consultation:

    i. It must be undertaken at a time when proposals are still at a formative stage;

    ii. The proposer must give sufficient reasons for any proposal to permit of intelligent consideration and response;

    iii. Adequate time must be given for consideration and response; and

    iv. The product of consultation must be conscientiously taken into account in finalising any statutory proposals.

59. In *R (Moseley) v Haringey London Borough Council* [2014] UKSC 56, [2014] 1 WLR 3947, Lord Wilson (at para 25) endorsed the *Gunning* principles. He also advanced (at para 24) two purposes of the duty to consult which he took from the judgment of Lord Reed in *R (Osborn) v Parole Board* [2014] AC 1115, paras 67 and 68:

    i. A fair consultation "is liable to result in better decisions, by ensuring that the decision-maker receives all relevant information and that it is properly tested";

    ii. It avoids "the sense of injustice which the person who is the subject of the decision will otherwise feel".

60. Lord Wilson added (at para 24) that the duty to consult affected members of the public has an important democratic value. In another well-known passage, he held at para 27:

> "Sometimes, particularly when statute does not limit the subject of the requisite consultation to the preferred option, fairness will require that interested persons be consulted not only upon the preferred option but also upon arguable yet discarded alternative options."

61. Even when the subject of the requisite consultation is limited to the preferred option, fairness may nevertheless require "passing reference to be made to arguable yet discarded alternative options" (para 28).

62. Section 3 of the National Health Service Act 2006 sets out duties of CCGs as to the commissioning of health services. It provides in so far as relevant:

> "(1) A clinical commissioning group must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility –
>
> (a) hospital accommodation,
>
> (b) …
>
> (c) medical, …nursing and ambulance services,
>
> (d) …
>
> (e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the [CCG] considers are appropriate as part of the health service,
>
> (f) such other services or facilities as are required for the diagnosis and treatment of illness."

63. Section 14R of the same Act lays down a duty on CCGs as to improvement in quality of healthcare services. It provides in so far as relevant:

> "(1) Each clinical commissioning group must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness.
>
> (2) In discharging its duty under subsection (1), a clinical commissioning group must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services
>
> …".

This duty is owed to everyone (irrespective of personal characteristics).

64. Section 14T sets down duties as to reducing inequalities between patients in accessing healthcare services and in the outcomes achieved by such services:

> "Each clinical commissioning group must, in the exercise of its functions, have regard to the need to—
>
> (a) reduce inequalities between patients with respect to their ability to access health services, and
>
> (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services."

65. The duty is to "have regard" to the need to reduce inequalities. In December 2015, NHS England published guidance to assist decision-makers including CCGs in discharging the duty ("Guidance for NHS commissioners on equality and health inequalities legal duties"). It mentions a "move towards greater investment in health and health care where the level of deprivation is higher". CCGs should look at "how the outcome is distributed across society by area of deprivation and by different groups, rather than by focusing on average outcomes for all people". Achieving universal healthcare may require targeting specific population groups and by ensuring that "the quantity and quality of services in deprived areas is adequate."

66. Section 14V deals with the duty on CCGs as to patient choice:

> "Each [CCG] must, in the exercise of its functions, act with a view to enabling patients to make choices with respect to aspects of health services provided to them."

67. Section 14Z2 concerns duties on CCGs to involve and consult the public in planning and developing healthcare services including proposals for change. It provides in so far as relevant:

> "(1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").
>
> (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)—
>
> (a) in the planning of the commissioning arrangements by the group,
>
> (b) 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
>
> (c) 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.
>
> …"

68. The duty in section 14Z(2)(b) to involve and consult the public in relation to changes in the provision of health services extends only to proposals for change. There is no duty to consult on options which the CCGs deem to be unviable, unrealistic or unsustainable as they do not represent proposals for change: *Nettleship*, para 56.

69. The public sector equality duty (PSED) is contained in section 149 of the Equality Act 2010 which provides:

> "(1) A public authority must, in the exercise of its functions, have due regard to the need to—
>
> (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
>
> (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
>
> (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
>
> …
>
> (3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
>
> (a) remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
>
> (b) take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
>
> (c) encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.
>
> …"

70. Public bodies must therefore have "due regard" to the factors and considerations set out in section 149. That duty is an integral and important part of the mechanisms for ensuring the fulfilment of anti-discrimination legislation: *R (Bracking) v Secretary of State for Work and Pensions* [2013] EWCA Civ 1345, para 26.

The grounds for judicial review

71. The claimants and the second interested party raised lengthy grounds of challenge. Although not every ground was supported by each of them, it is convenient to set out the grounds compendiously:

> **Ground 1:** The defendants misunderstood or failed to discharge the health inequality duty under section 14T of the Act. The defendants' decision to close the QEQM stroke unit means that the most deprived areas to the east of Kent including Thanet will experience an increase in travel times to hospital by ambulance. Only 81.3% of those

from the most deprived quintile of the population will be able to access stroke services within 45 minutes compared to 92.4% of the general population. Of Thanet's population, 17% will not be able to access a HASU in 60 minutes.

Ground 2: The defendants failed to consider and failed to make sufficient inquiries into whether and how stroke prevention measures could mitigate the effects of the decision to remove stroke services from QEQM. The grounds for judicial review contend that: "Given how critical prevention was deemed to be to the decision, it was irrational for the [defendants] to proceed to [a] final decision without adequately considering and making sufficient inquiry into the matter of prevention".

Ground 3: The defendants "failed to make sufficient inquiry into workforce recruitment issues" when deciding that it was not viable to have a HASU at QEQM.

Ground 4: The defendants failed to discharge their duty as to patient choice under section 14V of the 2006 Act.

Ground 5: The defendants' consultation was unlawful. It breached the common law duty of consultation and/or section 14Z2 of the 2006 Act.

Ground 6: The defendants failed to have due regard to the PSED under section 149 of the Equality Act 2010.

Ground 7: The defendants failed to conduct sufficient inquiry into the impact of increased travel times to the reconfigured hospital services before making the decision, in breach of its duty to inform itself of essential information.

Ground 8: The decision was unlawful as the defendants failed to consider its effect on patient flows from outside the Kent and Medway area and/or it was *Wednesbury* unreasonable to support an option which will support NHS services for patients outside the defendants' area in preference to a configuration which will provide services to patients predominantly within the defendants' own areas.

The interpretation of section 14T(a)

72. In making their submissions on the defendants' duties as to reducing health inequalities, the case presented to me by the claimant and second interested party was essentially that the time needed for patients and their families to reach a hospital (whether by ambulance or otherwise) was the key to access to health services under section 14T(a). They appeared to want to interpret "the ability to access health services" under section 14T(a) as meaning the ability to arrive at a hospital building. At any rate, they did not seem to propose or deploy in their submissions an interpretation of section 14T(a) that went beyond physical access to a hospital.

73. In my judgment, Parliament did not intend such a limited approach. The key point about access to health services is the ability to receive medical treatment for the purpose of avoiding death and (if possible) to make a recovery to good health. I agree with Ms Morris that the "ability to access health services" in section 14T(a) means the ability to take advantage of and benefit from a health service. Shorter journey times may be relevant but they are not determinative of access to health services.

Competing statutory duties

74. As Ms Morris submitted, the particular duties on which the claimants and interested party rely are part of a suite of high level duties under the 2006 Act. The range and scope of these duties may be understood from the exposition of Green J as he was then in *R (Hutchinson) v Secretary of State for Health and Social Care* [2018] EWHC 1698 (Admin), paras 28-45. They include (for example) the duty to exercise functions effectively and economically (section 14A); the duty to promote integrated health services (section 14Z1); and the duty to assist in ensuring the continuous improvement in the quality of primary medical services (section 14S).

75. The 2006 Act therefore imposes a number of different duties relating to a wide range of factors, reflecting the complexity of decision-making in an advanced healthcare system such as the NHS. The defendants' decision was therefore multi-factorial, involving the allocation of limited resources between competing needs. The 2006 Act duties engage socio-economic interests and do not all pull in the same direction. In balancing the competing factors, the 2006 Act clearly involves the exercise of substantial discretion, judgment or assessment (*R (Pharmaceutical Services Negotiating Committee & another) v Secretary of State for Health* [2018] EWCA Civ 1925, [2019] PTSR 885, para 81).

76. Neither the written nor oral submissions on behalf of the claimants or second interested party took this approach on board. Their approach comprised a commentary on selected parts of the documents in order to highlight to the court what was said to be a lack of reference to the particular duties that they wished to emphasise. Ms Morris was able to deal with this approach by making a list of key references to documents in the hearing bundle showing where the defendants dealt with the issues of health inequalities arising from economic deprivation as well as a list of references to the defendants' consideration of travel times.

77. The important point, however, is that the defendants considered health inequalities but did not rate them as a key evaluative criterion in determining the location of HASUs. Parliament intended CCGs to enjoy a broad discretion when choosing how to commission (*Hutchinson*, para 94). In the absence of a public law error, there is no reason for this court to interfere.

The scope of judicial review

78. As Ms Richards emphasised, QEQM was the only hospital in Kent and Medway that was not included in any of the proposed, shortlisted options set out in the consultation paper. Under the defendants' proposals, people who live in Thanet will be unable to attend their local hospital for a serious medical condition. However, judges in judicial review applications are concerned to supervise decision-makers so that they do not step outside the powers which our elected Parliament has given to them. It is an axiom of the law of judicial review that the court does not concern itself with the merits of executive action.

79. The supervisory nature of the court's jurisdiction is an important constitutional principle. It delineates the respective democratic functions of judges and those who are elected, or delegated by Parliament in legislation, to take decisions on behalf of the public. The principle should not be undermined by invitations to the court to cherry-

pick evidence or to interpret the defendants' decision-making documents and the consultation documents like a statute. By going down these routes, the submissions on behalf of the claimants and the second interested party strayed into the merits of the decision.

Professor Rudd's evidence

80. This impermissible approach was particularly marked by the challenge to the evidence of Professor Tony Rudd. He is the National Clinical Director for Stroke with NHS England. He has overseen the Review since its inception. Among other positions, he chairs the Intercollegiate Stroke Working Party at the Royal College of Physicians which has been responsible for developing the National Clinical Guidelines for Stroke and running SSNAP.

81. Professor Rudd has provided a witness statement on behalf of the defendants. He says that the new model of care for stroke services in Kent and Medway is fully supported by NHS England and is in line with stroke services across the rest of the country. He himself has clinically validated the decision under challenge. It will deliver what is established best practice based on national and international evidence.

82. Professor Rudd says that the defendants' decision will enable a full seven-day a week stroke service in Kent and Medway with specialist staff available round the clock. Patients will be admitted directly to the new HASUs rather than waiting in the emergency department before they see a stroke specialist. They will have brain scans and clot busting drugs, where appropriate, within two hours of calling for an ambulance. Evidence from HASU services in Greater Manchester, London and Northumberland demonstrates that patients living in those areas have better stroke services than in Kent. In Northumberland, some patients travel over 60 miles (which takes more than an hour) to reach the only HASU. There has been no increase in deaths since the HASU was established. Patients receive treatment faster and spend fewer days as in-patients before going home.

83. Professor Rudd confirms:

> "The evaluation process identified that three was the optimal number of HASUs for Kent and Medway, based primarily on the number of staff needed to run more than three units, and the numbers of patients each unit would see. These two criteria are critical to the quality of high-power acute stroke care (intensive support and care in the critical 72 hours after a stroke). When units do not have round-the-clock, seven day a week expert teams, patient outcomes are likely to suffer. When units do not see the minimum of 500 confirmed strokes (and ideally at least 600) the staff do not hone their skills and build expertise, and patient outcomes suffer".

84. Dealing with the claimants' case that stroke services ought to be situated at QEQM as an area of high deprivation, Professor Rudd says:

> "There is no evidence to show that the location of hyper acute stroke units improves deprivation or reduces health inequalities…"

85. Dealing with the claimants' case that deprived communities are those with highest need for stroke services, he says:

> "There is no evidence to show that HASUs should be sited in areas of highest incidence or prevalence."

86. Professor Rudd deals with the important factors in deciding the location of stoke services:

> "a. Access: can the population reach the unit within a specified timeframe?
>
> b. Availability of co-dependent and co-adjacent services: does the hospital site have the necessary co-dependent services for a HASU, and how many of the desirable services are also available at the site?
>
> c. Workforce: are the staff available to provide 24/7 care to stroke patients?"

87. The claimants and second interested party made observations and comments about Professor Rudd's statement with a view to undermining it. There was in my judgment no proper, public law reason to go behind what Professor Rudd has said. Others may take a different clinical view or reach a different conclusion on the merits of how the Review was conducted. That is not relevant in the absence of a properly formulated challenge on recognised judicial review grounds.

88. Professor Rudd's clinical opinion was attacked on the grounds that it failed to take into consideration that each minute of travel time to hospital counts in accessing successful treatment for stroke. Mr Lock led the criticism on the basis of a quotation from a journal article cited in the literature review carried out for the defendants as part of their evidence-based approach. The journal article is one among very many sources considered in the literature review and it states that "the odds of treatment decrease by 2.5% for every minute of transfer time." This led to somewhat trenchant submissions that, in achieving good outcomes for stroke patients in Thanet, every minute counts.

89. Ms Morris produced the underlying journal article which showed that the research underpinning the 2.5% statistic related to delays in hospital-to-hospital transfer of stroke patients in or around Chicago in 2010. The 2.5% statistic was plucked out of the wealth of evidence considered by the defendants without regard for context or the facts. It does not engage any point of public law.

90. Similarly, in pressing their case for the shortest possible travel times to hospital, the claimants and second interested party emphasised evidence from the Stroke Association that a person loses an estimated 1.9 million neurons every minute a stroke is untreated. I do not doubt that that statistic has force but, as a judge, I am bound to consider it within the framework of judicial review principles. Professor Rudd deals with travel

times in his witness statement. He says that the model of care under the proposed new HASUs will be that:

> "the 20% or so of patients who need clot busting treatment will receive it within 120 minutes of calling 999".

91. He accepts that he may be wrong about this but goes on to say that it is:

> "important to stress that travel time is just one aspect of stroke care and it is not the critical factor in improving outcomes for patients".

In his view, the most important factor in saving lives and reducing disability is round-the-clock care on fully staffed units. On conventional principles of public law, Professor Rudd's conclusions are unimpeachable.

92. The claimants and second interested party drew my attention to the SSNAP Acute Organisational Audit 2016 which states: "Outcomes are better the earlier thrombolysis is administered." I have no reason to doubt that that is the case – but it is inapt to take this information out of context and to treat it like a part of a statute giving rise to duties on health authorities. What is required is a "fair and straightforward reading of the documents as a whole, in their full context": *R (Pharmaceutical Services Negotiating Committee & another) v Secretary of State for Health* [2018] EWCA Civ 1925, [2019] PTSR 885, para 79.

93. By focusing on travel times and by asking the court to dig deeper into individual pieces of the evidence which they regard as relevant to health outcomes, the submissions on behalf of the claimants and second interested party ignore the wider context. The defendants took a multi-factorial decision which was quality assured both clinically and procedurally. I have not read or heard submissions which raise any public law argument as to why I should enter into the arena and determine a factual issue, or why I should reject Professor Rudd's analysis.

94. The travel time data used by the defendants is taken from a nationally recognised data source called Basemap which allows for congestion, tourist traffic, accidents, bad weather and any other factors that affect journey times. South East Coast Ambulance NHS Foundation Trust compared their actual blue light journey times and found that they were somewhat less than the Basemap times. The defendants therefore have a very high level of confidence that the travel times are adequate. This court has no reason to conclude otherwise. There are no grounds for concluding that the defendants were irrational in their approach to the risk that the 120-minute target may be missed on account of unpredicted journey times.

The grounds of challenge: analysis and conclusions

95. **Ground 1:** Mr Blundell submitted that vague references to health inequalities in the documents before the court were inadequate to discharge the duty to have regard to the need to reduce inequalities in relation to access to services and outcomes (i.e. the two limbs of section 14T). I reject that submission. It is plain from any reasonable reading of the documents that the defendants had in mind inequality arising from social deprivation when formulating and taking their decision. Mr Douglas confirms in his

witness statement that deprivation was considered but discarded as an evaluation criterion as it was not a sufficient differentiating criterion between the options on the medium list. There is no good reason to go behind what Mr Douglas has said and no reason to consider that the defendants did not take into consideration the evidence in relation to impacts on socially deprived communities in Thanet.

96. In my judgment, this part of Mr Blundell's argument amounts upon analysis to a disagreement with the weight given to the impact of travel times on deprived communities. Weight was a matter for the defendants to determine and it does not raise a hard-edged question of law.

97. Mr Blundell submitted that the defendants were wrong to take a "whole population average" approach by which Mr Blundell meant that the defendants focused on average travel times to HASUs across the whole population rather than on travel times in deprived areas such as Thanet.

98. I do not discern any real public law challenge here. In my judgment, the defendants took into consideration all relevant factors including the impact on travel times for deprived communities. Nothing in section 14T obliged them to reach any fixed conclusion. They were not obliged to cite section 14T or quote it in a formulaic manner. They were obliged to perform the obligation which it stipulates: that is what they did.

99. Mr Blundell submitted that the defendants had misunderstood their section 14T duty by relying on the fact that longer travel times for deprived communities will be mitigated by rapid treatment once at the HASU. This submission fails to take on board Professor Rudd's evidence that factors other than travel time lead to improved clinical outcomes and save lives.

100. Mr Blundell criticised the defendants' conclusion that the positive health aspects from the proposed changes, including improved clinical outcomes, are likely to be experienced disproportionately by socially deprived patients because of their higher propensity to require stroke services. He submitted that it would render the purpose of section 14T meaningless if the duties it imposes could be satisfied by making generic improvements to universal services and claiming that socially deprived communities are the beneficiaries as the most frequents service users.

101. In response to this part of Mr Blundell's argument, Ms Morris submitted that, as a matter of logic, health inequality stands to be reduced if all people in Kent have access to improved stroke services. Those from deprived communities use stroke services disproportionately and so they (as opposed to other sections of the community) will be the greater beneficiaries of improvements brought about by the introduction of the new model.

102. I set aside whether this conclusion is, strictly speaking, one of logic. However, in my judgment, it is reasonable for the defendants to take the view that improved stroke services will benefit those from deprived communities in Thanet and elsewhere in Kent to a greater degree than others and so play a part in reducing health inequalities. It is right that other groups will benefit too, such as older people and frail people who may suffer strokes but who may not suffer social deprivation. However, as Ms Morris submitted, nothing about section 14T mandates the defendants to locate stroke services in areas of high deprivation.

103. Mr Lock submitted that the section 14T duty is a legal duty requiring CCGs to give particular focus to the needs of certain patients in preference to others. The duty requires positive action in favour of socially deprived people and against other cohorts of patients. It is a duty of positive discrimination.

104. Both Mr Lock's and Mr Blundell's submissions ringfence one particular aspect of the multi-factorial, broad-brush assessment which the defendants were obliged to undertake. The duty under section 14T is to have regard to the need to reduce health inequalities. As I have mentioned, the terms of section 14T do not mandate a particular outcome. Section 14T does not oust other duties. The defendants in this case had regard to health inequalities. There was no breach of section 14T.

105. For these reasons, while the arguments before me warrant permission to apply for judicial review, the challenge on ground 1 is dismissed.

106. **Ground 2:** Mr Blundell submitted that the defendants failed adequately to consider whether, how and when stroke prevention measures were required in order adequately to mitigate the impact of the closure of the unit at QEQM. The failure to make sufficient inquiries into steps needed to prevent stroke breached the duty of inquiry in *Secretary of State for Education and Science v Tameside Metropolitan Borough Council* [1977] AC 1014.

107. In my judgment, this ground of challenge cannot succeed. The decision under challenge was at no stage contingent on putting in place measures to prevent or reduce the number of people who suffer stroke. The PCBC has a section on prevention but does not link prevention strategies to the proposed reconfiguration. The DMBC described a number of initiatives that may reduce stroke, such as reduction in smoking rates, improvements in diabetes detection and addressing obesity. It stated that staff and organisations in health and social care will need to work together to deliver these initiatives and "embed prevention in all aspects of service delivery." However, the DMBC makes plain that the defendants' focus was on hospital stroke services. It does not say that initiatives to prevent stroke must be developed before the proposals can safely go ahead. Initiatives relating to prevention are (as Ms Morris submitted) part of a parallel but different strategy to reduce stroke in deprived communities.

108. Mr Blundell's skeleton argument sets out a number of disconnected parts of the evidence which discuss ways of mitigating the negative impacts of the defendants' decision. He highlights, for example, that the Senior Responsible Officer for the Review is recorded as having told the Medway Council Health Scrutiny Committee on 12 March 2019 that the defendants had recognised that improvements delivered by HASUs would not address health inequalities and had therefore made a commitment to the development of a prevention Business Case. Those words are taken out of context. In the same paragraph of the minutes of the Scrutiny Committee meeting, the Officer is recorded as saying that the existing stroke units in Medway and Thanet were among the worst rated in the country and that the proposals would result in improved outcomes for patients regardless of where they lived.

109. Mr Blundell asked the court to give weight to a meeting of the JCCCG on 20 December 2018 at which "mitigations and responses" to a projected rise in stroke incidence was discussed, such as maximising bed resource. This has little or nothing to do with the decision under challenge.

110. None of the passages on which Mr Blundell relies – individually or together - raise a question of public law. There is no reason to go behind Professor Rudd's evidence that the review was concerned with the provision of acute stroke services and was not concerned with prevention. Decisions about prevention are a further and different strand of work to improve stroke services. I shall refuse permission to apply for judicial review on this ground.

111. **Ground 3:** Mr Blundell went on to criticise the defendants for relying on confirmation from East Kent Hospitals University NHS Foundation Trust (EKHUFT) that it would be unable to recruit enough staff for two HASUs. He submitted that the defendants had failed in their duty of inquiry to interrogate or investigate the Trust's position in this regard and failed to make adequate inquiries as to why a HASU within QEQM (whether it amounted to a fourth stroke unit or otherwise) could not attract or deploy an adequate skilled workforce.

112. As part of the work to shortlist options, EKHUFT concluded that it would not be possible to run two HASUs owing to recruitment issues. Of the sites run by EKHUFT, it identified that William Harvey Hospital was the better option because it could offer other services that are desirable to have alongside a HASU. Mr Blundell submitted that, even if the defendants were entitled to take into consideration the existence of desirable services at William Harvey Hospital, they were required to make further inquiries in relation to workforce recruitment.

113. This ground does not reflect what actually happened. The defendants carried out detailed workforce modelling of their own which was presented in the DMBC. The methodology for the modelling cannot be impugned on public law grounds and no attempt was made to impugn it. Mr Blundell did not identify any further inquiries which ought to have been carried out.

114. The defendants developed and circulated a questionnaire to individual Trusts about their willingness and ability to deliver the necessary changes to support the service reconfiguration. QEQM completed the questionnaire. There is no reason to go behind either the information provided by QEQM or the information provided by EKHUFT. Nor can the defendants be criticised for consulting EKHUFT whose views were a relevant factor to be considered.

115. Professor Rudd's unchallenged view is that:

> "It would be, in my view, and based on the current availability of specialist stroke workforce, an impossible task to recruit the additional 14 consultants required to safely staff four HASUs in Kent".

In my judgment, the claimants have failed to raise any arguable point of law on workforce issues. I shall refuse permission to apply for judicial review.

116. **Ground 4:** The next ground of challenge is that the defendants failed to discharge their duty to consider patient choice under section 14V of the 2006 Act on the erroneous basis that it was not relevant to a decision about the configuration of acute services. The defendants erroneously conflated the need to consider patient choice when it comes to commissioning services with the different question of whether an individual patient

can establish a legal right to choose a secondary care provider for elective referrals. The defendants "shut their eyes" to the question of patient choice.

117. In his witness statement, Mr Douglas confirms that HASUs are for patients who require urgent treatment following a stroke. Such patients are mostly conveyed by a blue light ambulance to the nearest service. Patient choice does not arise for such urgent cases. The PCBC shows that choice most commonly came last in the ranking of evaluation criteria by stakeholders and the public before the public consultation. In my judgment, the defendants were not under any legal duty to consult further or give any further consideration to patient choice in these circumstances. I refuse permission to apply for judicial review on this ground.

118. **Ground 5:** Ms Richards took the lead in making oral submissions on ground 5 which concerns the fairness of the consultation process. I shall grant permission to apply for judicial review on this ground.

119. Ms Richards emphasised that all options put forward for public consultation involved the closure of stroke services at QEQM which is the only hospital in Kent and Medway currently providing stroke services which was not included in any of the potential options for a HASU. There was, in consequence, no effective public consultation as to the future of stroke services at QEQM. It followed that the defendants' public consultation breached the statutory duty of public involvement and consultation in section 14Z2 of the 2006 Act and breached the common law duty to consult.

120. Ms Richards submitted that the defendants were under a statutory duty to involve the public and a common law duty to consult specifically on QEQM because there is a well-established stroke service there. QEQM passed the hurdle criteria and was part of a clinically viable set of options. The closure of the stroke unit would deprive the residents of Thanet of a stroke service. A local stroke service is significant and important to a deprived community such as Thanet. Consultation about QEQM would have led to better decision-making and would have respected the democratic principle outlined in *Moseley*.

121. Ms Richards submitted that the evaluation criteria (which is where options containing QEQM failed) did not have clear-cut answers and so the views of consultees should have been sought. There is no evidence that consultation on QEQM would have been unduly onerous. The failure to consult on QEQM has given rise to a feeling of injustice as the various witness statements from Thanet stroke campaigners have explained. Consultation specifically on QEQM could have made a real difference because it would have led to better public information about options containing QEQM which would in turn have led to more effective public scrutiny. This case can be distinguished from *Nettleship* because options containing QEQM were realistic and viable (having surmounted the hurdle criteria).

122. The defendants had a statutory duty in section 14Z2 to involve and consult the public on proposals for change. I am in no doubt that they met their duty. The defendants built public involvement into their decision-making process There was significant public involvement across the various stages by which they reached the new three-HASU model.

123. Having involved the public in the development of evaluation criteria, the application of those criteria produced a short list of proposals for change. Those criteria were rational and were applied rationally. The options put to the public in the formal public consultation were the proposals for change within the meaning of section 14Z2. In my judgment, the effect of *Nettleship* is that a decision-maker need only consult on proposals for change: it does not need to consult on arguable yet discarded options. Passing reference will suffice.

124. Ms Richards submitted that *Nettleship* stands for the proposition that all "realistic and viable options" should have been the subject of full public consultation (see *Nettleship* para 60). On the facts of this case, I am not persuaded that the lack of clinically desirable services at QEQM could make a stroke service "realistic and viable". The evidence shows that many key services for stroke patients are not available at the QEQM site. The DMBC makes clear that options which included William Harvey Hospital (the other EKHUFT site) were evaluated more highly because it has all major emergency services and the location of a HASU there would be consistent with it becoming a major emergency centre. It is not the function of this court to assess the clinical pros and cons of the evaluation criteria which ruled out QEQM or to criticise the evaluation criteria for giving weight to the existence of co-adjacent services. I do not understand the court in *Nettleship* to mean that every clinically viable option must be the subject of public consultation – even those which are inferior in some important respect. It seems to me that such a wide approach was expressly disavowed (see para 59).

125. There was in any event more than passing reference to QEQM in the consultation document. I have been provided with the questionnaire that accompanied the consultation paper. It is plain from the questionnaire that the defendants did not exclude the public from expressing their views not only about the proposed options but also about any other option. The questionnaire expressly asked for views on (among other things) the potential advantages or disadvantages of the proposed changes; any other criteria that the defendants should consider in their decision-making; any other ways as to how and where specialist urgent stroke services should be located; anything else that should be taken into consideration; any other comments in relation to the proposals; and any comments on the way that the consultation had been run.

126. It is not in dispute that, during the consultation period, 701 telephone interviews took place; 2,240 online surveys were completed; 334 paper surveys were returned. Listening events took place in 28 locations across Kent and Medway including Thanet. Those events generally consisted of an unstructured question and answer session in plenary followed by group table discussions on various issues including other options falling outside those discussed in the consultation paper. Members of the consultation team took questions and comments at a further five meetings of local groups.

127. Engage Kent were commissioned to hold sessions with community groups who experience barriers to accessing services or who are under-represented in healthcare decision-making. The target groups were BAME communities, people whose liberty is restricted, homeless people and those less likely to participate in civic activities as a result of health, substance misuse or older age. An additional 171 people took part in these events.

128. Engage Kent undertook other "public focussed conversations" with 94 residents selected by the weighting of relevant factors that could increase the risk of stroke. Rural communities were targeted for street surveys (116 in total). A random sample of 61 shoppers in Margate was surveyed over a two-hour period on one day.

129. Emails and letters were sent to the consultation team from individuals and others. The defendants' Facebook presence reached 169,496 people and its Twitter presence reached over 200,000 people. Comments made by the public on Facebook and Twitter were considered and reviewed by theme.

130. SONiK responded to the consultation in detail. Its objections to the proposals were (among other things) that they would not improve stroke services, would endanger the lives of those who would lose services in a local hospital, and had been formulated without adequately considering alternatives or consulting the public. It accused the defendants of having already closed their minds to alternatives and criticised the decision not to locate a HASU at QEQM. The SONiK response dealt with the list of desirable co-adjacent services, asserting that they had been "used to simply eliminate hospitals".

131. It is therefore plain that those who wanted to respond to the consultation were able to do so and to give their views about QEQM. That is what residents of Thanet did. The preference of many residents for a stroke service in Thanet was a key theme to emerge from the consultation and decision-makers responded by giving it further consideration. In my judgment, the consultation was fair and adequate.

132. I also accept Ms Morris' submission that residents of Thanet are not losing a service in the sense that they will forever be deprived of stroke treatment. Their service will continue albeit in a different place. In the context of access to NHS services for life-threatening illness, I do not accept that the physical relocation of a service which would thereby stand to be enhanced amounts to the withdrawal of a benefit requiring fuller consultation process than happened here.

133. I need to deal specifically with the claimants' sense of injustice which has formed one of the foundations of their claim for judicial review. It should not be belittled. Nevertheless, it seems to me that the purpose of section 14Z2 is to promote and ensure the democratic imprimatur of a key public service – upon which the court touched in *Moseley*. By the time of the publication of the PCBC, the following groups had been involved in the development of proposals for change: the public; patients; service users; carers; voluntary organisations; community groups; and volunteers working at affected organisations. The court was not provided with any concrete submissions as to who else ought to have been involved.

134. Public involvement was not haphazard but was an inherent aspect of the processes deployed by the defendants for effecting change. A "communications and engagement lead" had been appointed for the Review. An independent review by Healthwatch Kent had scrutinised pre-consultation engagement and concluded that the public had been involved in shaping and developing the case for change. Healthwatch Kent deemed the two-year period of patient and public involvement to meet standards of good practice. The PCBC itself made plain that local health services should be created in partnership with citizens and communities.

135. The PCBC also made plain that the focus of public engagement should be on equality and narrowing inequalities. While there are no references to sections of statutes, it is plain that the PCBC had in mind the PSED and the section 14T duty.

136. The PCBC set "objectives for engagement" with stakeholders including:

> "To ensure the patient, staff and stakeholder voice is represented by engaging identified audiences in the design and implementation of the plans and proposals at each stage".

The purpose of such public involvement was to:

> "Help meet statutory duties and best practice guidance".

137. The defendants adopted a number of principles that would underpin the public consultation. Those principles included:

> "We will cover the geography, demography and diversity of Kent and Medway and our boundary populations, including the working population, silent majority, seldom heard, people who are mostly well, and people who aren't, and those with protected characteristics, to gather a fair representation of views and feedback."

138. The defendants took into consideration that the IIA had highlighted groups which may have a disproportionate need for stroke services including deprived communities. The defendants were not only concerned to engage those groups in the consultation exercise but to target the views of those with protected characteristics and those in deprived communities:

> "**We also made a commitment to ensuring we targeted**…the needs of seldom heard groups and others with special requirements. These groups include, for Kent and Medway and in our neighbouring CCG areas, for example: the young, the working well, **those in deprived communities**, those in more rural communities, …. We also **committed to seeking views** on the proposals from those representing **the nine protected characteristics**: age, disability, gender reassignment, marriage and civil partnership, pregnancy race, religion and belief, sex and sexual orientation" (emphasis added).

139. Statutory duties (such as the PSED or the section 14T duty) mean that it is lawful for some voices (such as those with protected characteristics or those from deprived communities) to be specifically sought or targeted in the process of public involvement and consultation – which is what happened here. I accept Ms Morris' submission that, once that is done, the sense of injustice felt by particular claimants or particular interest groups will need to be viewed in the context of the more general democratic process which the 2006 Act promotes. It will be harder for individuals to argue that their own particular sense of injustice should prevail when the wider democratic exercise has been performed.

140. I have considered a number of other arguments relating to the consultation which were raised by Mr Blundell and/or by Ms Richards. They are not arguable. The public consultation provided a "fair opportunity for those to whom the consultation was directed adequately to address the question in issue": *R (Keep the Horton General) v Oxfordshire CCG and others* [2019] EWCA Civ 646, para 66. For these reasons, this ground does not succeed and is dismissed.

141. **Grounds 6 and 7:** These grounds were advanced by the second claimant and may be taken together. As originally pleaded in the Claim, the point of Ground 6 seems to have been that the IIAs made no reference to the section 149 duty and that there was no evidence that the defendants had due regard to the duty in form or substance. Put in these broad and unqualified terms, that submission goes nowhere.

142. Ms Richards did not seek to advance Ground 6 as pleaded. Nor did she seek to advance Ground 7 (which concerns the defendants' failure to make proper inquiries into increased travel times) as a discrete ground of challenge. Instead, she narrowed the focus of her submissions in order to concentrate specifically on increased travel times for patients, their families and carers. She submitted that the defendants had (a) failed to discharge the PSED and (b) failed to conduct sufficient inquiry into the increased travel times that these groups would face if the unit at QEQM closes.

143. Ms Richards submitted that the defendants had breached the PSED because they failed to have due regard to eliminate discrimination in relation to two characteristics protected by section 149(7), namely age and disability. A third factor – race – was advanced in Ms Richards' skeleton argument but not pursued orally.

144. Ms Richards submitted that the PSED applied to the decision as to where to locate HASUs. The September 2018 IIA had identified a number of negative impacts in relation to longer journey times. The increased stress and anxiety of making an unfamiliar journey to a hospital as well as increased travel costs are likely to affect older and disabled people disproportionately. Older and disabled patients are more likely to be affected by barriers to travel as they are more reliant on family and carers who may be inhibited from travelling if the journey is longer and more costly.

145. Ms Richards submitted that the minutes of the 14 February 2019 meeting, at which the defendants' decision was taken, make no reference in form or substance to the section 149 duty. She was however bound to accept that the DMBC was before the defendants at the February meeting and that it contained a section on equalities implications based on the IIAs. However, as I understood her submission, she challenged the IIAs as failing to refer to the statutory objectives of section 149 and as failing to consider the retention of stroke services in QEQM.

146. The short answer to Ms Richards' submissions is that they fail to acknowledge the breadth of the evidence that founded the defendants' decision. There can be no suggestion that those attending the 14 February meeting were inadequately briefed about the extensive procedures and evidence-gathering that led to the preferred option.

147. The defendants carried out two, full IIAs which dealt expressly and in a focused way with the impact of the recommended options upon those with protected characteristics. They addressed in substance the key questions required by section 149. The IIA dealt in detail with the negative impacts of the defendants' proposals on groups with protected

characteristics under equality law. The DMBC, which was supplied to attendees of the February 2019 meeting, cited the negative impacts, as set out in the IIA, so that decision-makers had evidence of equality impacts before them. The PSED was not breached.

148. Ms Richard further submitted that the PSED required a comparative IIA for every option on the medium list before it could progress to the short list. As Ms Morris emphasised, there is no authority for that proposition and it would not, in the circumstances of this case, provide an answer that would be material to the location of HASUs.

149. Ms Richards submitted that the Travel Advisory Group (which has been established and which will consider how to mitigate longer travel times for friends, family and carers) amounted to post-decision mitigation whereas some form of other or further inquiry ought to have been carried out prior to the decision. No concrete suggestion for further inquiry was advanced and no challenge was raised to the defendants' conclusions about travel times.

150. In reaching their decision, the defendants considered evidence about peak hour driving times for the public (which would include family, friends and carers of stroke patient) across all thirteen of the medium list options. In short, the maximum times both in the seven options that included QEQM and in options that did not include QEQM was 67 minutes. Given that travel times over 60 minutes would apply to less than 1% of the population, the defendants concluded that maximum travel times would not differentiate between options. It is not irrational or otherwise unlawful for the defendants not to rely on a non-differentiating factor when selecting options for the short list. In any event, the documents before the defendants at the time of their decision conclude that travel difficulties for visitors and carers would be outweighed by better clinical outcomes for patients. The defendants were entitled as a matter of law to adopt a model for stroke services that prioritised clinical outcomes.

151. The defendants have taken into consideration (for example in the PCBC) that access to public transport is "extremely important" for friends, relatives and carers. The Transport Advisory Group is designed to tackle increased journey times. There was no duty on the defendants to await its conclusions before taking a decision. Given the defendants' compliance with the PSED and the ample evidence demonstrating that the defendants took journey times into consideration, I do not see what this ground adds to the claim.

152. Grounds 6 and 7 raise no arguable error of law. Permission to apply for judicial review is refused.

153. **Ground 8:** This ground was advanced by the second interested party but Mr Lock did not pursue it in his skeleton argument or orally. I shall refuse permission to apply for judicial review.

Summary

154. In summary, permission to apply for judicial review is granted on grounds 1 and 5 but refused on other grounds. The claim is however dismissed.