Neutral Citation Number: [2016] EWHC 2626 (TCC)

Case No: HT-2016-000201

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
TECHNOLOGY AND CONSTRUCTION COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 26/10/2016

Before :

MRS JUSTICE JEFFORD

- -

Between :

PERINATAL INSTITUTE	**Claimant**
- and -	
HEALTHCARE QUALITY IMPROVEMENT PARTNERSHIP	**Defendant**

- -
- -

Mr Joseph Barrett (instructed by **Gardner Leader LLP**) for the **Applicant/Defendant**
Miss Rebecca Haynes (instructed by **My Business Counsel**) for the **Respondent/Claimant**

Hearing dates: 5th October 2016

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Approved Judgment

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

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MRS JUSTICE JEFFORD

Jefford J:

1. In this case, the Defendant, Healthcare Quality Improvement Partnership ("HQIP") applies for an interim order under Regulation 96(1)(a) of the Public Contracts Regulations 2015 to lift the automatic suspension of contract award under Regulation 95(1) imposed as a consequence of the commencement of these proceedings by the Perinatal Institute ("PI").

The parties

2. HQIP is an independent organisation led by the Academy of Medical Royal Colleges, The Royal College of Nursing and National Voices (a coalition of health and social care charities in England). HQIP was established in April 2008 to promote quality in healthcare and in particular to increase the impact of clinical audit on healthcare quality improvement.

3. PI is a national not for profit company. It describes itself as having a public interest purpose with its primary mission being to enhance the quality and safety of maternity care.

The background

4. This case arises out of HQIP's procurement of a project to implement standardised perinatal mortality reviews across the NHS in England, Wales and Scotland principally through training and the use of software to enable local and national collection and analysis of data.

5. It is not in dispute between the parties that rates of perinatal death (encompassing stillbirths and early neonatal deaths) are higher in the UK than they could or ought to be. They are significantly higher than in other developed high income countries. Mr Barrett, on behalf of HQIP, submitted to me that the data on perinatal death rates showed that the lives of 1000 babies a year could be saved in the UK if UK mortality rates were reduced to match those in Scandinavia.

6. One issue is thought to be an inconsistent approach to review and reporting for perinatal mortality which leads to missed opportunities to learn from such deaths and avoid or reduce the risk in similar instances in the future. This is something which PI has been concerned with for some time and PI has been advocating the improvement of reporting and analysis.

7. The reduction of perinatal deaths has been identified as a priority in the NHS Outcomes Framework 2016/2017 and, in November 2015, the Secretary of State for Health, Jeremy Hunt, announced targets for a reduction of 20% by 2020 and 50% by 2030. This announcement included the development of a new web-based system to be used across the NHS to enable NHS staff to review and learn from these tragic deaths.

8. It is this that led to the Department of Health in England and the devolved governments in Scotland and Wales giving HQIP the task of commissioning this project.

Events

9. An invitation to tender ("ITT") was sent out on 29 March 2016. It provided that the timetable for the procurement was that the contract award decision would be notified on 17 June 2016; the contract would be awarded on 28 June 2016; and the contract would commence on 1 July 2016 for a national roll out in March 2017.

10. PI submitted a Tender Response Document and Schedule of Offer, as did the consortium led by Oxford University's National Perinatal Epidemiology Unit ("NPEU"). Following the evaluation process, to which I refer further below, the contract award decision was, in fact, notified to tenderers on 30 June 2016. NPEU's was the winning bid with a score of 88.44%. PI's score was 80.24%, a difference of 8.2 percentage points.

Principles

11. It is also common ground between the parties that the approach to the issue of whether the suspension should be lifted is akin to the application of the principles in ***American Cyanamid***. That this is the right approach in principle has been set out repeatedly by the Courts, including in ***Openview Security Solutions Ltd. v. The London Borough of Merton Council*** [2015] EWHC 2694.

12. The issues I, therefore, have to consider and that were argued before me are these

- Is there a serious issue to be tried?
- If there is, are damages nonetheless an adequate remedy?
- If damages are not an adequate remedy, where does the balance of convenience lie?

Serious issue to be tried

13. Whilst acknowledging that the threshold test for deciding whether there is a serious issue to be tried is a low one, HQIP have nonetheless argued strongly in this case that there is no serious issue to be tried.

14. To put this argument in context, it is necessary for me to set out in some detail the relevant facts, the arguments that PI raise in their Particulars of Claim and raised on this application, and HQIP's response.

The Invitation to Tender

15. Annex B2 of the ITT contained HQIP's Specification for the project. Within Section A: Project specific requirements included Key Requirements. These included:

(i) under "Element 1: web-based tool for perinatal mortality reviews":

> *"The perinatal mortality review tool is to be developed for use by NHS maternity and neonatal units in England, Scotland and Wales. Data will be inputted by midwives, obstetricians, perinatal pathologists, neonatologists and data clerks. The data will be available locally at unit level.*

For each case review the tool will need to be able to produce a taxonomy based on responses to the questions in the data-set, which includes a grading of case and generates a local action plan for improvements in the provision of care. It is expected that the tool will generate reports for discussion and learning within organisations and that there will be a process to feed these reports up to networks Specifically, following input of the data by the user, the tool will need to be able to:

- *be compatible for use across all Trusts and Health boards in England, Scotland and Wales*
- *prompt for when and how to seek parents input into the review and when to communicate with parents about outcomes*
- *validate use input and notify errors*
- *generate case reports listing risk factors and learning actions*
- *allow users to generate customised report*
- *generate maternity unit-level reports on common themes and learning actions*
- *print PDF summaries of records*
- *have access permission*
- *enable multiple users to access and input data from different sites, at the same time*
- *provide system back-up*

....”

I have underlined the item that, as will be seen, is relied on particularly by PI.

(ii) Further, under “Information Governance and Duty of candour”:

> *“From 1 April 2015, all registered providers must meet the new duty of candour regulation. The aim is to ensure that providers are open and transparent with people who use services. It also sets out specific requirements when things go wrong with care and treatment, including informing people about an incident, providing reasonable support, providing truthful information and an apology. ..... Bidders must provide details on how they will manage patient identifiable information in England, Scotland and Wales. This should include details on how they would secure approval requirements relating to Section 251 support under the Health and Social Care Act, ... “*

(iii) Under element 4: Service user involvement:

> *“The perinatal mortality review tool should incorporate the parents’ perspective about the care they and their baby received during the antenatal, intrapartum and postnatal period and any concerns they raised about their care. However, the parents’ perspective will be inputted into the tool through health professionals – parents will not have direct access to the tool.*
> *Parents must be fully informed about the outcomes of the review.”*

16. Annex B3 comprised the Tender Response Document. Section 5 was headed Data Security and at 5.2 asked for a response to the following:

> ***“Data confidentiality. How will good practice be followed in ensuring patient confidentiality?***
> *Will section 60/section 251 Health and Social Care Act/ NHS act approval be required from the Confidentiality Advisory Committee (CAG) or will explicit patient consent be sought? Is there a plan for acquiring approval?”*

17. The references to section 251 are to the relevant section of the National Health Service Act 2006. To summarise the position:

    (i) Under subsection (1), the Secretary of State may make regulations for the processing of patient information as he considers necessary or expedient in the interests of improving patient care or in the public interest.

    (ii) Subsection (4) provides:
    "Regulations under subsection (1) may not make provision requiring the processing of confidential patient information for any purpose if it would be reasonably practicable to achieve that purpose otherwise than pursuant to such regulations, having regard to the cost of and the technology available for achieving that purpose."

    (iii) Pursuant to this power, the Secretary of State has made the Health Service (Control of Patient Information) Regulations 2002.

    (iv) Under these regulations, confidential patient information may be processed for specified types of or aspects of medical research if that processing has been approved by the Health Research Authority ("HRA").

    (v) HRA has itself established a Confidentiality Advisory Group ("CAG") to advise it on applications for approval.

    (vi) HRA published "Principles of Advice" which sought to clarify the position of CAG in its approach to public interest and "reasonably practicable alternative". Paragraph 2 of this document, presumably referring to s. 251(4), says that: *"The regulations cannot be used to set aside the common law duty of confidence if it would be "reasonably practicable" to achieve the purposes of the processing "otherwise than pursuant to the regulations". ……. Typically, when considering its advice on the issue of reasonable practicability the question that CAG has to consider is: Is it reasonable to expect the applicant, in practice, to either seek consent for the proposed use of confidential patient information or to achieve their purposes using data in a de-identified form. "*

    (vii) PI also identifies a position paper published by the HRA which, amongst other things, states that *"s.251 support to access the confidential patient information of the living, without consent, cannot usually be given if a patient has been asked to give explicit consent to that processing and has not responded to the request."*

18. The duty of candour regulation referred to is Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 20(1) provides that *"A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity."* In the event of a "notifiable safety event" (which includes the death of or moderate or serious harm to a service user), the health service body must notify the relevant person. PI's case is that the 2002 Regulations should be read in the light of the duty of candour in Regulation 20 such that s. 251 approval cannot be relied upon where there is a duty to notify under Regulation 20, as that affords an opportunity to obtain parent consent to the processing of their information.

PI's case on patient consent

19. These provisions form the basis for PI's first complaint about the tender process. PI relies on the scoring against item 5.2 in the tender response set out above. PI scored 7.14, while NPEU scored 8.93:
    (i) In respect of PI's proposals, the decisions stated that "the panel was not assured that obtaining individual patient consent would be the best way to address participation and patient confidentiality. The panel would have liked to have seen more consideration of the challenges inherent in seeking patient consent."
    (ii) In respect to NPEU's bid, the decision stated that "the University of Oxford provided the panel with greater assurance because of their plans to use s. 251 approval to address patient confidentiality. The panel felt that this would ensure the best possibility for participation and rolling out the programme nation-wide."

20. It seems to me that the key complaints in PI's Particulars of Claim are as follows:
    (i) That HQIP has misdirected itself as to the law relating to s. 251 in that approval under the Regulations is not available where it is practicable to obtain patient consent.
    (ii) That HQIP has misdirected itself and/or erroneously or irrationally concluded that patient consent cannot be obtained in circumstances where its own specification and the duty of candour necessarily renders patient consent a practicable option.
    (iii) That HQIP has selected a bid which will not or is unlikely to gain approval

21. This case is strongly disputed by HQIP. Their position is that the Specification required the tool to include functionality to incorporate the parents' perspective and that NPEU's proposals do so. On that matter I have the evidence of Jane Ingham who is the CEO of HQIP. HQIP say, however, that the review of cases will not be limited to those cases where that input is provided. So the operation of the tool in accordance with the Specification does not necessarily provide an opportunity to seek patient consent and there may be circumstances in which s. 251 approval is required. Nor does the duty of candour mean that there would always be such an opportunity since it is only engaged when there is a notifiable incident.

The time bar

22. Regulation 92(2) of the Public Contracts Regulations provides that proceedings must be started within 30 days beginning with the date when the economic operator first knew or ought to have known that grounds for starting the proceedings had arisen. Sub-paragraph (3) provides, in effect, for later dates for the commencement of proceedings that relate to decisions.

23. HQIP argues that PI's case is in truth a complaint about the Specification: the Specification clearly contemplates reliance on s. 251 approval which on PI's case could not or should not be given because any tool that otherwise complies with the Specification and/or takes account of the duty of candour would necessarily provide an opportunity to obtain patient consent to the use of confidential information. Therefore, any complaint ought to have been made within 30 days of the issue of the ITT and it is now too late.

24. For PI, Ms Haynes submits that that misses the point which is about how tenders were evaluated. She submits that the Specification anticipated that there might be both patient (or parent) input (and consent to the use of confidential information) and s. 251 approval. The Decision, on its face, gives rise to the appearance that HQIP has preferred a bid that makes no provision for patient or parent input (since if it did it would not rely on s. 251 approval) but instead relies solely on s. 251 approval. If that is right, the bid is not compliant with the Specification and it would be irrational to have preferred such a bid. If NPEU's proposal does allow for parent input, then, having regard to the question that CAG identifies it will ask itself, it will not or is unlikely to give a wide s. 251 approval, so it is irrational for HQIP to have reached its Decision simply because of NPEU's proposal to obtain such approval, without considering the restrictions on obtaining or giving of such approval.

25. I prefer Ms Haynes' submissions on this point and find that there is at least a serious issue to be tried as to whether any or all of the complaints which fall under this head are complaints about the evaluation process rather than the tender which are not time-barred.

26. Assuming that PI can rely on these complaints, Mr Barrett for HQIP nonetheless says that there is no serious issue to be tried on them. For PI's case to success, it must establish that HQIP's evaluation fell into manifest error in the sense that it was an irrational decision in the **Wednesbury** sense. For this proposition, which as I have already indicated was not disputed by PI, HQIP relies on the decision of Coulson J. in ***By Developments v Covent Garden Market Authority*** [2012] EWHC 2546. In that case, Coulson J emphasised that the court is carrying out a limited review of the decision reached by the public body and not substituting its own view for that previously reached. HQIP submits that its decision could not possibly be held to be irrational.

27. Whilst HQIP has adduced evidence to the effect that the winning bid does make provision for patient or parent input, this does not seem to me to be sufficient for me to say that there is no serious issue to be tried on PI's case. The parties' cases raise complex issues as to the interpretation both of the Specification and the legislation which may impact on the evaluation of the bids. PI's case cannot be said at this stage to be misconceived: the inference which it draws that the winning bid does not allow for patient input is tenable and the evidence to refute that inference is limited and does not give any detail as to NPEU's bid. If the inference PI draws is right, that would mean that a bid has been preferred that makes no provision for patient input and PI has at least an arguable case that to prefer such a bid is irrational.

Scoring

28. The further point made by HQIP is that even if PI were to succeed in persuading a court that the evaluation panel's scoring of item 5.2 in the Tender Response was irrational, it would make no difference to the overall result.

29. For the purposes of evaluation, each element of the bid was scored on a scale of 0 to 4 which was then given a weighting to produce a total mark out of 100%. HQIP says, rightly in my view, that NPEU could not have been given a score of 0 on item 5 (data capture and quality) because that item had two elements and no issue is taken about

the first element. Even if NPEU had been awarded a score of 1 or 2 against item 5, it would have made no difference to the outcome.

30. In answer to that, Ms Haynes points out that PI's case makes numerous other complaints about the evaluation process. PI's evidence on this application was given by Professor Jason Gardosi who is executive director of PI. Although for the purposes of this application, Prof. Gardosi identified two matters (namely patient consent and the lack of technical expertise on the evaluation panel) as the crux of the case, PI has not abandoned the other elements of its case. The net effect of success for PI on some or all of these issues would be to make them the highest scoring bidder. Although I am conscious that this allows PI to take advantage of allegations that HQIP describe as generalised, and that were not subject to any scrutiny at the hearing, I consider that I cannot conclude that there is no serious issue to be tried because of the limited impact of the scoring of item 5.2, ignoring the other issues raised by PI.

31. Therefore it remains my view that there is a serious issue to be tried on PI's case, although I say a little more about this below.

PI's case: the evaluation panel

32. PI's second key complaint is that the ITT sought a complex software solution which entailed a response from bidders containing technical explanations of software functionality, development and implementation but the evaluation panel did not include a member with "any background or reasonable technical understanding of or professional competence in the field of IT or software." In argument, Ms Haynes said that PI relied on this as giving raise to unfairness in the evaluation of the bid.

33. HQIP again says that this complaint comes too late. In the course of the bid process there was a clarification meeting held on 13 June 2016. An agenda was sent out on 27 May 2016 which listed the members of the panel and Ms Ingham's evidence is that Professor Gardosi was told at the meeting what the background of the members was. So it is argued that any complaint ought to have been made within 30 days of that date but was not. That point was not responded to in Prof Gardosi's second statement but I was told in the course of the hearing that it is disputed whether he was informed of the background of the evaluators and Ms Haynes relied on the fact that this point was not pleaded in the Defence and is not supported by any documentary evidence.

34. In the circumstances, I cannot say that there is no serious issue to be tried as to whether this complaint is time-barred.

35. So far as the complaint itself is concerned, it seems to me important to recognise that PI's complaint is that the absence of a person on the panel with what it considers to be appropriate expertise led to the making of errors in the evaluation of the bids. Whilst that flows from the constitution of the panel, the core of the complaint is that aspects of the evaluation were unfair or irrational, as a result.

36. Ms Ingham's evidence identifies the expertise of the panel members who included those with vast specialist medical expertise, expertise in healthcare administration and an experienced parent/ carer representative. She says that the technical aspects of the software tool required for this project are neither particularly complex or difficult.

37. Ms Ingham may well be right that the assessment of the bids was well within the panel's expertise and that they made none of the errors PI rely on but I do not see how I can decide that there is no serious issue to be tried on PI's case simply because the panel appears to be a sensible one for HQIP to have constituted.

Are damages an adequate remedy?

38. It follows that this is the question I come to next. In ***Covanta Energy v Merseyside Waste Disposal Authority*** [2013] EWHC 2922 (TCC), Coulson J. set out the relevant principles on the adequacy of damages. I do not set out those principles in their entirety here but the first two he formulated were as follows:

"(a) If damages are an adequate remedy, that will normally be sufficient to defeat an application for an interim injunction, but that will not always be so ….
(b) in more recent times, the simple concept of the adequacy of damages has been modified at least to an extent, so that the court must assess whether it is just, in all the circumstances, that the claimant be confined to his remedy of damages …"

39. As is apparent from Coulson J.'s decision in ***Bristol Missing Link Ltd. v Bristol City Council*** [2015] EWHC 876 (TCC), the effect of that formulation is to blur the line between the issue as to the adequacy of damages and the balance of convenience, or to bring the issue of adequacy of damages under the umbrella of the balance of convenience, by recognising that the Court should take in to account the justice of a party being confined to its remedy in damages.

40. I adopt that approach and I ask myself the question posed by Coulson J. namely "is it just in all the circumstances that a party should be confined to his remedy in damages?"

41. PI's case is, in essence, that damages are not an adequate remedy or that it is not just that it should be limited to any remedy in damages because it is a not for profit organisation and it did not intend to make any profit from this project. In other words, there are no monetary losses for which damages would compensate it. I note that PI does not suggest that there is some other loss, such as a loss of reputation, which it might be difficult to compensate in damages.

42. In this context, PI also relies on the decision of Coulson J. in ***Bristol Missing Link Ltd. v Bristol Council***. The case concerned a contract for domestic violence and abuse support. The Claimant, BMML, already provided such support to Bristol Council. BMLL was not a profit making organisation: it had included nothing for profit in its tender and only a nominal allowance for overheads. At paragraph 55, the judge concluded:

> *"In my view, a non-profit making organisation, which has bid for a contract making no allowance for profit at all, and a minimal amount for overheads, is entitled to say that, in such circumstances, damages would not be an adequate remedy."*

43. Coulson J. then considered the other consequences for BMLL of the suspension being lifted. He identified five consequences:

(i) The work done for the Council in relation to domestic violence amounted to a third of BMLL's total turnover. Without this contract, BMLL would suffer catastrophic harm.

(ii) BMLL provided a range of services dealing with linked problems of domestic violence, sexual violence and mental health. The lifting of the suspension would disconnect the services in respect of domestic violence.

(iii) This part of BMLL's work could not be replaced so there would be a knock on effect to the provision of services in other locations.

(iv) If the suspension was lifted, BMLL would be locked out from this core element of its work for the 3 to 5 years of the contract which would also have a knock on effect on other services.

(v) The lifting of the suspension would have a significant effect on BMLL's reputation.

Coulson J. described these consequences as catastrophic. He concluded that damages were not an adequate remedy.

44. The same issue of the adequacy of damages for a non-profit organisation came before Stuart-Smith J. in ***Kent Community Health NHS Foundation v NHS Swale Clinical Commissioning Group and others*** [2016] EWHC 1393 (TCC). Stuart-Smith J. questioned the breadth of the statement in paragraph 55 in the ***BMLL*** judgment and said that he could see no reason why damages should be regarded as an inadequate remedy simply because the Claimant, whether a not for profit organisation or otherwise, had not suffered or would not suffer substantial financial loss. But he nonetheless agreed with Coulson J. that the further factors in ***BMLL*** were capable of being a good reason for finding that damages were not an adequate remedy.

45. I do not read what Coulson J. said at paragraph 55 of the judgment, quoted above, as setting out an absolute rule or principle that a non-profit organisation can never be adequately compensated in damages. Rather, in my view, he identifies that this is an argument open to a non-profit organisation against which background he then considered the consequences for BMLL of the lifting of the suspension in order to answer the question of whether it would be just to confine BMLL to recovering its minimal financial loss. The fact that an organisation is non-profit may make it more likely that it cannot be adequately compensated in damages and the BMLL case itself provides an example where that was the case because the project in question was at the heart of its activities, there would be a significant knock on effect to its other activities, and it would suffer significant reputational damage.

46. In this case, HQIP firstly points out that there are 2 matters for which PI may be compensated in damages: (i) PI must have incurred tender costs for which it could be compensated even though these do not form part of its claim and (ii) if successful, PI would have recovered through this contract some contribution to its general overheads for which it could also be compensated. This latter point requires some further explanation.

47. On PI's evidence, it derives its income from service contracts with NHS Trusts and Health Boards throughout the UK on projects designed to provide IT and other tools to assist health professionals to monitor pregnancy and pregnancy outcomes. One of those tools is a bespoke software tool, used to review and learn from adverse pregnancy outcomes, known as Standardised Clinical Outcome Review or SCOR.

48. It is inevitable that PI incurs costs and carries overheads to do so and PI charges a small annual sum of £1000 for the use of SCOR. PI's activities are, therefore, income, if not profit, generating. Indeed, Prof. Gardosi's evidence was that if PI had been successful in obtaining this project, PI would have been able to offer the software free of charge. Although it was not entirely clear from that evidence whether Prof. Gardosi was referring to the SCOR software generally or to the software (which is developed from SCOR) on this project alone, it was clearly anticipated that this project could cover some of the costs of SCOR.

49. Consistently with this:

(i) PI's Schedule of Offer showed that some of the costs of clinical lead and other staff were allocated to this project and included sums, albeit not large ones, for overheads, including, under the heading "Office Accommodation and Other Costs" for accommodation and for "HR, Finance and Legal (in house)".

(ii) The Tender Response Document identified the project team and stated that the team would have ongoing support from other members of the Institute "all easily accessible in our open plan offices" including the director, finance manager, IT support, the head of midwifery and other project midwives.

(iii) In answer to tender clarification questions, PI said that all the staff listed in the original submission work within support teams in the Institute, those teams being identified as the Midwifery Team, the IT Team, the Data Team and the Administrative Team.

50. PI, however, argued that the only overheads in its tender were "project specific" and therefore it suffered no loss of contribution to its general overheads. On the evidence before me both as to the make up of the tender (which clearly shows sums for general overheads), it does not seem to me that that can be right. Nor is it consistent with the fact that the staff identified for this project are said to work within or have the support of existing teams, so that the funding for this project will go to defray their costs.

51. Accordingly, leaving aside the matter of tender costs, there is, in my judgment, a financial loss which can be compensated in damages. Is it then just, in all the circumstances that PI should be confined to that remedy? In my judgment the answer to that question is yes. PI's position is in no way similar to that of BMLL. There is no existing service provision which PI will be deprived of if the suspension is lifted and there is no suggestion or evidence that failure to obtain this contract will have any negative, let alone, catastrophic impact on PI's activities. PI may feel strongly that their bid was a better bid; they may have grave concerns about the NPEU bid; and these may be of far greater importance to them than any potential claim for damages, but that does not mean that it would be unjust to confine PI to its remedy in damages.

53. It follows that I would lift the suspension on the award of this contract.

Balance of convenience

54. If I had not reached this view as to the adequacy of damages, I would have reached the same conclusion on the balance of convenience.

55. Here HQIP rely very much on the public interest in this project proceeding as soon as possible. As the courts have recognised there are potentially competing public interests in the proper application of the Public Contracts Regulations and the interest of contracting authorities being able to go ahead with their plans promptly. Both fall to be taken into account.

56. On the one hand and in the context of the application of the Public Contracts Regulations, I take into account the strength of PI's case. Whilst I have found that there is a serious issue to be tried, this does not seem to me to be particularly strong case. To refer back to one point only as HQIP point out, even if PI are right in their complaint about the evaluation of item 5.2, that would not affect the scores sufficiently to mean that PI would have been the winning bidder. To reach that point, PI would also need to succeed on a number of its other complaints. So the hill PI has to climb to establish that the Regulations have been breached in any way that impacts on the outcome of this bid process is that much higher.

57. On the other hand, there is a clear public interest in this project proceeding as soon as possible. It is a data collection and review project aimed at the reduction of perinatal mortality rates. Prof Gardosi's evidence is that this is a project that PI has for some years been advocating should be undertaken. PI (or perhaps more accurately its predecessor) produced a report in 2010 emphasising the need to standardise the review process, also setting up a stakeholder group with clinical and patient representatives to develop an electronic tool for standardised review which was then piloted in England and Wales. Further, the apparent success of PI's SCOR tool, about which Prof Gardosi gives evidence, demonstrates that the standardised collection and review of data can have significant benefits.

58. This type of standardised review may not result in an immediate saving of babies' lives but there is unanimity in the view that it is likely to have a positive impact over time. It follows that the sooner it is implemented, the sooner it is likely to result in babies' lives being saved and their parents being spared from tragedy.

59. I recognise that PI argues, and Prof Gardosi's evidence is, that NPEU will not or is unlikely to receive s. 251 approval, so that if NPEU's proposals depend on this approval, there will be further delay in the implementation of this project. HQIP's evidence is to the contrary and is that it is likely to receive approval. For that, HQIP rely on the views of Prof Kurinczuk of NPEU who also sits on the CAG.

60. Taking this evidence into account, it does not seem to me that Prof. Gardosi's concerns about what may happen are enough to swing the balance back in PI's favour.

61. For completeness I should also deal with two further points that were raised in this context.

62. Firstly, PI argued that there had been undue delay by HQIP in making this application and that that should weigh in the balance against lifting the suspension. I do not consider that there was any undue delay. After the decision was made, the parties

engaged in correspondence to explain their positions to each other and see if they could resolve their differences. In a letter dated 18 August 2016, HQIP's solicitors stated that they were preparing an application to lift the suspension; HQIP's Defence was served on 30 August 2016; and this application was made on 21 September. Given the need to have the support of the Department of Health and the devolved governments for this application and that much of these events took place over the holiday period, I cannot see that there was any undue delay, and even if there were it would not be enough to tip the balance.

63. Secondly, PI also relied on the argument that there would be an expedited trial of the issues. Their estimate for such a trial was 2 weeks although HQIP suggested that 3 to 4 weeks was a more realistic estimate. No specific dates for a hearing were identified but, with disclosure and statements, there could not be a trial before next year. PI suggested that there could be a trial within 4-6 months, with judgment to follow. Even on this best case scenario, there would be months of delay in the implementation of the project. If there were an appeal or a re-run of the tender process the delay would be greater. The public interest that I have identified above weighs heavily in favour of avoiding this further delay.

64. As I have said, it follows that, even if I had reached a different view about the adequacy of damages, I would have found that the balance of convenience favoured the lifting of the suspension. The view that I have formed about the adequacy of damages also weighs in the balance of convenience in favour of lifting the suspension.

65. The automatic suspension on the awarding of the contract will, therefore, be lifted and I will hear any further submissions from the parties as to the form of order and costs, if necessary, in due course.