NHS England

Paper: PB.24.05.2018/10

NHS ENGLAND – BOARD PAPER

Title: Decision of the High Court in favour of NHS England on the judicial review challenge to whole population payments
Lead Director: Ian Dodge, National Director – Strategy & Innovation
Purpose of Paper: The Board is asked to note, for information, the decision of the High Court rejecting the argument that our approach to payment reform and tariff design is incompatible with the 2012 legislation. The Court's conclusions are attached, for information only.
Patient and Public Involvement: Not applicable
The Board is invited to: Note the Court's ruling

Case No: CO/5025/2017

Neutral Citation Number: [2018] EWHC 1067 (Admin)

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

Hearing at Leeds Combined Court Centre,
1, Oxford Row, Leeds LS1 3BG

Judgment handed down at
Manchester Civil Justice Centre
1 Bridge Street West,
Manchester M60 9DJ

Date: 15/05/2018

Before:

THE HON MR JUSTICE KERR

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Between :

THE QUEEN ON THE APPLICATION OF JENNIFER SHEPHERD (on behalf of 999 CALL NHS)	**Claimant**
- and -	
NATIONAL HEALTH SERVICE COMMISSIONING BOARD	**Defendant**

- and –

(1) NHS CALDERDALE CLINICAL COMMISSIONING GROUP
(2) MONITOR

Interested Parties

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DAVID LOCK QC and LEON GLENISTER (instructed by **Leigh Day**) for the **Claimant**
FENELLA MORRIS QC and ROSE GROGAN (instructed by **DAC Beachcroft LLP**) for the **Defendant**
FENELLA MORRIS QC and IAIN STEELE (instructed by **NHS Improvement Legal Team**) for the **Second Interested Party**

The **First Interested Party** did not appear and was not represented

Hearing date: 24th April 2018

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Judgment

Reasoning and Conclusions

73. I start by reminding myself that the issue I have to decide is one of pure statutory construction. There is no *Padfield* challenge before the court; therefore, I can discount any suggestion that the statutory powers of the Board and Monitor are being misused in a manner intended, without breaching the letter of the law, to promote an ulterior purpose that is contrary to the true purpose of the provisions.

74. The use of the WPAP in an ACO contract is therefore, straightforwardly, either unlawful or lawful. If it is capable of operating in a manner that accords with the statutory regime, the claim must fail. But if, conversely, the provisions cannot lawfully accommodate use of the WPAP as a payment mechanism, the court should say so by granting appropriate relief.

75. At present, the ACO contract is in draft. There is no doubt that use of the WPAP is intended, subject to further consideration, to form a substantial part of the payment mechanism that will eventually be put in place. That should only happen if use of the WPAP is lawful.

76. In considering whether it is lawful or not, I turn first to the question what is meant by a health care service in the statutory provisions. The phrase is split into two parts: "health care" and "service", but they are closely linked. The first expression, health care, refers (see section 150(1) and 64(3) of the 2012 Act) to health care "provided for individuals", whether relating to physical or mental health.

77. Section 64(3) adds the further (probably superfluous) words: "a reference in this Part to health care services being read accordingly… ." Taking no chances, the drafter then added section 64(5): "[a] reference to the provision of health care services for the purposes of the NHS is a reference to their provision for those purposes in accordance with that Act [the 2006 Act]."

78. What are "services" in this context? They are those which a CCG must arrange under section 3(1) of the 2006 Act to the extent necessary to meet the reasonable requirements of persons for whom it has responsibility: namely, hospital and other accommodation and medical, dental, ophthalmic, nursing and ambulance services; and other "services or facilities" for care of pregnant and breast feeding women and for young children; and such other "services or facilities as are required for the diagnosis and treatment of illness".

79. I think "services" also includes discretionary services provided under section 3A(1) of the 2006 Act, namely "such services or facilities as it [the CCG] considers appropriate for the purposes of the health service that relate to securing improvement … in the physical and mental health of the persons for whom it has responsibility …" (section 3A(1)(a)), or "in the prevention, diagnosis and treatment of illness in those persons" (section 3A(1)(b)).

80. Furthermore, although section 3 and 3A both speak of "services or facilities", in these over-articulated provisions section 150(1) of the 2012 Act goes on to state that "'service' includes facility" and that "facilities" has the meaning it bears in section 275 of the 2006 Act which includes provision or use of "premises, goods, materials, vehicles, plant or apparatus".

81. Such a rich profusion of superfluous and overlapping definitions is inconsistent with the claimant's narrow conception of a health care service as a simple singular

treatment episode of one patient. It does not follow that, because the definition of "health care" (section 150(1) and 64(3) of the 2012 Act) refers to health care "provided for individuals", a "health care service" within section 115 can only refer to a service provided to an individual patient.

82. By the same reasoning, I accept the submission of Ms Morris that the health care services referred to in section 115(1) and (2) of the 2012 Act include making available resources to enable medical procedures to be performed, such as providing an A&E department or ambulance transport, as well as specific treatments such as a hip replacement or cataract surgery.

83. The next point is that health care services can be "bundled" together or kept separate and their shape may be moulded in accordance with the liberal and permissive provisions in the detailed subsections of sections 116 and 117. The following features demonstrate how flexible is the process of delineating and remunerating services:

(1) the national price for a service may vary depending on the circumstances in which it is provided or other factors relevant to its provision (section 116(4)(a)).

(2) By a bizarre provision (section 116(5)), rules "may specify health care services which are not specified under subsection (1)(a)". While the drafting lacks clarity, it cannot mean a service may be specified and not specified at the same time; it could mean that non-specified services may become specified.

(3) The same service may be specified in more than one way and rules can determine which specification of the service is to apply in particular situations or circumstances (section 116(6)).

(4) Services with the same specification may command different remuneration rates or price variants depending on what type of provider is providing the service (section 116(9) and (10)), e.g. depending on whether the provider is in the public or private sector (section 116(10)(a)).

(5) Services may be specified by reference to their "components" (section 117(1)(a)) or as a "bundle" that "comprises two or more health care services which together constitute a form of treatment" (section 117(1)(b)) or as a "service in a group of standardised services" (section 117(1)(c)).

84. The next matter that must be considered is how health care services, widely conceived as they are in the statutory provisions, are to be remunerated. Initially, this depends on whether the service in question is "specified" or not. If it is, the governing provision is section 115(1) of the 2012 Act. If it is not, the governing provision is section 115(2).

85. I reject the submission of the claimant that the words appearing in both subsections ("the price payable for the provision of that service … is") create an independent statutory duty owed by the CCG to the ACO to pay the amount due. There is no good reason why those words should confer a right on the ACO to sue the CCG for the amount due.

86. The chosen mechanism for delivering services is by means of an ACO contract, which may be a particular type of "NHS contract" as provided for in section 9 of the 2006 Act; i.e. it is "an arrangement under which one health service body ('the commissioner') arranges for the provision to it by another health service body ('the

provider') of goods or services which it reasonably requires for the purposes of its functions." (section 9(1)).

87. These NHS contracts are created pursuant to statute but they are contracts nonetheless and enforced as such. I accept the submission of the Board and Monitor that the source of a CCG's obligation to pay an ACO for a service provided is the ACO contract and not the statutory provisions: the obligation to pay is contractual not statutory.

88. I also reject the submission of the claimant that the "tariff" refers merely to the going rate for a particular episode of treatment. Mr Lock referred to the dictionary definition of "tariff" in the Shorter Oxford Dictionary, which refers to "[a] table or scale of fixed charges … as a list of prices …". But it is clear from the statutory scheme that the "national tariff" is much more than that and indeed that the expression "national tariff" is in part a misnomer.

89. The national tariff is, first, a published document and as such not a tariff at all. Second, it is an amorphous collection of rules and guidance that may be diffuse and far removed from a rigid list of prices or scale rates. The claimant's characterisation of the national tariff and the charging regime do not do justice to the fiscal complexities and the fluidity of the regime.

90. The breadth of "health care services" and the ways in which they may be remunerated, point to a wide and liberal interpretation of the link phrases "in accordance with" and "on the basis of" in section 115(1); and of the same phrase, "in accordance with", in section 115(2); which I prefer to the narrow and rigid interpretation advocated by the claimant.

91. If the provisions simply required there to be a fixed price per patient treatment episode, I would expect the provisions to state that the price payable is such price as is fixed by the national tariff; and I would expect the national tariff to consist of fixed prices as suggested in the dictionary definition in the Shorter Oxford Dictionary. The reality of the regime and the provisions is otherwise.

92. Does use of the WPAP as a method of remunerating health care services offend against the provisions, thus interpreted? In my judgment, it does not. It is true that the WPAP does not enable an observer to determine in advance how much is to be paid for an individual treatment episode and may not enable identification of the amount paid in respect of each service within a bundle of services that are grouped together.

93. But I do not think that makes the WPAP unlawful. I accept the submission of Ms Morris that nothing in the statutory provisions prevents remuneration according to an estimate of the capacity of the ACO to provide a service or services (specified or not specified), rather than by fixing a price for the actual provision of that service or those services.

94. Thus, by way of example, a CCG might agree to pay a WPAP of £X million to an ACO in respect of the financial year 2020-2021, for providing a raft of services - let us suppose, 20 or 30 bundled up services ranging from hip replacements to MRI scans to A&E provision to ambulance transport to cataract surgery, etc. The services are then provided as required during that financial year.

95. The payment of £X million in return for providing them is the price payable under the ACO contract. That price is calculated by reference to the local population in the ACO's area. Once it is appreciated that section 115 does not require visible prices fixed in advance for each individual treatment episode, it becomes apparent that such an arrangement does not breach section 115.

96. Nor do I accept that the WPAP fails to respect the delineation between specified and non-specified services. The services remunerated in accordance with the WPAP in the manner just described, may be specified or unspecified or a mixture of the two.

97. I do not accept that the payment systems used when applying the national tariff require differentiation as between payment for primary and secondary care. The claimant says the former are outside the national tariff regime altogether. This is true of many not all primary care services, but that is by virtue of provisions in the current national tariff. There is no statutory exclusion of primary care services from the scope of the national tariff, as explained by the Board and Monitor in their skeleton argument.

98. As to variation of prices, it is clear and obvious that a variation under section 116(2) of the 2012 Act is a separate and distinct process from a modification under section 124 of 125. The latter is there to protect providers against unexpected losses if they find themselves unable to provide a contracted service at the price agreed without the provision being "uneconomic". The former is intended for use during ordinary commercial negotiations in normal economic conditions.

99. I should add that where section 116(2) is used, there must be a pre-existing pricing regime contained within the national tariff. An ACO contract cannot "vary" a price that has never been specified in the first place. The current draft ACO contract may need adjusting to deal with this possible difficulty. But as long as there is a pre-existing pricing regime that can be varied, there is no difficulty in relying on section 116(2) to underpin the variation.

100. Finally, the claimant complains that the WPAP imposes budgetary control at the expense of not being "demand led": the ACO does not know how many hip replacements it will have to fund from its fixed budget. This, the claimant argued, encourages the very price competition which the 2012 Act was supposed to banish and which, politicians have said publicly, does not work.

101. That is a political objection and is not a matter for the court. There are no doubt advantages and disadvantages to every payment system. The WPAP can be judged in the political arena but this court does not find anything unlawful in its use as the law stands.

Disposal

102. The claim therefore fails and is dismissed. Under a costs capping order made by Males J, the claimant's costs liability is capped at £25,000. On 3 April 2018, His Honour Judge Davis-White QC made an order that the claimant pay the costs of an unsuccessful application for directions including transfer of the case to London to be heard with another case pending there.

103. HHJ Davis-White QC did not vary the costs capping order, nor mention it in his written reasons. It seems to me that the making of that order does not prevent the

£25,000 cap from remaining in place and that the costs payable by the claimant, as ordered by the judge, are included within the capped liability.

104. I will therefore limit the claimant's costs liability to the sum of £25,000. That sum, or such lesser sum as may be agreed or assessed by the court, is payable to the defendant. The interested parties have not sought any order for costs in their favour.