



Neutral Citation Number: [2018] EWCA Civ 2849

Case No: C1/2018/1310

**IN THE COURT OF APPEAL (CIVIL DIVISION)**  
**ON APPEAL FROM THE HIGH COURT**  
**QUEEN'S BENCH DIVISION, ADMINISTRATIVE COURT**  
**MR JUSTICE KERR**  
**[2018] EWHC 1067 (ADMIN)**

Royal Courts of Justice  
Strand, London, WC2A 2LL

Date: 20/12/2018

Before :

**PRESIDENT OF THE FAMILY DIVISION**  
**SIR ANDREW McFARLANE**  
**LORD JUSTICE HADDON-CAVE**  
and  
**LADY JUSTICE NICOLA DAVIES**

Between :

<b>THE QUEEN ON THE APPLICATION OF JENNIFER SHEPHERD (on behalf of 999 CALL FOR THE NHS)</b>	<b><u>Appellant</u></b>
<b>- and -</b>	
<b>THE NATIONAL HEALTH SERVICE COMMISSIONING BOARD</b>	<b><u>Respondent</u></b>
<b>- and -</b>	
<b>(1) NHS CALDERDALE CLINICAL COMMISSIONING GROUP (2) MONITOR</b>	<b><u>Interested Parties/ Respondents</u></b>

Mr David Lock QC and Mr Leon Glenister (instructed by Leigh Day Solicitors) for the  
Appellant

Ms Fenella Morris QC, Mr Iain Steele and Ms Rose Grogan (instructed by DAC  
Beachcroft LLP) for the Respondent

Hearing date : Tuesday 20<sup>th</sup> November 2018

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**APPROVED JUDGMENT**

## **LORD JUSTICE HADDON-CAVE :**

### **INTRODUCTION**

1. This appeal concerns the statutory construction of the pricing provisions of the Health and Social Care Act 2012 (“the 2012 Act”).
2. The Appellant appeals the order of Mr Justice Kerr, dated 15<sup>th</sup> May 2018, dismissing her application for judicial review challenging the lawfulness of the payment mechanism known as the “*Whole Population Annual Payment*” (“WPAP”) under a proposed new form of draft NHS Contract now entitled the “*Integrated Care Provider Contract*” (“the draft ICP Contract”). The draft ICP Contract has been developed by the Respondents, the National Health Service Commissioning Board (“NHS England”) and Monitor, as an alternative to the current model for payment of health care services known as “*Payment by Results*” (“PbR”).
3. The Appellant acts on behalf of a campaign group “999 Call For the NHS” (“the Group”), which campaigns locally and nationally on behalf of NHS patients. The Appellant and the Group contend that the proposed change in the payment system from PbR to WPAP is unlawful and would put the quality and safety of NHS services for patients at risk. The Respondents contend that the Appellant’s claim is premised on an incorrect construction of the pricing provisions of the 2012 Act and the WPAP mechanism would help promote integration and innovation in NHS services.
4. Mr Justice Kerr held that the WPAP scheme was lawful under the 2012 Act and dismissed the Appellant’s claim. Permission to appeal was given on 13<sup>th</sup> August 2018 by Arden LJ (as she then was) who said: “A key question of statutory interpretation in this appeal is whether the judge was right to hold that section 115 of the Health and Social Care Act 2012 does not require “visible prices fixed in advance for each individual treatment episode (judgment [95])”.
5. The Appellant was represented before us by Mr David Lock QC and Mr Leon Glenister. The Respondents were jointly represented by Ms Fenella Morris QC, Mr Iain Steele and Ms Rose Grogan.

### **BACKGROUND**

6. Whilst the questions of construction are of fairly narrow compass, it is necessary to explain a considerable amount of background in order to set the issues in context. The following summary of the roles and responsibilities of NHS England and Monitor is taken from the Respondents’ helpful joint skeleton.

### **NHS England**

7. NHS England is a statutory body created under the 2012 Act which amended the National Health Service Act 2006 (“the 2006 Act”). NHS England is under a statutory duty, concurrently with the Secretary of State for Health and Social Care (“the Secretary of State”), to promote a comprehensive health

service in England.<sup>1</sup> NHS England must exercise its statutory functions in relation to bodies known as Clinical Commissioning Group(s) (“CCG”) so as to secure that services are provided for the purposes of the health service in England in accordance with the 2006 Act.

#### *Clinical Commissioning Group(s) (“CCG”)*

8. CCGs were also established under the 2012 Act. CCGs are clinically-led statutory bodies with responsibility for the planning and commissioning of health care services for its local population.<sup>2</sup> Each CCG has the function of arranging for the provision of services for the purposes of the health service in England in accordance with the 2006 Act (s.1I). A CCG must arrange for the provision of certain services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility (s.3), and has powers to arrange other services (s.3A). A CCG fulfils these functions by entering into contracts with providers of services, which include NHS Trusts<sup>3</sup>, NHS Foundation Trusts<sup>4</sup> and a range of independent sector organisations.

#### *Duties*

9. NHS England’s statutory duties include duties to exercise its functions “*effectively, efficiently and economically*” (s.13D); in the exercise of its functions, “*to promote innovation in the provision of health services (including innovation in the arrangements made for their provision*” (s.13K); and to exercise its functions with a view to securing that health services are provided “*in an integrated way*” where it considers that this would (a) improve the quality of those services, or (b) reduce inequalities with respect to ability to access services, or (c) with respect to the outcomes achieved (s.13N). CCGs have similar statutory duties to exercise their functions effectively, efficiently and economically (s.14Q); to promote innovation (s.14X); and to promote integration (s.14Z1).

#### *NHS power to draft model contracts*

10. NHS England is granted power to draft model commissioning contracts for CCGs to use to commission services under the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (“the 2012 Regulations”). The 2012 Regulations require, by r.16, that a commissioning contract contains terms and conditions that ensure that the provider complies with certain duties.<sup>5</sup> The

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<sup>1</sup> See s.1H, s.9 and Schedule A1 of the 2006 Act.

<sup>2</sup> “*Commissioning*” is the term used to refer to the process of planning, purchasing and monitoring health services.

<sup>3</sup> “*NHS trusts*” are bodies corporate providing NHS goods and services in England. NHS trusts preceded NHS foundation trusts and are subject to powers of direction by the Secretary of State.

<sup>4</sup> “*NHS foundation trusts*” are public benefit corporations providing NHS goods and services in England under the 2006 Act. They differ from NHS trusts in that they are not, for example, subject to the same powers of direction by the Secretary of State.

<sup>5</sup> In summary, these are duties to act in accordance with the duty of candour under r.20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and to co-operate with local

2012 Regulations also require NHS England to draft terms and conditions as it considers appropriate (r.17(1)(b)). NHS England also has a power to draft model commissioning contracts which reflect the terms and conditions it has drafted pursuant to r.17(1) (r.17(2)). Once they are mandated by NHS England, a CCG must incorporate these terms and conditions in its commissioning contracts (r.17(4) and r.17(5)).

11. NHS England has exercised its power to draft model commissioning contracts. For the period 2017/19, NHS England drafted two model commissioning contracts, known as the “*full-length*” NHS Standard Contract and the “*shorter-form*” NHS Standard Contract. NHS England mandated these model contracts for use by CCGs in circumstances defined in Technical Guidance published with those model contracts.<sup>6</sup>

#### *Whole Population Annual Payment (WPAP) term*

12. NHS England drew up a model commissioning contract entitled the “*NHS Standard Contract (Accountable Care Models) [(fully integrated)] [(partially integrated)] 2017/18 and 2018/19*” or the “*Accountable Care Organisation*” Contract (“the draft ACO Contract”). On 3<sup>rd</sup> August 2018, the draft ACO Contract was renamed the “*NHS Standard Contract (Integrated Care Provider) [(fully integrated)] [(partially integrated)] 2018/19*” (i.e. the draft ICP Contract). The draft ICP Contract contains a proposed term (GC11) entitled “*Whole Population Annual Payment*” (i.e. the WPAP) which is the subject of the present challenge in these proceedings (see further below). Counsel for the Respondents inform us that NHS England has put the draft ICP Contract out for consultation, with a view to deciding whether or not to publish it (with or without further amendment) as a model contract which CCGs may choose to use in the future in appropriate circumstances.

#### **Monitor**

13. Monitor was established by the Health and Social Care (Community Health and Standards) Act 2003 as the independent regulator of NHS Foundation Trusts, a role that was confirmed by the 2006 Act. Under the 2012 Act, Monitor’s role was extended such that it is now the independent sector regulator of NHS “*Health Care Services*” (“HCS”) in England. Part 3 of the 2012 Act makes provision on regulation of health and adult social care services. Chapter 1 makes general provision regarding Monitor, including its general duties. Monitor’s main duty in exercising its functions is to protect and promote the interests of people who use health care services by promoting provision of HCS which (a) are economic, efficient and effective, and (b) maintains or improves the quality of the services (s.62(1)). Since April 2016, Monitor and the NHS Trust Development Authority have operated as a single organisation under the operational name “*NHS Improvement*”, but there has been no formal merger and Monitor remains a separate corporate entity

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education and training boards in planning the provision of, and in providing, education and training for health care workers.

<sup>6</sup> The Technical Guidance can be viewed at: <https://www.england.nhs.uk/nhs-standard-contract/17-19-updated/>.

responsible for relevant statutory functions.

14. Monitor must exercise its functions: (i) “...with a view to preventing anti-competitive behaviour ... which is against the interests of people who use such services” (s.62(3)); and (ii) “with a view to enabling health care services provided for the purposes of the NHS to be provided in an integrated way where it considers that this would ... improve the quality of those services ... or the efficiency of their provision...” (s.62(4)(a)), and would “reduce inequalities” in access to those services ((b)) or “with respect to the outcomes achieved ...” ((c)).
15. Monitor is responsible for publishing the “National Tariff” (“NT”) for certain HCS, having first developed and agreed proposals with NHS England and engaged with providers of services, commissioners of services and others (ss.115-118). Monitor also has an enforcement role in relation to compliance by commissioners with the NT and payment (s.116(2), (4) and (6) and s.117(5)).

### **History of NHS funding and legislation**

16. The following summary of the history of NHS funding and relevant legislation is taken from the parties’ agreed note drawn up pursuant to the order of Arden LJ dated 13<sup>th</sup> August 2018.

#### *NHS funding before the Health and Social Care Act 2012*

17. Before the reforms introduced by the National Health Service and Community Care Act 1990, NHS hospital and community services were provided by health authorities which received funding allocations from the Secretary of State. The 1990 Act provided the legislative framework for the move to an “internal market” in which the bodies who arranged or commissioned services (health authorities) were separate from those which provided services (primarily, NHS trusts). Providers were able to compete to provide services to health authorities. In practice, however, commissioners generally managed payment by agreeing “block contracts” with NHS trusts – i.e. agreeing a single contractual payment for the services to be provided for a financial year, rather than individual payments for specific services or episodes of treatment.
18. In 2000, the Government published the “NHS Plan”<sup>7</sup>, paragraphs 2.19-2.22 of which identified that the NHS lacked clear incentives to improve performance. A policy commitment was given at paragraph 6.25 to introduce a new system of incentives which would support the delivery of better services for patients, including financial recognition to organisations for improved performance.

#### *Payment by Results*

19. “Delivering the NHS Plan”<sup>8</sup> (2002) proposed the introduction of “payment by results” (i.e. PbR) (see paragraphs 4.4-4.12). The document explained the desire of the then government to improve the incentives for improving care for

<sup>7</sup> <http://1nj5ms2li5hdggbe3mm7ms5.wpengine.netdna-cdn.com/files/2010/03/pnsuk1.pdf>

<sup>8</sup> <http://www.nhshistory.net/deliveringthenhsplan.pdf>

patients. As part of the proposals to provide better incentives, the document stated that: “[e]xperience of the internal market taught us that price competition did not work” and proposed introducing “Healthcare Resource Groups” (“HRGs”) to establish a standard tariff for the same treatment regardless of provider (see paragraphs 4.10, 4.12).

20. A White Paper, “*Reforming NHS Financial Flows: Introducing payment by results*”<sup>9</sup> (2002), consulted on proposals for the introduction of PbR. The proposals included moves towards a nationally agreed set of prices, commissioning at speciality level based on volumes adjusted for ‘case-mix’ and a shortlist of those HRGs which should be commissioned and monitored individually. The short-term focus was on the commissioning of elective care between Primary Care Trusts (the commissioning bodies at the time) and NHS trusts, but it was proposed that it would ultimately encapsulate all commissioning arrangements within the NHS.
21. PbR was implemented initially with national tariffs for 15 HRGs in 2003/4. From that year to 2010, there was a period of expansion and development of PbR. By 2007/8 the NT covered most acute inpatient admissions, outpatient attendances and accident and emergency (“A&E”) attendances (similar to current coverage of the statutory “national prices”).
22. The policy intention behind PbR was to move away from “block contracts”. As the paper “*A simple guide to Payment by Results*” explained:

*“Before PbR, commissioners tended to have block contracts with hospitals where the amount of money received by the hospital was fixed irrespective of the number of patients treated. PbR was introduced to:*

- (a) support patient choice by allowing the money to follow the patient to different types of provider;*
- (b) reward efficiency and quality by allowing providers to retain the difference if they could provide the required standard of care at a lower cost than the national price;*
- (c) reduce waiting times by paying providers for the volume of work done; and*
- (d) refocus discussions between commissioner and provider away from price and towards quality and innovation”.*

23. However the guidance also explained:

*“PbR is meant to be a tool, not a straitjacket. It should never be seen as a barrier to providing the best care for patients. Flexibilities allow for deviation from tariff rules where the*

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[http://webarchive.nationalarchives.gov.uk/20110908064137/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4018704.pdf](http://webarchive.nationalarchives.gov.uk/20110908064137/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4018704.pdf)

*patient and the NHS benefits. For example, innovation payments give commissioners the flexibility to make an additional payment for a new device, drug or technology that gives better care than is provided for in the tariff.”*

24. In 2010 the Coalition Government published its NHS White Paper “*Equality and excellence: Liberating the NHS*”<sup>10</sup>. The proposals reflected, and built upon, the PbR system (see paragraphs 3.17-3.18). It also proposed a statutory system of price regulation as part of Monitor’s economic regulatory role (see paragraphs 4.27- 4.30). The Paper stated that prices would be calculated on the basis of the most efficient, high quality services rather than average cost and that payment would depend on quality of care and outcomes, not just volume (see paragraph 5.12).
25. In December 2010, the Government published its response to consultation on the White Paper proposals, including “*Liberating the NHS: legislative framework and next steps*”<sup>11</sup>, pricing being dealt with at paragraph 3.37-3.38 and paragraphs 6.101-6.111. The Glossary provided that “*in relation to payment by results, the tariff is the calculated price for a unit of healthcare activity*”.

#### *Health and Social Care Bill*

26. The Health and Social Care Bill was first tabled in the House of Commons in January 2011. Pricing was dealt with in clauses 103 to 112 of the Bill. Clauses 103 and 104 would eventually become ss.115 and 116 of the 2012 Act and originally provided for, *inter alia*, maximum prices.
27. During the passage of the Bill through Parliament, Ministers moved amendments to remove the reference to “*maximum prices*” and substituted “*national prices*” in what became section 115(1). Statements were made by Ministers expressing a view to the effect that price competition does not work and that competition between providers in the NHS should solely be on the basis of the quality of service provided and not on price.

#### *The 2012 Act*

28. The relevant provisions on pricing are set out in Chapter 4 of the 2012 Act. On 1<sup>st</sup> April 2013, the pricing provisions in Chapter 4 were partially brought into force so as to enable Monitor<sup>12</sup> to produce the first NT. The particular provisions of Chapter 4 of the 2012 Act which are in issue in the present case are ss. 115, 116, 117, 124 and 125:

- (1) Section 115 (the price payable by commissioners for NHS services);

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<sup>10</sup><https://www.gov.uk/government/publications/liberating-the-nhs-white-paper>

<sup>11</sup>[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213797/dh\\_122707.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213797/dh_122707.pdf)

<sup>12</sup> Under the 2012 Act, Monitor, one of the Respondents in these proceedings, is established as the independent sector regulator of health care services in England. Since April 2016, Monitor and the NHS Trust Development Authority have operated as a single organisation under the operational name “NHS Improvement”, but there has been no formal merger and Monitor remains a separate corporate entity responsible for relevant statutory functions.

- (2) Section 116 (the NT, and in particular the scope of s.116(2));
  - (3) Section 117 (a further provision on the NT, and in particular s.117(1) as to how a health care service can be “*specified*” and s.117(4) and (5) which give Monitor the power to take action against commissioners where they have agreed to pay a price other than that payable by virtue of Chapter 4 of the 2012 Act); and
  - (4) Sections 124 and 125 (modification of prices).
29. These are set out and examined in detail below. In summary, the statutory scheme requires Monitor to publish the NT. The NT is the document which defines the services which are “*specified*” for the purposes of section 115(1). If a health care service is so “*specified*” (and subject to ss.124 and 124), the price payable is the price as is determined in accordance with the NT on the basis of the price “*specified*” therein (known as the “*national price*”) for that service.
30. The NT is the document which sets rules for determining local prices pursuant to section 115(2). The NT may also specify “*national variations*” to the “*national prices*” in particular circumstances, rules under which providers and commissioners could reach agreement between themselves on “*variations*” to “*national prices*” or specifications pursuant to s.116(2) and rules for determining local prices. The NT was also entitled to include guidance on “*local modifications*” pursuant to s.124 and 125 where provision of the service at the price determined in accordance with the NT would be uneconomic.
31. The first NT was published on 17<sup>th</sup> December 2013 and was accompanied by explanatory notes.<sup>13</sup> It came into effect on 1<sup>st</sup> April 2014. The current version of the NT is the third version, for financial years 2017/2018 and 2018/2019, which came into effect on 1<sup>st</sup> April 2017.

#### *Policy since the 2012 Act*

32. In October 2014, NHS England published a Policy Document “*The NHS Five Year Forward View*”<sup>14</sup>. Chapter 3 of the document set out a ‘New care model’ of ‘Primary and Acute Care Systems’ (or PACS) and stated:

*“We will now permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services...At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget – similar to Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.”*

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<sup>13</sup> <https://www.gov.uk/government/publications/national-tariff-payment-system-2014-to-2015>.



33. In March 2017 NHS England published “*Next Steps on the NHS Five Year Forward View*”<sup>15</sup>. This document included NHS England’s plans for local NHS areas for Accountable Care Systems and stated:

*“In time some ACSs may lead to the establishment of an accountable care organisation. This is where the commissioners in that area have a contract with a single organisation for the great majority of health and care services and for population health in the area”.*

34. It noted a few areas which were on the way to establishing an ACO, although it would take several years.

#### *The proposed ACO Contract*

35. In August 2017, NHS England published the draft ACO Contract, and the associated guidance. The draft ACO Contract provided for a form of payment arrangement called the “*Whole Population Annual Payment*” (i.e. the WPAP). The ACO Contract was the form of contract which was under challenge and which Kerr J had before him.

#### *The draft ICP Contract*

36. As stated above, the draft ACO Contract has now been replaced by the draft ICP Contract which was published in August 2018. The draft ICP Contract was the subject of a 12 week national consultation, which concluded on 26<sup>th</sup> October 2018.
37. It is agreed between the parties that this appeal should proceed on the basis of a consideration of the draft ICP Contract in its current form.
38. The draft ICP Contract under consultation is different from the draft ACO Contract in some material respects, including as to clause GC11.1A (see below). The court was informed that it may be subject to further amendment in the light of responses to the consultation. Separately, the Secretary of State has concluded a consultation into proposed changes to various regulations required to facilitate the operation of ICPs. The Secretary of State does not intend to lay these regulations (with or without amendment) before Parliament until the conclusion of NHS England’s consultation, and its consideration of responses to it. The Secretary of State is also expected to consult on draft Directions, which concern the terms to be included in a contract in relation to the provision of primary medical services. This consultation exercise is anticipated to begin following the conclusion of the NHS England consultation on the draft ICP Contract, referred to above.

## **THE LEGAL FRAMEWORK**

### **Health and Social Care Act 2012**

39. I set out below the relevant sections of the Health and Social Care Act 2012, namely sections 115-117 and 124-125 which appear in Chapter 4 (entitled
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“Pricing”) of Part 3 of the 2012 Act (entitled “*Regulation of Health and Adult Social Care Services*”):

**“Chapter 4 PRICING**

**115 Price payable by commissioners for NHS services**

- (1) *If a health care service is specified in the national tariff (as to which, see section 116), the price payable for the provision of that service for the purposes of the NHS is (subject to sections 124 and 125) such price as is determined in accordance with the national tariff on the basis of the price (referred to in this Chapter as “the national price”) specified in the national tariff for that service.*
- (2) *If a health care service is not specified in the national tariff, the price payable for the provision of that service for the purposes of the NHS is such price as is determined in accordance with the rules provided for in the national tariff for that purpose.*

**116 The national tariff**

- (1) *Monitor must publish a document, to be known as “the national tariff”, which specifies—*
  - (a) *certain health care services which are or may be provided for the purposes of the NHS,*
  - (b) *the method used for determining the national prices of those services,*
  - (c) *the national price of each of those services, and*
  - (d) *the method used for deciding whether to approve an agreement under section 124 and for determining an application under section 125 (local modifications of prices).*
- (2) *The national tariff may provide for rules under which the commissioner of a health care service specified in the national tariff and the providers of that service may agree to vary—*
  - (a) *the specification of the service under subsection (1)(a), or*
  - (b) *the national price of the service.*
- (3) *Where a variation is agreed in accordance with rules provided for under subsection (2), the commissioner of*

*the service in question must maintain and publish a written statement of—*

- (a) the variation, and*
  - (b) such other variations as have already been agreed in accordance with rules provided for under that subsection in the case of that service.*
- (4) The national tariff may also—*
- (a) specify variations to the national price for a service by reference to circumstances in which the service is provided or other factors relevant to the provision of the service,*
  - (b) provide for rules for determining the price payable for the provision for the purposes of the NHS of health care services which are not specified under subsection (1)(a), and*
  - (c) provide for rules relating to the making of payments to the provider of a health care service for the provision of that service.*
- (5) Rules provided for under subsection (4)(b) may specify health care services which are not specified under subsection (1)(a).*
- (6) The national tariff may also provide for rules for determining, where a health care service is specified in more than one way under subsection (1)(a) or in more than one way in rules provided for under subsection (4)(b), which specification of the service is to apply in any particular case or cases of any particular description.*
- (7) The national tariff may include guidance as to—*
- (a) the application of the method specified under subsection (1)(d),*
  - (b) the application of rules provided for under subsection (2), (4)(b) or (6),*
  - (c) the discharge of the duty imposed by subsection (3), or*
  - (d) the application of variations specified under subsection (4)(a),*

*and a commissioner of a health care service for the purposes of the NHS must have regard to guidance under this subsection.*

- (8) *Different methods may be specified under subsection (1)(b) for different descriptions of health care service.*
- (9) *The national tariff may, in the case of a specified health care service or health care services of a specified description, specify different national prices or different variations under subsection (4)(a) in relation to different descriptions of provider.*
- (10) *A description for the purposes of subsection (9) may not be framed by reference to—*
  - (a) *whether the provider is in the public or (as the case may be) private sector, or*
  - (b) *some other aspect of the status of the provider.*
- (11) *The national tariff may not specify a national price for a health care service provided pursuant to the public health functions of the Secretary of State, or of a local authority, under the National Health Service Act 2006.*
- (12) *The national tariff has effect for such period as is specified in the national tariff (or, where a new edition of the national tariff takes effect before the end of that period, until that new edition takes effect).*
- (13) *In exercising its functions under this Chapter, Monitor must (in addition to the matters specified in section 66) have regard to the objectives and requirements for the time being specified in the mandate published under section 13A of the National Health Service Act 2006.*

### **117 The national tariff: further provision**

- (1) *The ways in which a health care service may be specified in the national tariff under section 116(1)(a), or in rules provided for in the national tariff under section 116(4)(b), include in particular—*
  - (a) *specifying it by reference to its components,*
  - (b) *specifying it as a service (a “bundle”) that comprises two or more health care services which together constitute a form of treatment,*
  - (c) *specifying it as a service in a group of standardised services.*

- (2) *In the case of a service specified in the national tariff under section 116(1)(a), the national tariff must—*
- (a) *if the service is specified in accordance with subsection (1)(a), specify a national price for each component of the service;*
  - (b) *if it is specified in accordance with subsection (1)(b), specify a national price for the bundle;*
  - (c) *if it is specified in accordance with subsection (1)(c), specify a single price as the national price for each service in the group.*
- (3) *In the case of a service specified in rules provided for in the national tariff under section 116(4)(b), the rules may—*
- (a) *if the service is specified in accordance with subsection (1)(a), make provision for determining the price payable for each component of the service;*
  - (b) *if it is specified in accordance with subsection (1)(b), make provision for determining the price payable for the bundle;*
  - (c) *if it is specified in accordance with subsection (1)(c), make provision for determining the price payable for each service in the group.*
- (4) *Where the commissioner of a health care service for the purposes of the NHS agrees to pay a price for the provision of the service other than the price that is payable by virtue of this Chapter, Monitor may direct the commissioner to take such steps within such period as Monitor may specify to secure that the position is, so far as practicable, restored to what it would have been if the commissioner had agreed to pay the price payable by virtue of this Chapter.*
- (5) *Where the commissioner of a health care service fails to comply with rules provided for under section 116(2), (4) or (6), Monitor may direct the commissioner to take such steps within such period as Monitor may specify—*
- (a) *to secure that the failure does not continue or recur;*
  - (b) *to secure that the position is, so far as practicable, restored to what it would have been if the failure was not occurring or had not occurred.*

### ***124 Local modifications of prices: agreements***

- (1) *The commissioner and the provider of a health care service may agree that the price payable to the provider for the provision of the service for the purposes of the NHS in such circumstances or areas as may be determined in accordance with the agreement is the price determined in accordance with the national tariff for that service as modified in accordance with the agreement.*
- (2) *An agreement under this section must specify the date on which the modification is to take effect; and a date specified for that purpose may [be earlier than the date of the agreement (but not earlier than the date on which the national tariff took effect)]<sup>1</sup>.*
- (3) *An agreement under this section has effect only if it is approved by Monitor.*
- (4) *An agreement submitted for approval under subsection (3) must be supported by such evidence as Monitor may require.*
- (5) *Monitor may approve an agreement under this section only if, having applied the method specified under section 116(1)(d), it is satisfied that, without a modification to the price determined in accordance with the national tariff for that service, it would be uneconomic for the provider to provide the service for the purposes of the NHS.*
- (6) *Where an agreement is approved under subsection (3), Monitor must send a notice to the Secretary of State and such clinical commissioning groups, providers and other persons as it considers appropriate.*
- (7) *Monitor must also publish the notice.*
- (8) *The notice must specify—*
  - (a) *the modification, and*
  - (b) *the date on which it takes effect.*
- (9) *If the Secretary of State considers that the modification gives or may give rise (or, where it has yet to take effect, would or might give rise) to liability for breach of an EU obligation, the Secretary of State may give a direction to that effect; and the modification is (or is to be) of no effect in so far as it is subject to the direction.*

### ***125 Local modifications of prices: applications***

- (1) *Monitor may, on an application by a provider of a health care service who has failed to reach an agreement under section 124 with the commissioner, decide that the price payable to the provider for the provision of the service for the purposes of the NHS in such circumstances or areas as Monitor may determine is to be the price determined in accordance with the national tariff for that service as modified in such way as Monitor may determine.*
- (2) *An application under this section must be supported by such evidence as Monitor may require.*
- (3) *Monitor may grant an application under this section only if, having applied the method under section 116(1)(d), it is satisfied that, without a modification to the price determined in accordance with the national tariff for that service, it would be uneconomic for the provider to provide the service for the purposes of the NHS.*
- (4) *Subsections (5) to (8) apply where Monitor grants an application under this section.*
- (5) *The decision by Monitor on the application takes effect on such date as Monitor may determine; and a date determined for that purpose may be earlier than the date of the decision (but not earlier than the date on which the national tariff took effect).*
- (6) *Monitor must send a notice of the decision to the Secretary of State and such clinical commissioning groups, providers and other persons as it considers appropriate.*
- (7) *Monitor must also publish the notice.*
- (8) *The notice must specify—*
  - (a) *the modification, and*
  - (b) *the date on which it takes effect.*
- (9) *If the Secretary of State considers that the modification gives or may give rise (or, where it has yet to take effect, would or might give rise) to liability for breach of an EU obligation, the Secretary of State may give a direction to that effect; and the modification is (or is to be) of no effect in so far as it is subject to the direction.”*

### **The draft ICP Contract**

40. The draft ICP Contract includes draft General Conditions (“GC”), Service Conditions and Particulars, similar to those in existing NHS model

commissioning contracts, as well as the WPAP price mechanism (as explained below). It is described by the Respondents as an optional ‘prototype variant’ of the NHS Standard Contract designed (a) for use by CCGs to commission a ‘package’ of health care services for the population in their area from a single provider or organisation in an ‘integrated service model’, and (b) to enable planning for the longer term and to allow the most flexible use of funding to best meet the needs of the population, for example encouraging preventative interventions and treatment closer to home. The provider under an ICP Contract will be, by definition, an ‘integrated care provider’, and may either be an NHS body or an entity from the independent sector.

*The Whole Population Annual Payment (“WPAP”)*

41. A key feature of the draft ICP Contract is the WPAP mechanism. This is set out in GC11. The first two sub-paragraphs of GC11 provide as follows:

***“GC11 Payment Terms***

***Whole Population Annual Payment***

*11.1 Subject to any express provision of this Contract to the contrary, the Commissioners will in respect of each Contract Year pay to the Provider, as full consideration for all the Services that the Provider delivers and performance of all other obligations on the part of the Provider under the draft ICP Contract:*

*11.1.1 the Whole Population Annual Payment; and*

*11.1.2 the Activity-Based Payments.*

*11.1A The WPAP and the Activity-Based Payments constitute (insofar as they relate to Services in respect of which the National Tariff specifies a National Price and/or a national currency) a Local Variation agreed in accordance with the rules set out in the National Tariff. That Local Variation and any subsequent Local Variation reflecting any agreed adjustment to the WPAP and/or Activity-Based Payments must be, recorded in Schedule 4E (Local Variations), submitted to NHS Improvement in accordance with the National Tariff and published in accordance with section 116(3) of the 2012 Act.” [Emphasis added]*

42. It will be noted that GC11.1A provides that WPAP and the Activity-Based Payments constitute “*Local Variation[s]*” which are to be agreed “*in accordance with the rules set out in the National Tariff*”. The guidance “*Finance and Payment Approach for ACOs*” explains:

*“Commissioners and providers should note that the National Tariff Payment System (NTPS) would continue to apply to*



*payment for many of the NHS healthcare services included within an ACO arrangement. For this reason, local implementation of an integrated budget for ACO services<sup>16</sup> within scope of NTPS must comply with the local pricing rules set out in the NTPS. These rules allow, for example, one or more commissioners and one or more providers to agree “local variations” to vary the prices and specifications of the relevant services.”*

43. Further, GC11.2 envisages that the WPAP will be adjusted from time-to-time at scheduled Review Dates.

#### *Block contracts*

44. The draft ICP Contract and WPAP mechanism have some similarities with “*block contracts*”. A “*block contract*” is a contract which provides for payment by way of a lump sum or block payment, *i.e.* a fixed sum regardless of the number and type of activity undertaken by the provider. “*Block contracts*” are expressly permitted by the NT and available under existing NHS England model commissioning contracts. They are now extensively used by CCGs, in particular in relation to payments for mental health services, community health services and some acute services. In 2017-2018, “*block contract*” arrangements accounted for 37% of all NHS commissioning contracts.<sup>17</sup>
45. However, ICP Contracts and WPAP differ in two key respects: (a) scope - the WPAP permits a wider range of services to be included in the lump sum payment, including some primary medical services; and (b) price - WPAP is calculated by reference to the size and needs of the local population.
46. The Judge usefully summarised the idea behind the WPAP scheme as follows:

“50. The idea, at its simplest, is that the budget is worked out for the whole of the population in the care provider’s area and is paid in respect of the totality of the health care services the provider expects to provide during the budget period. The process by which the budget is calculated is, of course, a complex exercise starting from baseline figures including, most significantly for present purposes, the population served by the ACO in the area in which it provides health care services.”

#### **The WPAP statutory scheme**

47. In my view, notwithstanding the somewhat labyrinthine drafting of Chapter 4 of the 2012 Act, the intended scope and operation of the NHS statutory pricing scheme is tolerably clear. I set out below my understanding of the key aspects of the statutory scheme incorporating the WPAP payment mechanism.

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<sup>17</sup> NAO report: <https://www.nao.org.uk/press-release/sustainability-and-transformation-in-the-nhs/>.

48. First, Monitor’s core duties and discretions centre on the NT which Monitor is required to publish (s.116(1)). The key provisions governing Monitor’s role and responsibilities as regards the NT are to be found in ss.115-117. Monitor has a wide discretion both in relation to the content and makeup of the NT itself and in relation to the general categorisation, specification and treatment of health care services as regards pricing.
49. Second, the NT is not simply a ‘tariff’ or list of prices as its name might suggest: it is a detailed and complex document comprising prices, methods of calculation, as well as rules and guidance on a variety of matters (see further below).
50. Third, Monitor has a duty and discretion to decide which HCS are “*specified*” in the NT and which are “*not specified*” in the NT. This follows from s.116(1) which requires Monitor to publish an NT which specifies four things: (a) which “*certain*” health care services are “*specified*”, (b) the method used for determining the “*national price*” of those services, (c) what the “*national price*” of each of those services is, and (d) the method used for deciding whether to approve “*an agreement under section 124*” and for determining “*an application under section 125 (local modifications of prices)*” (see further below).
51. Fourth, significant consequences flow from the different categorisation of “*specified*” HCS or “*not specified*” HCS:
- (1) Specified HCS: Section 115(1) provides that the price for “*specified*” HCS is determined “*in accordance with the national tariff on the basis of the price (referred to in this Chapter as “the national price”) specified in the national tariff for that service.*” Thus, the actual price payable may differ from the original national price specified in the NT (see further below).
  - (2) Non-specified HCS: Section 115(2) provides that the price for “*not specified*” HCS is to be determined “*in accordance with the rules provided for in the national tariff for that purpose*”. Monitor has a discretion to make rules for determining the price payable for services which are “*not specified*” (s.116(4)).
52. Fifth, Monitor has a discretion as to how HCS may be designated, *viz.* respectively (a) in the NT as regards “*specified*” HCS, or (b) under the rules in the NT as regards “*not specified*” HCS, and this may be done in more than one way (ss.116(4)(a) and (b)). The ways in which Monitor may so designate may include in particular: (i) specifying the service by reference to its “*components*”, (ii) specifying it as a service that comprises two or more HCS which together constitute a form of treatment, *i.e.* a “*bundle*”, or (iii) specifying it as a service in “*a group of standardised services*” (s.117(1)-(3)).
53. Sixth, where two or more services are specified in a “*bundle*”, the NT must (a) stipulate a national price for the “*bundle*” in relation to “*specified*” HCS, or (b) make provision for determining the price payable for the “*bundle*” in relation to “*not specified*” HCS.

54. I turn next to explain the operation of the key provisions relating to the “*variation*” and “*modification*” of prices.

#### *Variation of prices*

55. There is provision for the “*variation*” of prices of HCS. As stated above, s.115(1) provides that the price for “*specified*” HCS is determined “*in accordance with the national tariff*” on the basis of “*the national price*”. Monitor has a discretion to make rules in the NT to enable the price for “*specified*” HCS to be varied so as to differ from the “*national price*” itself. There are two principal ways in which, “*in accordance with the national tariff*”, it is envisaged that such “*variations*” may be effected:

- (1) Local variations (under s.116(2)): pursuant to NT rules made under s.116(2), the commissioner and provider “*may agree to vary (a) the specification of the service under subsection [116](1)(a), or (b) the national price of the service*”. These are referred to as “*local variations*”, because they are agreed by individual commissioners and providers at a local level. A local variation may encompass a variation to the specification (and therefore, potentially a new price as well), or to the price or both. A commissioner must maintain and publish a written statement of the local variations it has agreed (s.116(3)).
- (2) National variations (under s.116(4)): pursuant to variations incorporated in the NT itself pursuant to s.116(4)(a), *i.e.* “*variations to the national price for a service by reference to circumstances in which the service is provided or other factors relevant to the provision of the service*”. These are referred to as “*national variations*”.

56. There is also provision for the “*variation*” of the “*national price*” of “*not specified*” HCS. As stated above, the price payable for “*not specified*” HCS “*is such price as is determined in accordance with the rules provided for in the national tariff for that purpose*” (s.115(2)). Section 6.4 of the current NT sets out a series of rules for determining these “*local prices*”. Commissioners have the freedom to agree prices for these “*not specified*” services as they see fit, subject to the applicable NT rules made under s.116(4)(b). Once they have agreed a price for a service, that will be the applicable price for the period covered by the agreement, until that period expires or a new price is agreed.

57. Thus, by reason of s.115(1) and s.115(2), the “*price payable*” by an HCS commissioner for the provision of “*specified*” and “*not specified*” HCS includes any such “*local variations*” (as described above). Whether an HCS commissioner is required to make a particular payment will depend on any rules on the making of payments (s.116(4)(c)) and any contractual or other provisions relating to payment (*e.g.* allowing set-off *etc.*).

#### *Modification of prices*

58. There is also separate provision for local “*modification*” of prices (s.116(1)(d)). As stated above, Monitor has a discretion to specify the

“method” used for deciding whether to approve a s.124 agreement or determine a s.125 application:

- (1) **Section 124 agreement:** Under s.124(1), an HCS commissioner and provider may agree that the price payable shall be the price determined in accordance with the NT “*as modified in accordance with the agreement*”. Monitor’s approval is required for a s.124 agreement to have effect (s.124(3)). Monitor may only approve such an agreement if it is satisfied that “*without a modification to the price determined in accordance with the NT, it would be uneconomic for the provider to provide the service for the purposes of the NHS*”(s.124(5)) (“the uneconomic test”).
  - (2) **Section 125 application:** Under s.125(1), an HCS provider who has failed to reach such an agreement, may apply to Monitor which has a discretion to decide that the price payable shall be the price determined in accordance with the NT “*as modified in such a way as Monitor may determine*”. Monitor must be satisfied of the uneconomic test before it may grant a s.125 application (s.125(3)).
59. Where it approves a “*local modification*” under s.124 or 125, Monitor must send a notice to the Secretary of State and such CCGs, providers and other persons as it considers appropriate (ss.124(6) and 125(6)) and must also publish the notice (ss.124(7) and 125(7)).
60. For ease of reference, I have attached a short glossary of terms to this judgment.

### **KERR J’S JUDGMENT**

61. At first instance, the Appellant argued that it was unlawful for a contract between a CCG and an ACO to include the WPAP as a payment mechanism for five principal reasons, namely (as summarised by the Judge):
- (1) The statutory provisions require payment to be made for a particular service; payment using the WPAP mechanism does not set a price for any particular service; instead, a global amount is, impermissibly, paid irrespective of what services are actually provided.
  - (2) Where the service in question is a “specified” service, payment by means of the WPAP, contrary to the statutory provisions, does not remunerate the provision of that service in accordance with the national price for the service set by or in accordance with the national tariff.
  - (3) Where the service is not a “specified” service, payment by means of the WPAP, contrary to the statutory provisions, does not remunerate the provision of that service by applying the rules set out in the national tariff for determining the amount payable in respect of it.
  - (4) The WPAP fails to respect the delineation between specified and non-specified services, treating them alike and remunerating them en bloc

as part of the same annual payment under the WPAP, instead of observing the distinction between the two types of service required by the legislation and the national tariff.

- (5) A lawful mechanism for payment would require identification of the number of patients treated and the type of service or treatment given to each. Furthermore, the national tariff requires differentiation of payments as between payment for primary care and for secondary care; the former are not included within the national tariff at all.”

62. In a judgment of admirable succinctness and clarity, Kerr J rejected the Appellant's submissions and what he referred to as the "narrow and rigid interpretation" of the 2012 Act advanced by Mr Lock QC on behalf of the Appellant. The Judge's main findings can be summarised as follows:
- (1) First, the term HCS is widely conceived in the 2012 Act with "a rich profusion of superfluous and overlapping definitions [which] is inconsistent with the claimant's narrow conception of a health service as a simple singular treatment episode of one patient" (paragraphs [81] and [84]).
  - (2) Second, HCS 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" (paragraph [83]).
  - (3) Third, the NT is an "amorphous collection" of rules and guidance not (merely) a rigid list of prices or scale rates (paragraphs [88] and [89]).
  - (4) Fourth, nothing in the WPAP offends against the 2012 Act which does not require the fixing of prices in advance on the basis of each individual treatment episode (paragraph [92]-[95]).
63. For these reasons, Kerr J dismissed the Appellant's claim that the WPAP was unlawful.

### **GROUNDS OF APPEAL**

64. The Appellant's seven (overlapping) grounds of appeal against Kerr J's judgment may be summarised as follows:
- (1) Kerr J's conclusion (at Judgment, paragraph [99]) required the finding that the draft ICP Contract failed to comply with mandatory statutory rules under a combination of the 2012 Act and the NT and his decision was thus unlawful in failing to make that finding.
  - (2) The Judgment fails to distinguish between the statutory roles of NHS England and Monitor and thus fell into error.
  - (3) Section 115 imposed a statutory duty to pay a price calculated in accordance with that section, and Kerr J erred in not so holding.
  - (4) The WPAP failed to follow the mandatory rules of the NT and was therefore unlawful, and Kerr J erred in failing to address this issue.
  - (5) Section 115 required payment to be calculated on the basis of the national price for a service, and the WPAP is therefore unlawful because it prevented any individual service having a price.
  - (6) The draft ICP Contract failed to differentiate between "*specified*" services, "*not specified*" services, and primary care services; in particular, the latter are excluded from the NT and therefore it is

unlawful for the WPAP to include payment for them because there is no relevant price for them.

- (7) Parliament intended the 2012 Act to allow competition on the grounds of quality and choice, but not price; and the construction upheld by Kerr J is contrary to this and therefore wrong.
65. Mr Lock QC supplemented these Grounds of Appeal in his oral submissions and by means of a ‘speaking note’. He made two concessions. First, he accepted that a combination of s.150 and s.64(3) of the 2012 Act and the provisions of the NHS Act 2006 mean that an HCS did not need to be specified by reference to a service to an individual patient; but could be specified by reference to a class of service without linking the payment to services provided to a particular patient. He abandoned, therefore, a central plank of his submissions before the Judge, namely that the meaning of HCS in paragraph 115(1) was a reference to ‘pre-defined medical treatment for an individual NHS patient provided by an NHS provider’. In my view, this concession was rightly made: there was no basis in the language of the 2012 Act for his restrictive construction.
66. Second, Mr Lock QC accepted that the statutory scheme was never intended to be totally rigid but submitted that the Judge was, nevertheless, wrong to have concluded that what he called the ‘limited flexibilities’ in the statutory payment system could be used to abandon any form of PbR and return to a single payment or “*block contract*” system, which he described as ‘entirely detached from the number of patients who are treated, the complexities of the treatments or the cost to the provider of delivering those treatments’ and would lead to what he described as a ‘race to the bottom’ on quality.
67. Mr Lock QC acknowledged that there was a political debate about the merits of the proposed WPAP contracting arrangements compared with the PbR contracting arrangements; but he accepted that the court was merely concerned with the strict legality of the proposed changes in contracting arrangements, not their merits. I agree.
68. In the light of these concessions, Mr Lock QC sought to recast his argument on construction. Mr Lock QC’s essential argument on construction can, I believe, be summarised as follows: (i) The only mechanism for variation of “*the national price...specified in the national tariff*” payable by commissioners for HCS is the mechanism laid down under ss.124 and 125, namely “*local modifications*” (under s.115); (ii) Agreements by way of “*local modifications*” require prior approval by Monitor to be enforceable (s.125(3)); (iii) Price changes by way of “*local modifications*” would, in practice, only be subject to increase because of the requirement for Monitor to apply the uneconomic test (s.124(5)); and (iv) There is no material distinction between “*local variations*” under s.116(2) and “*local modifications*” under ss.124-125; and (v) Section 115(1) imposes a statutory duty on an NHS commissioner to pay the specified price. It is on this basis that Mr Lock QC argues that the WPAP mechanism is not permitted under the 2012 Act and is unlawful.





### *Respondents' argument*

69. Ms Morris QC argued on behalf of the Respondents that the proposed WPAP scheme was lawful and consistent with both the letter and spirit of the 2012 Act. She submitted that the Appellant has misconstrued and misunderstood ss.115-125 of the 2012 Act and the WPAP mechanism which was properly in line with the aims of the legislation to promote quality, integration and innovation in the provision of NHS services.

### ANALYSIS

70. In my judgment, the Appellant's argument on construction is clearly wrong and misconceived for the following principal reasons.
71. First, the price payable under s. 115 is not simply "*the national price...specified in the national tariff*" as Mr Lock QC would suppose. It is important to pay close regard to the full wording of s.115 which, as its title suggests, governs the "*Price payable by commissioners for NHS services*". Sub-section 115(1) provides in terms that the price payable is: "*...such price as is determined [i] in accordance with the national tariff [ii] on the basis of the price (referred to in this Chapter as "the national price") specified in the national tariff for that service*" (subject to s.124 and s.125). All the words in the sub-section must be given meaning: the words "*in accordance with the national tariff...*" indicate that the price payable may differ from "*the national price*" by reason of the provisions of the NT itself.
72. Second, as observed above, the NT is not simply a list of prices. It is an extensive and complex document of 120 pages which provides for prices to be varied nationally or locally, by "*local variations*" or "*local modifications*". The NT describes itself accurately in its introduction as follows:

*"This document is the national tariff, specifying the currencies, national prices, the method for determining those prices, the local pricing and payment rules, the methods for determining local modifications and related guidance that make up the national tariff payment system ..." [Emphasis added]*

(A "*currency*" in this context is a unit of health care. These are broad and flexible and may include, *e.g.*, an attendance at Accident & Emergency, or a spell in hospital for an operation from admission through to discharge, as well as the provision of a particular facility or a "*bundle*" of services for a group of patients. "*Currencies*" are not confined to instances of the provision of a discrete service to an individual. New "*currencies*" may be created. "*National prices*" are set for health care "*currencies*").

73. As Kerr J rightly observed, Mr Lock QC's resort to the dictionary definition of "*tariff*" was misconceived: "[I]t is clear from the statutory scheme that the "*national tariff*" is much more than that and indeed the expression "*national tariff*" is in part a misnomer" (Judgment, paragraph [89]). I agree with the Judge's succinct characterisation of the NT: "The national tariff... is an amorphous collection of rules and guidance that may be diffuse and far

removed from a rigid list of prices or scale rates” (Judgment, paragraph [89]). As Ms Morris QC memorably put it, it is ‘baked in’ to the NT that it contemplates variation.

74. Third, contrary to Mr Lock QC’s assertion, there are a variety of ways in which the “*national price*” may be changed. Section 115(1) does not suggest there is only one method of departing from the “*national price*” as a result of applying the NT. On the contrary, s.115(1) refers broadly to determining the price “*in accordance with the national tariff*”. This covers *any* variation or modification permitted by the NT. The NT sets out in considerable detail the manner in which prices may be varied or modified. Thus, Section 5 of the NT, entitled “*National variations to national prices*”, sets out in detail how prices may be varied nationally (pages 64-77), and Section 6 of the NT, entitled “*Locally determined prices*”, sets out how prices and currencies may be determined locally, including by variation or modification, or, where there is no national price, by local agreement (pages 78-118).
75. Fourth, Mr Lock QC’s construction equates “*local variations*” under s.116(2) with “*local modifications*” under s.124/125 and leaves s.116(2) with no separate meaning or effect. In my view, it is plain that the two price adjustment mechanisms of “*local variation*” and “*local modification*” are quite separate and distinct. This is clear from the following points: (i) The distinct statutory language used, *i.e.* “*local variation*” as opposed to “*local modification*”. Parliament is presumed to have used legislative language “correctly and exactly, and not loosely and inexactly” (*New Plymouth Borough Council v Taranki Electric Power Board* [1933] AC 680 (PC) 682 *per* Lord Macmillan). There is a presumption that different words used in a statute have different meanings (*Re Globespan Airways Ltd* [2012] EWCA Civ 1159, *per* Arden LJ (as she then was) at paragraph 42). (ii) The absence of any cross reference between the s.116(2) and ss.124-125. (iii) The fact that, by contrast, s.116(1)(d) does expressly cross-refer to ss.124-125, in providing that the NT must specify the “*method*” used by Monitor for deciding whether to approve an agreement under s.124 and for determining an application under s.125, which reinforces the notion that, when it came to s.116(2), Parliament was not simply repeating that the NT may provide for rules on s.124 agreements (as s.116(1)(d) already made clear), but rather had in mind a different type of agreement. (iv) The different treatment and outcomes of the two separate mechanisms, *viz.* a “*local variation*” may result in the price being increased or decreased, whereas a “*local modification*” will only result in the price being increased (where Monitor is satisfied that absent the modification it would be “*uneconomic*” to provide the service (s.124(5))).
76. Fifth, Mr Lock QC’s construction also ignores a host of key differences between the distinct statutory mechanisms for “*local variations*” and “*local modifications*”. I mention five highlighted by Ms Morris QC: (i) Section 116(2) envisages a commissioner and provider being able to agree to vary the specification (*i.e.* currency) of the service or the price for the service; whereas, by contrast, s.124 is solely concerned with agreements to modify prices. (ii) Section 116(2) refers to varying “*the national price*”, whereas s.124 refers to modifying “*the price determined in accordance with the national tariff*”. This

reflects the fact that “*local variations*” under s.116(2) are a mechanism for determining the price in accordance with the NT, whereas “*local modifications*” under s.124 are a process for modifying the price that has *already* been determined in accordance with the NT. For this reason, it is possible for Monitor to approve a “*local modification*” under ss.124 or 125 of a price that has *already* been varied by agreement under s.116(2). (iii) Section 116(2) provides that the NT “*may*” (not must) provide for rules to permit local variations. Monitor thus has a discretionary power which allows it, but does not require it, to include such rules in the NT. By contrast, the provisions of ss.124 and 125 ensure that there will always be a mechanism for “*local modifications*” to address uneconomic services. (iv) The effectiveness of local modification agreements is subject to important restrictions, namely the need for Monitor’s approval (s.124(3)) and the requirement for Monitor to be satisfied that absent the modification it would be “*uneconomic*” to provide the service (s.124(5)). Both restrictions only apply to an agreement “*under this section*”, *i.e.* under s.124. By contrast, there are no such restrictions on s.116(2) local variations. (v) Under s.116(3), a commissioner must maintain and publish a written statement of the local variations it has agreed in accordance with rules made under s.116(2). By contrast, the publication requirements in relation to local modifications rest not with commissioners but with Monitor (ss.124(6)-(7) and ss.125(6)-(7)).

77. Sixth, “*local variations*” are adjustments to a national price agreed between a provider and commissioner. Variation may involve either an increase or a decrease to a national price, and will often be accompanied by changes to service specification or currency. As the Explanatory Notes to the 2012 Act make clear (at paragraph 868):

*“[Section 116(2) makes] provision for rules which may be included in the NT providing for:*

- *providers and commissioners to agree to vary the prices payable under the national tariff or the specification of a health care service specified in the national tariff (subsection (2)). The intent is to enable flexibility to be provided within the national tariff, for example, to support innovation in service delivery, integration of services, or unbundling of services to enable components of care to be delivered and paid for separately, where this would be in patients’ best interests.”*

78. It is noteworthy that NT contemplates a wide variety of different “*local variations*” (including those based on a “*whole population budget*”). Thus, for instance, in relation to urgent and A&E care, the NT provides:

*“Examples of local variations for UEC services covered by the national tariff*

*361. Local areas should decide on the payment model and scope that will best deliver their aims locally ensuring*

*alignment with STP [sustainability and transformation plans]*

....

362. *Examples of the types of local variation that could be considered include:*

*a. payment based on an agreed level of activity and associated spend, overlaid with a gain and a loss share*

*b. payment comprising a fixed (core) element and an activity-based element*

*c. whole population budget (WPB), overlaid with a gain and loss share.”*

79. Seventh, by contrast, the “*local modification*” regime under ss.124-125 allows adjustments to price only, and in the form of a price increase only, in circumstances where Monitor is satisfied that it is “*uneconomic*” for the provider to provide services at the price determined in accordance with the NT (*i.e.* “*the national price*” as nationally or locally varied). As the Explanatory Notes explain (at paragraph 906):

*“[Section 124] specifies the process for a provider of a health care service for the purposes of the NHS and the relevant commissioner to agree a modification of prices payable in accordance with the national tariff (subsection (1)).”*

80. Eighth, I reject Mr Lock QC’s submission that the word “*or*” in s.116(2) means that “*local variations*” may be agreed to “*specifications*” or “*national price*” but not both. There is no warrant for such a strained and restrictive construction. The word “*or*” is usually used in its inclusionary rather than its exclusionary sense (*c.f.* Reed Dickerson, *Fundamentals of Legal Drafting* (Aspen Publishers, 1965), p.77). The context here also makes it clear that it is used in its inclusionary sense: the statutory scheme as a whole is broad, liberal and permissive and it would make no sense to construe s.116(2) as only allowing variation of specification or of price since a variation of one will often involve a variation of the other.
81. Ninth, I reject Mr Lock QC’s submission that “*local variations*” and “*local modifications*” are but stages in a single process and that the restrictions on “*local modifications*” under ss.124 and 125 apply to “*local variations*” under s.116(2), so that price can only be adjusted upwards. In my view, it is clear from the terms of sections ss.115-125 of the 2012 Act, as well as an overall reading of Chapter 4 of the 2012 Act, that the two price adjustment mechanisms are separate and have different purposes.
82. Tenth, like the Judge, I reject Mr Lock QC’s argument that somehow s.115 creates a statutory duty which requires a commissioner be liable to pay a provider “*the price payable*”, irrespective of what has been contractually agreed between them. I agree with Ms Morris QC that this argument is both incorrect and irrelevant. This was plainly not Parliament’s intention as the

scheme of the 2012 Act makes clear. If that had been Parliament's intention, it would have been unnecessary *e.g.* for Parliament to give Monitor various enforcement powers under ss.117(4) and (5). In any event, the point is irrelevant because, even if there were such a statutory duty (which there is not), this would not render the WPAP an unlawful payment mechanism. The Judge's pertinent comment at paragraph 99 of his judgment that in order for there to be a s.116(2) local variation, there must be a price to vary, does not assist Mr Lock QC. The Judge was not saying that the draft ICP Contract was not lawful. On the contrary, the Judge correctly concluded that the WPAP was a lawful payment mechanism under the statutory scheme. A commissioner which enters into an ICP contract with a WPAP will be paying the draft ICP Contractual Price payable under the ICP pursuant to s.115.

83. Finally, I reject Mr Lock QC's suggestion that the proposed WPAP scheme pays no regard to the principles which underpin NHS commissioning. The WPAP model expressly states:

*"1.1.4. ... In developing a WPB to support implementation of an ACO care model, commissioners and providers must be satisfied that their proposed local approach complies with the principles and rules detailed in the NTPS [National Tariff Payment System] local pricing section."*

84. The NT (or NTPS) sets out the following principles for locally determined prices:

***"6.1 Principles applying to all local variations, local modifications and local prices***

326. *Commissioners and providers must apply the following three principles when agreeing a local payment approach:*

- a. the approach must be in the **best interests of patients***
- b. the approach must **promote transparency** to improve accountability and encourage the sharing of best practice*
- c. the provider and commissioner(s) must **engage constructively** with each other when trying to agree local payment approaches."*

85. The NT further states that rules on acting in patients' best interests:

***"6.1.1 Best interests of patients***

*"328. Local variations, modifications and prices must be in the best interests of patients today and in the future. In agreeing a locally determined price, commissioners and providers must therefore consider the following factors:*

1. *Quality: how will the agreement maintain or improve the outcomes, patient experience and safety of healthcare today and in the future?*
2. *Cost effectiveness: how will the agreement make healthcare more cost effective, without reducing quality, to enable the most effective use of scarce resources for patients today and in the future?*
3. *Innovation: how will the agreement support, where appropriate, the development of new and improved service delivery models which are in the best interest of patients today and in the future?*
4. *Allocation of risk: how will the agreement allocate the risks associated with unit costs, patient volumes and quality in a way that protects the best interests of patients today and in the future?"*

86. The NT further makes clear:

*“357. [I]t is not appropriate for local variations to be used to introduce price competition that could create undue risks to the safety or the quality of care for patients”*

#### *Summary*

87. For the reasons set out above, in my view, the Appellant’s arguments on construction are misconceived and without merit. I agree with Kerr J that the WPAP payment mechanism under the draft ICP Contract may lawfully be promulgated and used under the flexible statutory scheme laid down by the 2012 Act, which allows for a variety of variations of prices and specifications.

#### *Reasons for rejection of Grounds of Appeal*

88. It will be apparent from the above that I reject all the Appellant’s Grounds of Appeal. However, for the sake of completeness, I briefly summarise below the reasons for doing so *seriatim*.

- (1) Ground 1 ‘The effect of NHS England not requiring a CCG and a provider to set a price for specified services’: The Appellant argues that the draft ICP Contract fails to deliver any enforceable variation of NT prices under s.116(2). However, it is wrong to say that there is no “*price*” as part of the WPAP for the varied specification for specified services. The WPAP is that price, *i.e.* the price payable under s.115.
- (2) Ground 2 ‘The Judge failed to recognise distinction between the statutory roles of NHS England and Monitor’: The Appellant criticises the Judge for ‘conflating’ the roles of NHS England and Monitor in paragraphs [82], [83] and [93]-[92] of the judgment. However, nowhere in the judgment is there any such conflation. On the contrary,

at paragraphs [22]-[26] the Judge sets out and explains their distinct roles.

- (3) Ground 3 ‘Section 115 imposed a statutory duty to pay a price calculated in accordance with that section, and Kerr J erred in not so holding’: The reasons why the Appellant’s main arguments on construction are wrong are set out above.
- (4) Ground 4 ‘The WPAP does not comply with NT rules on setting prices for non-specified services’: The Appellant argued that the method defined by NHS England which commissioners and providers should follow when agreeing the WPAP does not follow the NT decision making model whatsoever. However, this is incorrect. As the Judge correctly concluded, the 2012 Act (a) does not require a PbR basis for all prices, (b) permits the “*bundling*” of specified and non-specified services and (c) that (in the case of “*specified services*”) a WPAP could be implemented by a s.116(2) local variation. It is then for individual commissioners and providers to comply with applicable NT rules when agreeing a WPAP, *i.e.* the rules on local variations in respect of specified services and the rules on agreeing local prices in respect of non-specified services (see above).
- (5) Ground 5 ‘Prices of NT services must be “on the basis” of the NT prices, and NT services within a WPAP are not’: The Appellant argues that the WPAP is not a payment mechanism which defines the amount to be paid for specified services “*on the basis of*” the national price as required by s.115(1), and hence it cannot be lawful. As explained above, the Appellant’s construction ignores the full wording of s.115(1) and, in particular, the words “*in accordance with the national tariff...*” which precede the words “*...on the basis of the [national price]*”.
- (6) Ground 6 ‘The failure to differentiate (a) NT services, (b) NT non-specified services and (c) primary care services’: By Ground 6, the Appellant contends that “*primary care services*” are wholly outside the NT, such that they cannot lawfully be bundled together with other NHS services in the way envisaged by the draft ICP Contract. However, this contention is incorrect: “*primary care services*” fall within the scope of the pricing provisions of the 2012 Act, since they constitute HCS provided for the purposes of the NHS. “*Health care*” is defined at s.64(3) of the 2012 Act as all forms of health care provided for individuals, whether relating to physical or mental health, and references in Part 3 of the 2012 Act to HCS are to be construed accordingly.
- (7) Ground 7 ‘Parliamentary intention’: By Ground 7, the Appellant contends that the Judge failed to give effect to an alleged parliamentary intention that there is only one method of changing “*national prices*”. However, for the reasons given above, the construction of ss.115-117 and ss.124-5 of the 2012 Act is pellucid and it is not appropriate or

necessary to have to resort to the *travaux preparatoires* (c.f. *Pepper v. Hart* [1993] AC 593).

**CONCLUSION**

89. For the reasons set out above, in my view, Kerr J was right to hold that there is nothing unlawful about the proposed WPAP scheme. The answer to the question posed by Arden LJ is: ‘Yes, the Judge was right to hold that s.115 of the 2012 Act does not require visible prices fixed in advance for each individual episode’. I therefore reject the Appellant’s case on construction of the 2012 Act and would, accordingly, dismiss the appeal.

**LADY JUSTICE NICOLA DAVIES**

90. I agree.

**PRESIDENT OF THE FAMILY DIVISION, SIR ANDREW McFARLANE**

91. I agree.



## GLOSSARY

<b>Term</b>	<b>Reference text in judgment</b>
999 Call for the NHS	the Group
Accident and Emergency	A&E
Accountable Care Organisation Contract	the draft ACO Contract
Clinical Commissioning Group(s)	CCG
General Conditions (under draft ICP Contract)	GC
Health and Social Care Act 2012	the 2012 Act
Health Care Services	HCS
Healthcare Resource Groups	HRGs
Integrated Care Provider Contract	the draft ICP Contract
National Health Service Act 2006	the 2006 Act
National Health Service Commissioning Board	NHS England
National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012	the 2012 Regulations
National Tariff	NT
Payment by Results	PbR
Secretary of State for Health and Social Care	the Secretary of State
Whole Population Annual Payment	WPAP