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Case No: CA-2023-000244

IN THE COURT OF APPEAL (CIVIL DIVISION)
ON APPEAL FROM THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
ADMINISTRATIVE COURT
MR JUSTICE CHAMBERLAIN
[2023] EWHC 43 (Admin)

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 31/07/2023

Before :

LADY JUSTICE KING
LORD JUSTICE MOYLAN
and
LORD JUSTICE POPPLEWELL

Between :

THE KING on the application of
(1) AA (a child, acting by her father and litigation friend, SW)
(2) AK (a child, acting by her mother and litigation friend, CK)
(3) ALEXANDER HARVEY
(4) EVA ECHO

**Claimants/
Appellants**

- and -

NATIONAL HEALTH SERVICE COMMISSIONING BOARD
(Operating under the name "NHS ENGLAND")

Respondent

- and -

(1) TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST
(2) DEVON PARTNERSHIP NHS TRUST

**Interested
Parties**

Thomas De La Mare KC and Jason Pobjoy (instructed by **Rook Irwin Sweeney LLP**)
for the **Appellants**
Eleanor Grey KC (instructed by **Blake Morgan LLP**) for the **Respondent**

Hearing date: 11 July 2023

Approved Judgment

This judgment was handed down remotely at 2:00pm on 31 July 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

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Lord Justice Popplewell:

Introduction

1. The Appellants are two children (now aged 12 and 15) and two adults who all identify as a gender other than their natal sex assigned at birth and who have been referred by their GPs to specialist NHS services which provide assessment and treatment to those with gender incongruence/dysphoria. They have all waited a long time for such services to be provided, in three of the four cases for several years. This is a common experience for many people referred for NHS gender identity treatment. The Respondent is NHS England ('NHSE'), which is responsible for arranging for specialist gender identity services, amongst many others. Regulation 45(3) of the National Health Service Commissioning Board and Clinic Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (the '2012 Regulations') requires NHSE to "make arrangements to ensure" that not less than 92% of a cohort of patients being referred for non-acute treatment wait less than 18 weeks. The cohort includes those being referred for at least some gender identity services, but is by no means limited to them; it includes a much wider class of those seeking various treatments for which NHSE is responsible.
2. The appeal raises two issues of importance for all NHS patients, not merely those referred for gender identity services. The first is whether the duty is one to achieve the 18 week standard, or a duty to act with a view to achieving that result. The Judge accepted NHSE's case that it was the latter, in public law parlance a 'target duty' following the coining of that phrase by Woolf LJ in *R v Inner London Health Authority ex pte Ali* (1990) 2 Admin LR 822. I shall call this the duty issue. The second issue is whether the cohort to whom the duty is owed is restricted to those referred for consultant-led treatment. The Judge held that it was not. NHSE challenge that conclusion by a Respondent's Notice. I shall call this the cohort issue.

The statutory framework

The primary legislation

3. Part 1 of the National Health Service Act 2006 ('the 2006 Act'), as amended by the Health and Social Care Act 2012, is concerned with the promotion and provision of the National Health Service in England. Section 1H(1) in Part 1 of the 2012 Act established a body corporate known as the National Health Service Commissioning Board, which by s.1 Health and Care Act 2022 was renamed NHS England. Section 1H(2) provides that NHS England is subject to the duty to promote a comprehensive health service concurrently with the Secretary of State. That duty is set out in section 1(1) of the 2012 Act as a duty to "continue the promotion in England of a comprehensive health service designed to secure improvement - (a) in the physical and mental health of the people of England, and (b) in the prevention, diagnosis and treatment of physical and mental illness."
4. Pursuant to section 1H(3)(a) of the 2006 Act, NHSE has the function of arranging for the provision of NHS services in England for the purposes of discharging that duty and under 1H(3)(b) must do so "so as to secure that services are provided for those purposes in accordance with this Act.". Under s.3A it commissioned most secondary care through Clinical Commissioning Groups ('CCGs'), and under s.14Z it has done so since 2022 through Integrated Care Boards ('ICBs'), which replaced CCGs. However by s.3A(3)

there are some services which it is required to commission itself, namely those identified in s.3B (services designated as such by the Secretary of State in Regulations) or s.4 (secure psychiatric services). I shall call these services for which NHSE has direct responsibility ‘NHSE only services’. The Secretary of State’s designation power in respect of NHSE only services is expressed in s.3B to be a power to make Regulations to require NHS England to arrange provision of certain types of health service “to such extent as it considers necessary to meet all reasonable requirements.”

5. The 2012 Regulations were made by the Secretary of State in exercise of this power. They were also made in exercise of a power in s.6B of the 2012 Act under which the Secretary of State may impose “standing rules” on NHSE and ICBs as to how they go about fulfilling the exercise of their commissioning functions. In particular, and so far as relevant to the issues in this appeal, s.6E(2)(a) empowers regulations requiring NHSE to “arrange for [treatments/services] to be provided for...within a specified period”. Section 6E(2)(b) empowers regulations making provision “as to the arrangements that NHSE or [ICBs] must make for the purposes of making decisions as to “...(ii) the periods within which [treatments/services] are to be provided”. The waiting time provisions in regulation 45 and following were made pursuant to s.6E(2)(a), not as Mr De La Mare KC submitted, s.6E(2)(b), which is concerned with decision making. The background to the interpretation of regulation 45(3) for the purposes of the duty issue is, therefore, that it is a regulation which the Secretary of State has made *requiring NHSE to arrange for* treatments/services to be provided for in accordance with the 18 week standard.

The 2012 Regulations

6. Part 3 of the 2012 Regulations sets out NHSE only services which are to be arranged by NHSE, rather than ICBs. They include dental services, services for the armed forces and their families, services for prisoners and most pertinently, by regulation 11, a category of services described as “specified services for rare and very rare conditions”, which are set out in Schedule 4. Schedule 4 lists a wide range of specialist services, including at paragraph 56 “Gender identity development service for children and adolescents” and at paragraph 57: “Gender identity disorder services”. I shall refer to these last two compendiously as ‘GI services’. Regulation 11 provides that NHS England “must arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision as part of the health service of the services specified in Schedule 4.”
7. Part 9 of the 2012 Regulations sets out standing rules regarding waiting times. Regulation 45, as amended, provides:

“(3) A relevant body must make arrangements to ensure that at the end of each [calendar month], not less than 92% of the persons falling with paragraph (4) have been waiting to commence appropriate treatment for less than 18 weeks.

(4) A person falls within this paragraph if—

- (a) the relevant body has responsibility for that person;
- (b) there has been a start date in respect of that person; and
- (c) the person's waiting time period, as specified in regulation 46, has not come to an end.”

8. The percentages required to meet the 18 week waiting time have changed since 2012. When the Regulations were made in 2012 it was 95% for admitted patients and 90% for out-patients. The Regulations were amended by the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) (No 2) Regulations 2015 to introduce a single 92% standard across all referrals.
9. Regulation 44 contains the following definitions which are relevant to the regulation 45 duty:

“appropriate treatment” means treatment that is the first treatment provided to a person as a result of, and in response to, an elective referral.

“elective referral” is a referral by an eligible referrer to a health service provider for assessment or treatment that is not identified as being immediately required at the time of referral.

“eligible referrer” means –

- (a) a general dental practitioner
- (b) a general medical practitioner
- (c) a person approved to make an elective referral under arrangements made by the relevant body which has responsibility for the person being referred
- (d) any other person whose request to refer is accepted by –
 - (i) a consultant,
 - (ii) a member of a consultant’s team,
 - (iii) persons providing interface services where a person who has been referred may be referred on by those services to a consultant or a consultant-led team,

who is to provide the assessment or treatment as a result of the referral;

“start date” means the date on which the person’s referral request was received by the health service provider to whom that person has been referred for the provision of health care services by-

- (a) in regulations 45 to 51 –
 - (i) an eligible referrer; or
 - (ii) themselves with the approval of an eligible referrer

“interface services” means services that are provided otherwise than by a consultant-led team, which provide clinical triage, assessment and treatment services, but does not include mental health services provided under a primary care contract.”

10. Regulation 2 of the 2012 Regulations provides that a “health service provider” is a person, other than NHSE England or an ICB, who has entered into a commissioning contract. It is not limited to those providing consultant-led services.
11. Pausing there, a number of aspects of the regulation 45 duty may be noted. First, NHSE and ICBs are “relevant bodies”, so that the duty applies to ICBs for the services for which they are responsible and to NHSE for the NHSE only services.
12. Secondly, the 18 week period is subject to regulation 46 which makes provision for when it is to come to an end. This is not only when treatment occurs, but includes also a number of other circumstances, for example where there is a clinical decision that no treatment is appropriate, or that it be provided by a primary care provider, or where waiting longer than 18 weeks is in the patient’s best interests, or where appointments are missed. The 8% margin in the waiting time standard is not, therefore, to cater for cases involving these circumstances, which do not count for the purposes of measurement in the data. The 8% margin allows for a failure to meet the standard for that proportion of the cohort despite it being the desired outcome for the entire cohort.
13. Thirdly, the nature of the referral services which defines the cohort for the waiting time standard in regulation 45(3) is to be found not only in the definitions of appropriate treatment and elective referral, which identify the referee as any health service provider, but also, at least in part, in the definition of eligible referrer, because the definition of start date means that the clock only starts for the purposes of the 18 week period if and when there has been a referral by an eligible referrer, as defined. The main focus of the argument on the cohort issue has therefore been on the definition of eligible referrer. Fourthly, the only reference to the nature of services in that definition comes in sub paragraph (d)(i), (ii) and (iii). Fifthly that is a definition which includes some but not all interface services, namely those which may result in a referral on to a consultant-led team. The submissions of both sides used the expression ‘consultant-led services’ to include this aspect of interface services, and I shall use the same shorthand.
14. Sixthly, and importantly, the 18 week standard is owed to a cohort as a class (whether or not limited to consultant-led services). No person can assert a breach of such duty owed to that person individually because of the 8% margin. Any particular patient may not receive treatment within 18 weeks irrespective of whether the 18 week period is achieved for 92% of the cohort. The evidence in this case advanced by the claimants focussed on waiting times for GI services, for understandable reasons. However there would be no breach of the regulation 45(3) duty, even if an achievement duty, if all GI patients waited longer than 18 weeks, provided 92% of the much wider cohort of patients to whom the duty is owed waited for 18 weeks or less. Accordingly the regulation 45(3) duty is not a duty owed to any individual. Indeed it is not just owed to the existing cohort of those referred for relevant services, but owed to the population as a whole, because any person may at any time fall into a category covered by the cohort definition.
15. Regulation 48 imposes a duty on NHSE and ICBs where the 18 week standard is not met. It is triggered by the expiry of the 18 weeks or an earlier notification that the 18 weeks will not be met. It arises only where there has been a referral by or with the approval of an “eligible referrer” by reason of regulation 47(2); and additionally it applies only to referrals for consultant-led services by virtue of regulation 47(3) which includes as one of the qualifying conditions that there has been a referral where:

“The referral is for assessment or treatment in the course of the provision of healthcare services by –

- (a) a consultant;
- (b) a member of a consultant’s team; or
- (c) persons providing interface services where a person who has been referred may be referred on from those services to a consultant or consultant led team”

16. This is the same definition as appears in (d)(i)-(iii) of the eligible provider definition for the purposes of the regulation 45(3) duty, for which I am using consultant-led services as the shorthand.

17. The duty is contained in regulation 48(1) which provides that the relevant body (NHSE or an ICB respectively) “must take all reasonable steps to ensure that the person is offered an appointment” with another provider in accordance with 48(2) to (4). Regulation 48(4) provides that if there is more than one suitable alternative provider the patient is to be given a choice between at least two such alternative providers.

18. A number of matters may be noted about this duty. First it is owed directly to individuals who have not or will not have the 18 week waiting time met. It is an individual duty, in contrast to the regulation 45(3) duty. Secondly, it is not a duty to achieve a result but only to “take all reasonable steps to ensure” the alternative provision. It is a target duty, not an achievement duty. Thirdly, it is only available to those who have previously had a referral to consultant-led services. It does not apply to those waiting more than 18 weeks for non consultant-led services. Fourthly, the alternative provision required is itself confined to consultant-led services.

19. Fifthly, it follows that if, as the appellants contend, the regulation 45(3) duty is an achievement duty and not confined to consultant-led services, there is a mismatch with this alternative provision regime in two respects, namely (1) that it applies to a different cohort because it is confined to those previously having had a referral to a consultant-led service; and (2) it imposes only a target duty for alternative provision.

20. The 2012 Regulations were published with an explanatory note at their conclusion which states, as is usual, that it is not part of the Regulations (‘the Explanatory Note’). There was also produced and laid before Parliament an explanatory memorandum prepared by the Department of Health (‘the Explanatory Memorandum’).

21. The Explanatory Note includes the following:

“The provisions in Part 9 underpin rights set out in the NHS Constitution, namely the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of alternative providers if this is not possible. Regulation 45 imposes a duty to make arrangements to ensure that treatment appropriate to the reason for an elective referral is provided within eighteen weeks of receipt of notice of such referral in a specified percentage of cases. Regulations 47 and 48 impose a duty to offer an alternative provider of healthcare services in certain circumstances where a person is not going to receive appropriate treatment within the eighteen week period.”

22. The Explanatory Memorandum states at paragraph 7.19 that the standing rules provide the legal basis for “three patient rights”, one of which is “The right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of alternative providers if this is not possible.”
23. It is common ground that such explanatory material is a legitimate aid to determining the construction and purposes of primary and secondary legislation: see Bennion *Bailey and Norbury on Statutory Interpretation* 8th edn at 24.24 and 24.14. However, external aids to interpretation such as these play a secondary role; it is the words of the provision itself, read in the context of the regulation as a whole, the other regulations, and the statutory framework, which are the primary means by which meaning is to be ascertained: *R (Project for the Registration of Children as British Citizens) v Secretary of State for the Home Department* [2022] UKSC 3; [2023] AC 255 at [29]-[30]. Reference to the explanatory notes may inform the assessment of the overall purpose of the legislation, and may also provide assistance to resolve any specific ambiguity in the words used in a provision in that legislation. Whether and to what extent they do so very much depends on the circumstances and the nature of the issue of interpretation which has arisen: *R (PACCAR Inc) v The Competition Appeal Tribunal* [2023] UKSC 28 at [42]. In *R(D) v Secretary of State for Work and Pensions* [2010] EWCA Civ 18, [2010] 1 WLR 1782 Carnwath LJ said at [49] that the assistance to be derived from explanatory material in the case of secondary legislation may be greater than for primary legislation since it emanates from the Secretary of State who is responsible for making the instrument; and because Parliament has no amending power, merely the ability to accept or reject the instrument as a whole when laid before it.

The RTT Rules Suite

24. Regulation 50 of the 2012 Regulations provides that, in carrying out its duties under regulation 45, NHSE must have regard to guidance in the document *The Referral to Treatment Consultant-led Waiting Times Rules Suite* dated October 2015 (‘the RTT Rules Suite’). The RTT Rules Suite states in its executive summary:
- “1. In England, under the NHS Constitution ‘patients have the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of alternative providers if this is not possible’. The Department collects and publishes monthly referral to treatment (RTT) data which are used to monitor NHS waiting times performance ...
2. The rules suite aims to set out clearly and succinctly the rules and definitions for referral to treatment *consultant-led* waiting times to ensure that each patient’s waiting time clock starts and stops fairly and consistently.” (my emphasis).
25. The RTT Rules Suite then goes on to provide many examples of how the 18 week period and the exceptions to it are to be applied in a range of situations. As its title and executive summary make clear, it is confined to consultant-led services.

The NHS Constitution

26. Section 2 of the Health Act 2009 requires NHSE to “have regard to The NHS Constitution” as published by the Secretary of State in 2009 or updated. The NHS Constitution in its various iterations draws a distinction between pledges and rights. It refers to “rights to which patients public and staff are entitled” as distinct from “pledges which the NHS is committed to achieve”. It provides that “A right is a legal entitlement protected by law.....This Constitution also contains pledges which the NHS is committed to achieve supported by its management and regulatory systems. The pledges are not legally binding and cannot be guaranteed for everyone all of the time, because they represent an ambition to improve, going above and beyond legal limits”.
27. In the 2009 version of the NHS Constitution, the waiting times commitments were described as pledges, not rights. At that date the waiting time commitments were imposed by directions given by the Secretary of State to primary care trusts. As explained at paragraph 176 of the explanatory notes, section 20 of the Health and Social Care Act 2012, which was the section inserting the new s.6E into the 2006 Act enabling the Secretary of State to make standing rules by regulations, was intended to provide for continuation of certain rights in the NHS Constitution which had previously been created by direction.
28. The waiting times changed from a pledge to a right in the 2010 version of the NHS Constitution which included the following in paragraph 2a on page 5:

“**You have the right** to access services within maximum waiting times or for the NHS to take all reasonable steps to offer you a range of alternative service providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.”

This rubric was also contained in the 2012 version revised shortly before the 2012 Regulations came into force and has remained in subsequent versions.

29. The change from pledge to right in the 2010 version followed the introduction for the first time in the Primary Care Trusts and Strategic Health Authorities (Waiting Times) Directions 2010 (‘the 2010 Directions’) of a duty in relation to waiting times. I shall return to consider the 2010 Directions below.

The Handbook

30. The Handbook referred to in the NHS Constitution in its various iterations is not a part of the NHS Constitution but a separate document which the Secretary of State is bound to publish, as is clear from s.1 of the Health Act 2009. Unlike the NHS Constitution, is not a document to which NHSE is under a duty to have regard under section 2 of the 2009 Act in exercising its health service functions.
31. The Handbook says on p. 21:

“You ... have the right to: start your *consultant-led* treatment within a maximum of 18 weeks from referral for non-urgent conditions... (my emphasis)

...

If this is not possible, the CCG or NHS England, which commissions and funds your treatment, must take all reasonable steps to offer a suitable alternative provider, or if there is more than one, a range of suitable alternative providers, that would be able to see or treat you more quickly than the provider to which you were referred.”

Department of Health Guidance

32. Guidance issued by the Department of Health in January 2012 provided:

“The 18 weeks commitment is a universal right, as set out in the NHS Constitution and the NHS Operating Framework. This commitment should be delivered for every patient, in every specialty and in every organisation unless the patient chooses otherwise or it is not in their best clinical interest. The tolerances provided by the national 18 weeks operational standards (a minimum of 90 percent for admitted patients and 95 percent for non-admitted patients to start treatment within 18 weeks) are for patients who choose to wait longer or for whom this is clinically appropriate.”

33. Whether or not it is true that the margins permitted by the 90% and 95% figures in 2012 were to cater for those who chose to wait longer or for whom waiting longer was clinically appropriate, that is not the case for the 8% margin in the 2015 introduced waiting time standard, as I have explained. This is not therefore an accurate statement of how the 92% duty in regulation 45(3) is to be understood.

GI Services

34. The Judge set out the arrangements for adult and child GI services and their historical development at [8] to [30] of the Judgment, which I do not need to repeat. There were seven providers of adult services, to which have been added five pilot projects. They are consultant-led. The only commissioned provider of child GI services was the Tavistock and Portman NHS Trust (‘Tavistock’), a mental health trust. Its Gender Identity Development Service (‘GIDS’) is led by a clinical psychologist and is not a consultant-led service. Following the Cass Report recommendations, the NHSE plan from July 2022 has been to close down the Tavistock GIDS and replace it initially with services at Alder Hey Children’s Hospital in Manchester and Great Ormond Street Hospital in London, and thereafter with seven or eight other providers becoming operational by 2024 on a phased basis. The intention is that these should be consultant-led services, but this has not yet occurred.

Waiting times

35. Andrew Jackson is Director of Performance Information at NHSE. He explained in his witness statement that NHSE collects RTT data only for its consultant-led services. The collection process is complex, and the results published on a monthly basis. For NHSE commissioned services, the proportion of patients whose first appointment is less than 18 weeks after referral dropped from 85% in January 2019 to 57% in March 2022. The figures for CCG/ICB commissioned services are broadly comparable (87% in January 2019, dropping to 63% in March 2022). It is plain that the pandemic is a major cause of these drops, but the January 2019 data also makes clear that the 92% figure was not being met before the pandemic. The most recent published figures available are those for April 2023 which reveal that 58.3% of referrals for NHSE only consultant-led services are dealt with within the 18 week period (subject to missing data from two Foundation Trusts).

NHSE accepts, and has accepted throughout the course of the judicial review proceedings, that the 92% figure is not being achieved for the cohort of those referred for consultant-led NHSE only services, and has not been for some time; and that the same is true for the sub-cohort of those referred for adult GI services, and children's GI services if contrary to its case they are consultant led, as is reflected in the figures the Judge gave at [32]-[33] of the Judgment. As at June 2022 when NHSE's evidence was served, GI patients were generally having to wait more than three years for an initial appointment with a GI specialist following referral by a GP. NHSE has been working to address the long waiting times in respect of GI referrals since around 2015. The effect of the delays on the four appellants was set out by the Judge at [35] to [38] of the Judgment. It is not necessary for a determination of the issues in the appeal to repeat it here, although of course I do not thereby ignore it or seek to minimise it.

36. In relation to waiting times for GI services, at [101] to [102] the Judge said:

“101. The causes of the current long waiting times include: (i) the very marked increase in demand for these services in the five years up to 2017; (ii) the recent clinical controversy surrounding GID treatment, especially but not only for children; (iii) the difficulty, across both children's and adults' services, of recruiting and retaining sufficient clinical specialists, despite the availability of funding for them; and (iv) the need, in the light of the foregoing matters, to redesign the commissioning model. It may be that NHSE was too slow to respond to the increase in demand for both children's and young people's and adults' services. Be that as it may, the evidence shows that concrete steps are now being taken with a view to reducing waiting times for both children and young people's and adults' services. These steps include not only the deployment of significant additional resources, but also restructuring the model on which the services are provided and encouraging the development of the relevant clinical specialisms.

102. NHSE has provided a detailed account of the steps now being taken and a cogent explanation of the reasons why it is expected that these steps will be successful in reducing waiting time, albeit not immediately. In my judgment, it is impossible to stigmatise these steps as unreasonable or inadequate ones...”

37. The Judge was there addressing and rejecting a submission that if, as he found, Regulation 45(3) imposed a target duty, NHSE was in breach of it in respect of GI services. That conclusion has not been challenged. I have already observed that the duty imposed by regulation 45(3) is addressed to a cohort which is very much wider than those referred for GI services. There was no investigation before the Judge of whether NHSE had taken all reasonable steps to seek to achieve the 18 week standard for the whole cohort because there was no allegation that it had failed to do so. Nor is any such case advanced by the appellants in this court. The appeal can only succeed, therefore, if the appellants are correct in their submission that the duty is not a target duty but one to achieve the waiting time standard.

The Judgment

38. The Judge addressed the cohort question, namely whether regulation 45 applies only to consultant-led services, at [63]-[72] of the Judgment. He observed that there was no doubt that prior to the 2012 Regulations coming into force, the 18 week standard was understood by the Department of Health as applicable to consultant-led waiting times. He

referred to the use of that expression in the January 2012 Department of Health Guidance document, the RTT Suite of Rules and the Handbook. The question, however, was whether that assumption was reflected in the language of the Regulations.

39. He recorded that Ms Grey's submission was that a hard return was to be inserted after "any other person" in para. (d) of the definition of eligible provider, so that (i)-(iii) applied to all that went before including (a), (b) and (c). The Judge treated this as, in reality, a concession that her "interpretation" required rewriting the legislation. He referred to the threefold test identified by Lord Nicholls in *Inco Europe Ltd v First Choice Distribution* [2000] 1 WLR 586, 529F-G, that the court could correct an obvious drafting mistake if it could be sure of three matters: "(1) the intended purpose of the statute or provision in question; (2) that by inadvertence the draughtsman and Parliament failed to give effect to that purpose in the provision in question; and (3) the substance of the provision Parliament would have made, although not necessarily the precise words Parliament would have used, had an error in the Bill been noticed". He referred to the principles being applied recently in the context of subordinate legislation by the Court of Appeal in *R (SSE Generation Ltd) v Competition and Markets Authority* [2022] EWCA Civ 1472: at [121]-[126], Green LJ (with whom Sir Julian Flaux C and Snowden LJ agreed) emphasised the limits of the power to correct mistakes and the need to avoid engaging in judicial legislation. The court decided in that case that it would be better to leave it to the Secretary of State to decide whether and how to correct the error.
40. The Judge said that Ms Grey could not explain the rationale for excluding from the duty in regulation 45 referrals to services which were not consultant-led. He said that there was no necessary or inherent inconsistency in an approach which makes the cohort duty in reg. 45 applicable to all referrals to a "health service provider" but the individual duties in regs 47-49 applicable only to referrals to consultant-led or interface services. The best Ms Grey could do was point to non-legislative documents showing that the regulation 45 duty has not been understood in that way, as to which the Handbook was of no assistance because it was addressing the individual rights in regulations 47-49 which are limited to consultant-led referrals (in which he was, I think mistaken) and because in any event it was merely seeking to summarise the Regulations; and the reference to consultant-led services in the RTT Suite of Rules, although something to which regard was to be had under regulation 50, was not sufficient to displace the clear words of regulation 45. Ultimately he said he could not be sure of any of the three matters referred to in *Inco Europe*, and he would leave it to the Secretary of State to decide whether to amend the 2012 Regulations.
41. The Judge dealt with the duty point at [73]-[99]. He first referred to case law on target duties and declaratory relief. He said that his review of the authorities revealed that the phrase "target duty" had been used to describe duties with one or more of three features. The first was a duty expressed in such open-textured terms that the legislator must have intended to confer a broad discretion, subject only to constraints of rationality, of which the duty in s.3B of the 2006 Act was an example. The second was where the language of the legislature on its proper construction imposed a duty to act with a view to achieving the result rather than to achieve it. The third was where a duty was owed to the population as a whole rather than to any individual, as explained by Baroness Hale in *R (Ahmad) v Newham London Borough Council* [2009] UKHL 14, [2009] 3 All ER 755.
42. He said that the language of the regulation, "make arrangements to ensure", did not indicate conclusively whether it was a target or achievement duty. He gave four reasons

for concluding that it was a target duty. First, it was not owed to an individual and so was a paradigm of the kind of duty identified by Baroness Hale as a target duty in *Ahmad*. Secondly, the fact that the legislative scheme involved a power of the Secretary of State to give directions to NHSE as to how to perform its functions under s.13ZC of the 2006 Act supported this conclusion. Thirdly he derived support from the bespoke remedies for individuals in regulations 47-49. Fourthly, he considered that the clearest pointer came from considering the effect of the relief sought by the claimants. A mandatory coercive order would not be granted because it would require NHSE to divert resources from one health service purpose to another and the court was not equipped, in terms of the information available to it or in terms of expertise, to form a judgment about whether such a diversion would be optimal. This would not be avoided by declaratory relief because that too would be intended to have coercive effect so as to require a reallocation of resources. These considerations were not only relevant to relief but also in order to determine the nature and scope of the regulation 45 duty: a duty to act with a view to achieving the 18 week target fitted better than an absolute duty to achieve that target in a scheme in which NHSE has multiple and potentially competing functions, all of them important, whose prioritisation cannot sensibly have been intended to be supervised by a court.

The Duty Issue

43. I agree with the Judge's conclusion that the duty in regulation 45 is a target duty, that is to say a duty to make arrangements with a view to meeting the waiting time standard, not a duty to achieve it. I do so for reasons which I would prefer to express slightly differently.
44. The starting point is the language in which the duty is expressed in regulation 45. It is a duty "to make arrangements to ensure" the achievement of the waiting time standard. There is an ambiguity in the use of the word "to", which can express either purpose or the achievement of a result, just like the latin *ut*. The Shorter Oxford English Dictionary has in its definition of *to*: "Exp(ressing) the relation of purpose, destination, result, effect, resulting condition or status. **a.** (Indicating aim, purpose, intention or design) for; for the purpose of; with the view or end of; in order to; towards or for the making of; as a contributory element or constituent of...**b.** Indicating result, effect or consequence: so as to produce, cause or result in."
45. So, for example, the answer "I went out to have dinner at a friend's" might be using "to" in either sense depending on the question. If the question were "where did you eat last night?" it would be using it in the sense of achievement of result. But if it were the beginning of an answer to the question "how come you had nothing to eat last night?" and went on to explain how I was prevented from getting there, it would be being used in its purposive sense.
46. The language of "making arrangements" is also capable of conveying a target duty or an absolute duty (see Underhill LJ in *R (on the application of Nash) v Barnet London Borough Council* [2013] EWHC 1067 (Admin) at [69(3)] cited by Males LJ in *R (on the application Williams) v Caerphilly County Borough Council* [2020] EWCA Civ 296 at [64]; cf *R (Tandy) v East Sussex County Council* [1998] AC 714, 746H-747A). All depends on context.
47. In the current context the use of the language of making arrangements is, in my view, significant. Regulation 45(3) does not say that NHSE "must ensure" the waiting time

standard is met, as it might have done if intended to impose an absolute achievement duty. The duty is to undertake an activity and the activity which is required is the making of arrangements. That is the kind of activity which NHSE undertakes in performing all its functions under the 2006 Act and 2012 Regulations. It is not itself a health care provider. It commissions health care services. Its role is to plan, implement, supervise and monitor the performance of those services by others. Regulation 45(3) is made pursuant to s.6E(2)(a) which empowers regulations requiring NHSE to “arrange for [treatments/services] to be provided for...within a specified period”. NHSE’s function is one of arranging. It cannot achieve a waiting time standard itself by the provision of services, but only by making arrangements designed to achieve it through the provision of services by others. Whether those arrangements do achieve it is not in NHSE’s hands. Moreover part of the function of making arrangements is monitoring and adjusting for outcomes which are not as optimal as intended.

48. There are many vicissitudes which may preclude the result being achieved which are beyond NHSE’s control; nor could NHSE reasonably anticipate their occurrence, severity or impact on waiting times. What the Judge identified as the reasons for NHSE failing to meet the standard in respect of GI Services at [101] is relevant, albeit confined to only part of the relevant cohort, because it illustrates some of the reasons why the standard may fail to be met for any given month, or longer period, across the range of services more generally to which it applies. These comprise not only the exceptional circumstances of a pandemic but a variety of other more common factors which are inherent in the nature of a health care service and in NHSE’s functions. These include, by way of example only: increased demand in the number of patients requiring particular services; the need to reorganise services with a view to better patient provision; shortages of staff qualified in the particular specialism required for the services and/or unwillingness of those with sufficient qualifications to be involved in particular activities; strikes by hospital doctors, nurses or other staff or providers of services; unavailability, or interruption in supply, of medicines or equipment; and the effect of new research on treatment methods requiring changes in practices. These are apt to apply to most if not all services provided by ICBs, but all the more so to the specialist NHSE only services for rare and very rare conditions listed in Schedule 4 to the 2012 regulations.
49. The impact of these and no doubt other factors will often be beyond NHSE’s control. Nor, often, could NHSE necessarily anticipate them so as to prevent falling short of the waiting time standard even for a single month. It might be said that it could anticipate them in the abstract, as for example a strike or even pandemic; but it would be absurd to suggest that NHSE was bound to arrange for such a margin of capacity in the system as to be able to achieve 18 week waiting times in the face of any such eventuality. Other examples of the factors I have identified by way of example illustrate that this is not primarily a question of resources. Problems such as these are not preventable or remediable simply by reference to allocation of resources by NHSE between competing demands.
50. Moreover there are important policy considerations which NHSE will have to make which may impact on waiting times, quite apart from any consideration of allocation of financial resources. Strategies for patient safety, treatment outcomes, staff training and working conditions, long term planning, regional capacity, and buildings and equipment are a few which readily come to mind. These are pre-eminently matters of policy involving discretionary judgments for the executive to make.

51. In my view the Secretary of State cannot sensibly have intended to impose upon NHSE an absolute duty which it may be unable to fulfil through no fault of its own by reason of factors inherent in the nature of provision of a health care system, and especially so where the fulfilment of the duty is dependent upon the impact of many other policy considerations of equal or greater importance.
52. I derive further support for this conclusion from the fact that the regulation 45(3) duty is owed to the population as a whole rather than to any individual. A general duty to the population, not enforceable as an individual duty, is a paradigm characteristic of a target duty as distinct from an absolute duty.
53. The case law supports these conclusions. In *R v ILEA ex p. Ali*, which has been referred to with approval in many subsequent authorities at appellate level, the applicant brought judicial review proceedings because 400 to 500 children in Stepney, East London had not been provided by the Inner London Health Authority ('ILEA') with school places against the background of a large increase in the school-age population in that area. It was said that, while ILEA had recently embarked on a school-building programme, their response to the problem had been ineffective and insufficient to meet their statutory duty. The applicants asked the Secretary of State to issue a statutory direction in relation to ILEA's statutory duties, but he refused, having formed the view that ILEA was taking reasonable steps to improve the situation. There was a preliminary issue about the court's jurisdiction to consider ILEA's compliance with its statutory duty in the light of the Secretary of State's refusal to issue a direction and about whether, if the court did have jurisdiction and found that there was a breach, it could grant any relief. In addressing that issue Woolf LJ, giving the leading judgment of the Divisional Court, identified the nature of the relevant school provision duty imposed on ILEA as the first issue which needed to be addressed.
54. The duty was imposed by s.8 of the Education Act 1944 which provided that "It shall be the duty of every local education authority to secure that there shall be available for their area sufficient schools ... for providing primary education, that is to say full-time education suitable to the requirements of junior pupils." The section went on to provide that schools would not be sufficient unless they were sufficient not just in number but also "in character and equipment to afford for all pupils opportunities for education offering such a variety of instruction and training as may be desirable."
55. Woolf LJ said at p. 828 A-D:

"In order to arrive at the correct interpretation of s.8 it is important to recognize that the duty which it places upon the local education authority is in very broad and general terms. It is a counterpart of the even wider duty placed upon the Secretary of State by s.1 ...

This type of duty can be described as a "target duty". In the language of Mr Goudie there is built into s.8 "a degree of elasticity". While there are a number of standards which are required to be achieved by the local authority, the setting of those standards is, in the first instance, for the local authority alone to determine as long as those standards are not outside the tolerance provided by the section.

There are going to be situations, some of which can and others which cannot reasonably be anticipated, where the education provided falls below the statutory

standard and the standards which the education authority would set for itself. It is undoubtedly the position that within the area for which I.L.E.A. is responsible at the present time, the statutory standards that it would set for itself are not being met but this does not mean that I.L.E.A. are necessarily in breach of their duty under s.8. The question is whether I.L.E.A. has taken the steps which the statute requires to remedy the situation which exists.”

56. At p. 829F-G he said:

“The duty under s.8 is, therefore, not absolute. A local education authority which is faced with a situation where, without any fault on its part, it has not complied with the standard which the section sets for a limited period is not automatically in breach of the section.”

57. I detect three strands to the reasoning that the duty in that case was not an absolute duty but a target duty. First, the duty to secure “sufficient” schools was subject to the local authority’s wide discretion as to what amounted to sufficiency. Secondly the duty was “of a kind to benefit the community”. Thirdly, that if it were an absolute duty the local authority might be in breach of it through no fault of its own and in circumstances which it could not reasonably anticipate.

58. The second of these applies in the present case: the regulation 45 duty is to benefit a wide class of patients but is not a duty to benefit any person individually. This consideration is also reflected in Lady Hale’s distinction in [13] of *Ahmad* between target duties owed to the population at large, and duties owed to individuals:

“[13] ... there is a fundamental difference in public law between a duty to provide benefits or services for a particular individual and a general or target duty which is owed to a whole population. One example of the former is in Pt VII of the 1996 Act, which deals with the housing authority’s duties towards individual homeless people. If certain conditions are fulfilled, s 193(2) requires that the authority ‘shall secure that accommodation is available for occupation by the applicant’. The individual applicant has the right to challenge a decision that the duty is not owed in the county court. Another example is in s 20 of the Children Act 1989, which requires a local children’s services authority to provide accommodation for ‘any child in need’ because, in effect, he has no one who can look after him properly. An example of a target duty is in s 17 of the 1989 Act, which provides that ‘[i]t shall be the general duty’ of local children’s services authorities to provide a range of services to safeguard and promote the welfare of children in need within their area. This does not give any particular child a right to be provided with a particular service: see *R (on the application of G) v Barnet London BC*, *R (on the application of W) v Lambeth London BC*, *R (on the application of A) v Lambeth London BC* [2003] UKHL 57, [2004] 1 All ER 97, [2004] 2 AC 208. In the case of social housing, there is not even a duty to provide it, although there is a duty to have and to operate a lawful allocation policy.

59. The third strand of Woolf LJ’s reasoning in *Ali* also applies in the present case, where if regulation 45(3) were an absolute duty, NHSE would be in breach of it through no fault of its own in circumstances which it could not reasonably anticipate.

60. Woolf LJ's first strand does not apply directly to the present case because the waiting time standard is hard edged and objectively measurable. However the reasoning is equally applicable to the present case because achievement of that standard is dependent upon a wide discretion in the complex policy and implementation decisions as to how to go about the provision of a national health service.
61. In any event I do not consider that this first strand of reasoning can be treated as the determinative reason for a target duty being found in *Ali*. In that case no question arose as to whether ILEA had appropriately assessed the criterion of sufficiency: there were simply no school places made available for 400-500 people. In *R (Tandy) v East Sussex County Council* [1998] AC 714 the issue was whether a local authority was entitled to reduce home schooling for a child with special needs from five hours a week to three hours a week in order to prioritise financial resources elsewhere. The duty in question under s.298 of the Education Act 1993 was "to make arrangements for the provision of suitable...education...". The House of Lords held that this was an absolute duty owed to the child and that prioritisation of financial resources in favour of discretionary expenditure elsewhere could not justify a breach. At p. 746H-747A Lord Browne-Wilkinson said:
- "It was suggested in argument that it made a difference that the statutory duty was "to make arrangements for the provision" of suitable education rather than just to provide suitable education. This view commended itself to the majority of the Court of Appeal. But once it is conceded, as it is, that the L.E.A. owes the statutory duty to each sick child individually and not to sick children as a class, I can see no force in the argument. The duty is to make arrangements for what constitutes suitable education for each child. That duty will not be fulfilled unless the arrangements do in fact provide suitable education for each child."
62. This passage and the decision itself is not of direct application to the present case because there the duty was owed to the individual, whereas NHSE's regulation 45(3) duty is not; and provision of suitable education was in the hands of the local authority so that there was no meaningful distinction to be drawn between provision and making arrangements for provision, whereas the distinction is fundamental to NHSE's functions. The decision does, however, cast light on Woolf LJ's first strand of reasoning in *Ali*. In *Tandy* the duty to provide "suitable" education involved the same breadth of considerations as the duty to provide "sufficient" education in *Ali*. However, just as in *Ali* the question of sufficiency did not arise on the facts, so too in *Tandy* the case was not about suitability decisions: five hours rather than three hours of home schooling had been provided as the suitable level and the issue was whether it could properly be reduced on financial grounds, not suitability. The decision therefore casts doubt on Woolf LJ's first strand of reasoning in *Ali* that the breadth of the "sufficiency" criteria justified treating the duty in that case as a target duty, notwithstanding that on the facts the sufficiency criteria did not come into play. The same is true of the suitability criteria in *Tandy*, but that did not preclude the duty being treated as an absolute rather than target duty.
63. I derive further support for my conclusion from three other matters, which are of lesser weight, but nevertheless some significance. The first is regulation 11 which defines the duty to provide the NHSE only services identified in Schedule 4 as a duty that NHSE "must arrange, to such extent as it considers necessary to meet all reasonable requirements, for the provision as part of the health service of the services specified in Schedule 4." This is an open-textured duty with wide discretion both as to the extent

services are considered necessary and as to what those services comprise so as to meet reasonable requirements, and one owed to the population at large. As such it bears the paradigm characteristics of a target duty. If the existence and content of the duty to arrange for any particular NHSE only service is a target duty, that suggests that the duty to arrange for it to be provided within 18 weeks is also a target duty. It would be odd to impose a discretionary duty to provide a service at all, or as to the nature of the service, but an absolute waiting time obligation if it is provided, especially where the discretionary factors as to whether and what to arrange to provide may have a bearing on the time by which they are arranged to be provided.

64. Secondly, the non-statutory materials which are a legitimate aid to construction, namely the terms of the NHS Constitution, to which the Secretary of State was bound to have regard in making the 2012 Regulations, and the Explanatory Note and Explanatory Memorandum, point to the same conclusion. The rubric in the NHS Constitution is that there is a *right* “to access services within maximum waiting times or for the NHS to take all reasonable steps to offer you a range of alternative service providers if this is not possible”. This is reproduced in the RTT Rules Suite to which NHSE is bound to have regard in carrying out its regulation 45(3) duty. The same language is used at paragraph 7.19 of the Explanatory Memorandum and in the Explanatory Note. The language is consistent with regulation 45(3) being a target duty and entirely accurate as a statement, expressed as it is in the alternative. The right is not to both, but to the reasonable steps alternative provision if access within the maximum waiting times is not possible. The language is not, however, consistent with the regulation 45(3) duty being an absolute duty. The first alternative is not itself a reflection of the regulation 45(3) duty, which even if absolute would not give rise to individual rights and in any event is not a duty to achieve the waiting times for more than 92% of a defined class of relevant individuals. The rubric must be read as a reference to individual rights, which is what the document is concerned to convey to individual members of the public. It can only sensibly be read as involving a right to only one or other of the alternatives, i.e. being treated within the 18 week maximum or reasonable steps being taken for alternative provision. This does not support, and is not consistent with, even a “public law right”, as Mr De La Mare characterised it, for the waiting time standard in regulation 45(3) to be achieved.

65. The third additional factor is Direction 2 of the 2010 Directions, the precursor of regulation 45(3). Neither side suggested that the nature of the waiting time duty was intended to be different in the latter, and the NHS Constitution, which was in the same terms for both, confirms that common ground. Direction 2 provides:

“Duty to make arrangements to meet 18 week operational standards

2. Each Primary Care Trust and Strategic Health Authority must make arrangements to ensure that any provider providing services to persons for whom that Trust or Authority is responsible complies with the operational standards relating to patients on an 18 week referral to treatment pathway as set out in Annex 1 of the NHS Performance Framework: Implementation guidance published on 24th April 2009(b).”

66. Direction 2 contained the equivalent duty to regulation 45(3) of the 2012 Regulations which replaced it, save that the times to be achieved were set out in a detailed schedule at Annex 1. That Annex has the hallmarks of a working departmental document rather than something drafted with an eye to legal definition, and is not entirely easy to interpret. It

is headed “Acute Standards and Targets” and has different percentages and waiting times for a list of various services, with performance indicator weightings which are then themselves used to produce an overall performance score, with figures used both (1) for “underperformance” or “performance under review” and (2) for “achievement of standards” where there are figures for “achieve” and “fail”. Directions 3 and 4 contained an alternative service provider duty broadly equivalent to that found in regulations 47-49 of the 2012 Regulations which replaced them.

67. The performance criteria covered by Annex 1 were not limited to elective referrals, or even to waiting times; they included, for example, waits in Accident and Emergency, and MRSA and C Diff infections. They included the 18 weeks standard with its then differential between admitted and non-admitted patients of 90% and 95% respectively. It did not define what services these applied to other than by simply using the shorthand “18 weeks RTT – admitted” and “18 weeks RTT – not admitted”. The “Achieve” figure was the 90% and 95% identified as “rights” in the NHS Constitution. However the “Fail” figure was in each case 5% lower, being 85% and 90% respectively. A fail had a performance weighting of 1 out of a total of 16 for all matters covered by the document. Scores for all matters were combined so as to provide that an overall score of 3 represented achievement, a score of 2 underachievement, a score of less than 2.1 as underperforming and a score of 0 as fail. I have not found these scoring values or overall performance score thresholds easy to interpret from the document itself. What is tolerably clear, however, and of significance for the duty issue in this case, is that the 18 week operational standard imposed by the 2010 Directions is not an achievement standard. That is clear both because the document contemplates 5% lower levels before there is “fail”; and because any failure is then imported into an overall performance weighting system which means that individual failure in the 18 week standard does not necessarily lead to a finding of failure or underachievement.
68. I turn to address a number of the arguments on both sides, and some reasons given by the Judge, which I regard as neutral or of such insignificant weight as not to affect the reasoning I have so far identified for my conclusion.
69. Unlike the Judge, I do not derive any assistance on the duty issue from the imposition of the individual duty to make alternative provision in regulations 47-49. That alternative provision duty is, to my mind, equally consistent with regulation 45(3) being a target duty or an absolute duty. The reasonable steps duty to make alternative provision only arises if and when the first referral has taken more than 18 weeks (or it is clear that it will do so). It recognises that for any particular patient within the cohort, the 18 waiting standard will not have been achieved despite the regulation 45(3) duty. That may have been because the regulation 45(3) duty is a target duty which it was contemplated might not be achieved. But it might equally have been aimed at those within the 8% margin where an absolute duty was fulfilled; or as an additional duty where it was not, of the kind “you must achieve x, but if you do not you must do y”.
70. Nor do I find any significance in the residual power of the Secretary of State in s. 13ZC of the 2006 Act to give directions to NHSE as to how NHSE is to exercise its functions, including in particular how and when to exercise them and what matters to take into account. Such a direction making power was a principal tool used by the Secretary of State before the regulation making power in ss.6B and 6E was introduced in 2012. Hence waiting times were dealt with in a direction in the 2010 Directions and a regulation in the

2012 Regulations. Once the latter were put in place, I do not see how the residual direction making power helps in interpreting the regulation in question.

71. Nor have I found assistance in a consideration of remedies. Had I concluded that the regulation 45(3) duty was an absolute one, it would, in my view, have been appropriate to grant a declaration to that effect, so as to reflect the determination by the court of the legal rights in issue. I agree with the Judge that the decisions which NHSE, and the Secretary of State, would be required to consider in relation to meeting those times are of a socio-economic nature involving policy considerations which are classically a matter for the executive not the courts. Those, which are not limited to questions of resources, are matters which point away from the existence of an absolute duty, as I have already said. However if the intention of Parliament expressed in regulation 45(3) was to impose an absolute duty to achieve a waiting time standard, it carries with it an obligation to pay for it, ahead of sums spent on statutory discretions; and if Parliament or the Government has not provided sufficient funds for all statutory duties, as distinct from spending on statutory discretions, that should be recognised and acknowledged. These points were clearly articulated in *Tandy* by Staughton LJ (whose dissenting conclusion in the Court of Appeal was upheld by the House of Lords in allowing the appeal) at p. 720H and Lord Browne-Wilkinson at p. 749A-F.
72. Mr De La Mare submitted that regulation 45(3) was to be regarded as an absolute duty because it was made pursuant to the target duties in the 2006 Act and was a specific duty “to clothe the skeleton of the target duties with enforceable flesh”. He submitted that this was the relevant distinction from the situation in the *Ali* case, in which there had been no such direction. This metaphor does nothing more than assume what it sets out to prove. Duties made in regulations made in pursuance of target duties may still be target duties. Regulations 47 to 49 are an example. The essential reasoning in *Ali* depends on the three strands I have identified, not the question whether the duty was to be found in primary legislation as opposed to directions or regulations made thereunder.
73. Mr De La Mare further submitted that the hard edged nature of what he called “the metric” i.e. the ability to measure objectively and with precision whether the 18 week waiting standard was met, militated in favour of an achievement duty. However, as he was ultimately minded to concede, the fact that the standard is capable of measurement tells one nothing about whether the duty is to achieve it or take all reasonable steps to achieve it (although the converse is not necessarily true).
74. Ms Grey KC submitted that the relevant ambiguity in the expression “make arrangements to ensure” lay in the word “ensure” relying on a dictum of Vaisey J in *Reliance Permanent Building Society v Harwood-Stamper* [1944] 1 Ch 362, 373. I did not find this persuasive. To my mind it is the word “to” which is ambivalent in expressing purpose or outcome.

Conclusion on the duty issue

75. For these reasons I would uphold the Judge’s conclusion on the duty issue and dismiss the appeal. Strictly speaking that renders it unnecessary to determine the cohort issue, which arises on the Respondent’s Notice. However since it has been fully argued and has far reaching implications for NHSE and patients generally, I think it right to express my views on it.

The cohort issue

76. The Judge correctly said that prior to the coming into force of the 2012 Regulations, the 18 week referral to treatment commitment was understood as applicable only to consultant-led services. That was the subtitle of the Department of Health's guidance document dated 2012. It is equally clear from such other materials outside the regulations themselves as are a legitimate aid to construction, that the 2012 Regulations were not intended to effect any change in that respect. The RTT Rules Suite, to which regard is to be had by reason of regulation 50, makes clear that the waiting times in question are intended to be for consultant-led services. The NHS Constitution, to which regard is to be had by the Secretary of State in making the 2012 Regulations under section 2 of the Health Act 2009, expresses the patient rights in the alternative terms I have discussed, which are only consistent with the regulation 45(3) duty and regulation 47-49 alternative provision duty applying to the same kinds of referral. If the construction for which the appellants contend is put upon regulation 45(3), the NHS Constitution commitment would have to have had qualifying words read into it so as to say something like

“You have the [public law] right [for 92% of you] to access [all types of elective services] within maximum waiting times or [for all of you but in respect of consultant-led services only] for the NHS to take all reasonable steps to offer you a range of alternative service providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.” (my italics for the necessary additions)

77. I can see no sensible reason for the mismatch I have identified if the regulation 45(3) duty applies to services other than consultant-led services. Irrespective of my conclusion on the duty issue, the alternative provision duty in regulations 47-49 seems clearly concerned to cater for those for whom the 18 week standard in regulation 45 has not been achieved, whether that be because it is a target duty which is not achieved; an absolute duty which is not achieved; or duty of either kind which is achieved but where the patient falls within the 8% tolerance. I asked Mr De La Mare whether he could suggest any rationale for such a mismatch. His suggestion was that it was to be found in the provision in regulation 48(4) that the alternative service duty required patient choice, and that consultant-led services had better information available to assist patients in making that choice by reference to patient outcomes. There was no exploration in the evidence, or at the hearing, as to whether the premise of greater information on patient outcomes being available in relation to consultant-led services is correct, but the suggested explanation founders on Part 8 which provides for patient choice in first time referrals, to which regulation 45(3) applies. They provide such choice in relation to original referrals, just as regulation 48(4) does for alternative provision. There is therefore no justifiable distinction between the scope of the two duties by reference to patient choice. But in any event, the suggestion does nothing to rationalise the mismatch because it is wholly unrelated to waiting times, which is the essential focus of both duties.

78. The Judge said that there was no necessary or inherent inconsistency in an approach which makes the cohort duty in regulation 45 applicable to all elective referrals to any health service provider but the individual duties in regulations 47-49 applicable only to referrals for consultant-led services. But in the absence of any discernible reason for a distinction, I do consider there to be a necessary and inherent inconsistency in treating the two duties as applicable to different cohorts.

79. Mr De La Mare frankly conceded that there were “all kinds of indicia” that the intention and policy of the regulation was that it should only apply to consultant-led services. However the critical problem, he submitted, is that the language is unambiguously clear in saying the opposite. He supported the Judge’s approach, which was to treat the language of the regulations as incapable of interpretation in any other way. He also supported the Judge’s conclusion that it was impossible to rewrite the plain language in accordance with the principles in *Inco Europe*.
80. I am unable to accept either limb of this reasoning.
81. As to the language, at first sight the definition of eligible referrer in regulation 44 might seem to impose the restrictions on treatment to consultant-led services in (d) (i)-(iii) in a way which is confined to a referrer of the kind identified in category (d), and being of no application to those referrers identified in (a), (b) or (c) (hereafter ‘abc referrers’ and ‘d referrers’ as shorthand). Moreover if all eligible referrers were confined to those referring for consultant-led services, there would have been no need to set out the consultant-led conditions in regulation 47(3), because 47(2) already confined the alternative provision duty to cases where there had been a failure to provide the services within 18 weeks of referral by an eligible referrer. Regulation 47(3) would be superfluous.
82. On closer analysis, however, this is not the only permissible reading of the language used. So far as concerns the identity of referrers, the definition covers anyone, without exception, because paragraph (d) is a sweep up which covers any person other than an abc referrer. That invites an inquiry as to who is intended to fall within this sweep up category, who are dealt with separately in the definition, and how they differ from abc referrers in a way which explains the way they are treated in the d referrer definition.
83. Category a referrers are dentists and b referrers are GPs; c referrers are a category whom NHSE has approved for the purpose. It was common ground that the approval for c referrers typically comes through commissioning/contractual arrangements. Examples include clinical nurse specialists, specialist physicians and senior clinical psychologists, each of whom may be found in primary or secondary care roles. Category (d) includes referrers of a similar kind who do not have such commissioning arrangements but make referrals on an ad hoc basis. It also includes self-referrals by patients. That self-referrals are contemplated appears not only from (a)(ii) of the definition of “start date” in regulation 44, but also from pages 5 and 17 of the RTT Rules Suite. Page 17 explains that self-referrals can take the form of a patient attending a walk-in centre or a patient whose waiting time clock has been stopped, for example because they declined an earlier offer of treatment, but with agreement that they can refer themselves back into the service at a future date, for example if they change their mind or their condition worsens. This again was common ground as to who might typically be a d referrer.
84. What distinguishes d referrers from abc referrers, therefore, is that the provider of the services does not typically have a commissioning agreement under which they are required to provide the services (subject to the contractual parameters): typically for d referrers, provision of the services is essentially discretionary.
85. One thing which distinguishes abc providers from d providers in the language of the definition of eligible referrer is that for d referrers the clock runs from *acceptance*: it only starts if and when the service provider agrees to accept the referral. This reflects the fact that d referrers are typically referring where there is a discretion as to whether the referral

is accepted; whereas, in general, referrals by abc providers are bound to be accepted. There are some circumstances in which a service provider may not be bound to accept referrals from abc referrers, such as where the referral is made to a trust which does not carry out the relevant procedure. But in those cases, that will not be the patient's fault and it is readily understandable that the clock is made to start from the time of the original referral if the patient has to be re-referred. That is what is stated to be the position in Q39 of a Frequently Asked Questions document published by NHSE to explain the workings of the RTT calculations.

86. The critical distinction between abc referrers and d referrers, therefore, does not lie in the nature of the services to which referral is made, but in the requirement of acceptance for d referrers. In other words, it is a permissible reading of the definition as a whole that it is implicit that the nature of the services to which referral is made is the same for all eligible referrals and that in abc referrals they are for the services identified in paragraph (d)(i),(ii) and (iii) just as much as for d referrals; but that the distinction lies in the requirement of acceptance of the referral for d referrers. Why then is the definition of the relevant services to be found in (d) rather than compendiously? The answer is that it is natural, or at least explicable, that one would find spelled out in (d) what is implicit in (a)-(c) because only (d) is concerned with something done by the person to whom the referral is made, and so it is there that one has to define the provider, rather than the referrer, which requires an identification of what is to be provided. It would certainly have been simpler and more elegant to achieve the intended purpose by language in the body of 45(3) where the waiting time duty is imposed; or at least in the definition of "elective referral" where there is to be found reference to a health service provider by way of identification of the person to whom relevant referrals are made. However given that the drafter's technique was to use the definitions to identify the scope of the duty, it is permissible to look to the definition of eligible referrer to identify the services which are to come within the scope of the duty, not least because on any view that definition purports to restrict the scope of the services to consultant-led services for at least some referrals.
87. It follows that the linguistic solution is not that which the Judge attributed to Ms Grey's submission, and which she effectively adopted in her submissions to this court, namely that one inserts a hard stop after the words "any other person" in (d) so as to apply what follows to abc referrals. That would be to destroy the relevant distinction, which lies in acceptance of the referral. The linguistic solution, which in my view is a permissible interpretation of the language used, is that the entire definition is concerned with referrals for the same kind of services and therefore it is implicit in (a)-(c) that these too are referrals for consultant-led services. That is spelled out for d referrer referrals because acceptance by the provider of the services is the critical element and it identifies who the provider is by reference to the services to be provided.
88. That this is not only a permissible construction of the language used but the correct one is supported by a number of factors. First, it gives effect to what is common ground as to the legislative purpose, as apparent from the legitimate aids to construction in the form of the RTT Rules Suite and NHS Constitution. They make clear that the waiting time standard was intended to apply only to consultant-led services.
89. Secondly, support is to be found in the language of regulation 46. Regulation 46 is concerned with defining the waiting time taken in relation to a given patient to whom the 18 week standard applies. It starts with the "start date" as defined, and ends if any of the things in (2) to (5) occurs. Regulation 46(5)(a) provides that the 18 weeks comes to an

end for a patient who has had an elective referral if they are notified that it is more appropriate for them to receive treatment from a primary care service. It was common ground that examples of primary care services are optometry, physiotherapy, rehabilitation for acute injuries, sexual health, and various nurse-led clinics. So if, for example, a patient were referred to a consultant-led team who then directed nurse-led treatment, the 18 weeks ceases; and there may well be no 18 week duty in relation to the on-referral because such consultant on-referral does not come within the eligible referrer definition as being from a d referrer, not being for consultant-led services. Yet on the appellant's case, the 18 week standard patient would apply to that wait for nurse-led treatment if they had been referred initially for such treatment by their GP. This is not a coherent reading of the provisions and cannot have been intended.

90. Thirdly, a similar point arises from regulation 46(3). Regulation 46(2) provides that the waiting time ends upon "appropriate treatment". The definition of "treatment" carefully carves out a category of case identified in 46(3). Regulation 46(3) provides:

"(3) The referred person commenced therapy or received a healthcare science intervention where a consultant, a member of a consultant-led team or an individual providing an interface service decides that the therapy or that intervention is the treatment most appropriate for that person."

91. What this means is that unlike referrals on to other primary care services, which under 46(5) stop the clock running, for those referred on for therapy or healthcare science intervention the clock continues to run until they commence that therapy or intervention, even if before then they have had some treatment commenced, which would otherwise stop the clock under the terms of regulation 46(2) and the definition of appropriate treatment. I do not know why there was this careful distinction between therapies/healthcare science interventions and other forms of treatment, but a distinction was clearly intended. What is significant for present purposes is that the provision which continues the clock running for therapy and science healthcare interventions is drafted in terms of onward referrals only by those providing consultant-led services; whereas if, as is the appellant's case, an initial elective referral to non-consultant led services started the clock, an onward referral by such a provider for therapy/science healthcare intervention would not keep the clock running. That would be an illogical distinction. Regulation 46(3) suggests that the whole scheme of regulation 45-46 is one applicable to referrals for consultant-led services.

92. Fourthly, if the intention were that the regulation 45(3) duty applied to all NHSE only services, not just consultant-led services, there would have been no need to have had a definition of eligible referrers at all. The waiting time standard applies to "elective referrals" which are defined so as to identify the receiver of the referral, the service provider, as "health service provider". This is wide in scope. If it were intended to apply to all services, whether or not consultant-led, the inclusion of a definition of eligible referrer is superfluous, and particularly so one which undoubtedly in some respect restricts the referral to one for consultant-led services. By including a definition of eligible referrers the drafter clearly intended to impose some further restriction.

93. Fifthly, I can see no rational basis for construing the eligible referrer definition in the way for which the appellants contend, and Mr De La Mare did not suggest any. Their construction involves confining the waiting time standard to consultant-led services for d referrers only. But there is no apparent reason for treating these referrals as confined to a

narrower category than abc referrals for the purposes of applicability of the waiting time standard, and none was suggested.

94. Sixthly, the interpretation I favour avoids the mismatch between the cohort for the regulation 45(3) duty and the cohort for the alternative provision duty in regulations 47-49, for which, as I have observed, there seems no rational explanation.

95. If I be wrong in this as a matter of linguistics, I would have been prepared to hold that each of the three conditions which Lord Nicholls identified in *Inco Europe* as justifying correcting a drafting mistake are fulfilled in the present case.

(1) The intended purpose of the regulation 45 duty is clear; it is clear from the interpretative materials which are a legitimate source for statutory intention, from the terms of regulation 46, and from the scheme of the regulations as a whole, in the respects to which I have referred in [75]-[93] above, that it was intended to apply only to elective referrals to consultant-led services.

(2) It is obvious that failing to give effect to that purpose (if I be wrong in my conclusion on the language) was through inadvertence of the draftsman; this follows from (1).

(3) The substance of the provision which would have been made, although not necessarily the precise words, is obvious had the error been noticed, namely that the Regulations would have made clear that the 18 week waiting standard time applied only to elective referrals for consultant-led services, whether by adding explicitly in the definition of eligible referrer that which I have identified as implicit, or by some freestanding provision.

Conclusion

96. I would dismiss the appeal, and subject to any further argument on the form of relief, make a declaration that NHSE's duty under regulation 45 applies only to referrals for consultant-led services in the sense in which I have been using that expression.

Lord Justice Moylan :

97. I agree.

Lady Justice King :

98. I also agree.