# NHS Acute Care Contracting

**Contents of this chapter:**


1. Introduction.
2. NHS Contracts.
3. The NHS Standard Contract
4. Non-contract activity: how commissioning arrangements work without a contract in place.
5. Payment for delivering NHS services and the NHS National Tariff: Introduction.
6. The meaning of a "health care service" in the National Tariff.
7. Is agreeing a changed price for a services specified in the National Tariff or "price competition" lawful as part of any NHS procurement or contracting arrangement?
8. How can prices for health care services be lawfully determined under the 2012 Act?
9. Are "block contracts" legally permissible under the 2012 Act statutory scheme?
10. How can the rules for determining prices be operated within a competitive procurement exercise?
11. The Dispute Resolution provisions within the NHS Standard Contract.


List of abbreviations used in this chapter

| | |
|---|---|
| 1990 Act | National Health Service and Community Care Act 1990 |
| 2003 Act | Health and Social Care (Community Health and Standards) Act 2003 |
| NHS Act | National Health Service Act 2006 |
| 2012 Act | Health and Social Care Act 2012 |
| 2012 Regulations | National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 |
| NHS England | National Health Service Commissioning Board |

| | |
|---|---|
| PbR | Payment by Results |
| Technical Guidance | NHS Standard Contract 2017/18 and 2018/19 Technical Guidance document |
| HRG | Healthcare Resource Group |

## 1. Introduction.

1.1. The separation of commissioning and providing within the NHS in England means that an "arrangement" is required to be in place between a commissioner and a provider of NHS services so that the provider knows what services it is required to provide to NHS patients and also knows how it will be paid for providing those services. There is no "contract" between the patient and the provider and thus the role of monitoring whether services are being provided to appropriate standards falls to the commissioner. Any arrangement between a commissioner and a provider of NHS services needs to have performance standards which enable the commissioner to know how NHS patients are being treated and whether services are being provided in accordance with the standards defined in the contract.

1.2. Prior to the creation of NHS England, the Department of Health published recommended forms of arrangement and developed payment mechanisms to support those arrangements. This was non-statutory until the implementation of the Health and Social Care Act 2012 ("**the 2012 Act**") when statutory rules were introduced to govern NHS contracting, with further restrictions imposed by the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ("**the 2012 Regulations**"). These Regulations require all NHS commissioners to use the NHS Standard Contract when contracting for NHS services (aside from primary care contracting).

1.3. Any arrangement between an NHS commissioner and an NHS provider operates under either an NHS contract or a legally binding contract, usually in the form of an NHS Standard Contract. This chapter looks at the rules and practice for NHS contracting (both under NHS contracts and legally binding contracts) in all circumstances other

than for primary care contracting (i.e. contracts with GP and dental practices). This chapter does not consider the steps that NHS commissioners are required to follow before deciding which organisation is best placed to provide services to NHS patients. That will be covered in the Procurement Chapter (which has yet to be completed).

1.4. The standard form of contract required commissioners to pay providers on an activity basis, known as Payment by Results ("**PbR**"). But PbR has as many limitations as it has benefits and, in the years since the 2012 Act was passed, NHS commissioners have sought to work creatively with NHS providers to deliver alternative models of care. It remains to be seen whether, given the statutory straightjacket imposed by the 2012 Act enables alternative contractual models lawfully be put in place[1].

## 2. NHS Contracts.

2.1. Arrangements between "purchasers" of NHS services and providers were originally service level agreements, called "NHS contracts". The word "contract" is something of a misnomer because, in law, these were not contracts. The National Health Service and Community Care Act 1990 ("**the 1990 Act**") first introduced NHS Trusts and thus created NHS contracts as a way of Health Authorities contracting with the new provider organisations. Section 4 of the 1990 Act[2] contained provisions which defined NHS contracts and provided they were not to give rise to legally enforceable obligations. There are a number of aspects of the statutory scheme under the 1990 Act describing NHS contracts which have survived into the present set of arrangements for NHS contracts. These provisions are now set out in section 9 of the National Health Service Act 2006 ("**the NHS Act**") which provides:

> "(1) In this Act, an NHS contract is an arrangement under which one health service body ("the commissioner") arranges for the provision to it by another health service body ("the provider") of goods or services which it reasonably requires for the purposes of its functions.

[1] This is explored at paragraph XX below.
[2] As originally enacted.

(2) Section 139(6) (NHS contracts and the provision of local pharmaceutical services under pilot schemes) makes further provision about acting as commissioner for the purposes of subsection (1).

(3) Paragraph 15 of Schedule 4 (NHS trusts and NHS contracts) makes further provision about an NHS trust acting as provider for the purposes of subsection (1).

(4) "Health service body" means any of the following—

(za) the Board,

(zb) a clinical commissioning group,]

(a) . . .

(b) . . .

(c) an NHS trust,

(d) a Special Health Authority,

(e) a Local Health Board,

(f) a Health Board constituted under section 2 of the National Health Service (Scotland) Act 1978 (c 29),

(fa) a Special Health Board constituted under that section,

(g) a Health and Social Services Board constituted under the Health and Personal Social Services (Northern Ireland) Order 1972 (SI 1972/1265 (NI14)),

(h) the Common Services Agency for the Scottish Health Service,

(i) the Wales Centre for Health,

(j) . . .

(k) the Care Quality Commission,

(ka) NICE,

(kb) the Health and Social Care Information Centre,

(kc) Health Education England,

(l) the Scottish Dental Practice Board,

(m) the Secretary of State,

(n) the Welsh Ministers,

(na) the Scottish Ministers,

(nb) Healthcare Improvement Scotland,

(o) the Northern Ireland Central Services Agency for the Health and Social Services established under the Health and Personal Social Services (Northern Ireland) Order 1972,

(p) a special health and social services agency established under the Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990,

(q) a Health and Social Services trust established under the Health and Personal Social Services (Northern Ireland) Order 1991,

(r) the Department of Health, Social Services and Public Safety.

(5) Whether or not an arrangement which constitutes an NHS contract would apart from this subsection be a contract in law, it must not be regarded for any purpose as giving rise to contractual rights or liabilities.

(6) But if any dispute arises with respect to such an arrangement, either party may refer the matter to the Secretary of State for determination under this section.

(7) If, in the course of negotiations intending to lead to an arrangement which will be an NHS contract, it appears to a health service body—

(a) that the terms proposed by another health service body are unfair by reason that the other is seeking to take advantage of its position as the only, or the only practicable, provider of the goods or services concerned or by reason of any other unequal bargaining position as between the prospective parties to the proposed arrangement, or

(b) that for any other reason arising out of the relative bargaining position of the prospective parties any of the terms of the proposed arrangement cannot be agreed,

that health service body may refer the terms of the proposed arrangement to the Secretary of State for determination under this section.

(8) Where a reference is made to the Secretary of State under subsection (6) or (7), he may determine the matter himself or appoint a person to consider and determine it in accordance with regulations.

(9) "The appropriate person" means the Secretary of State or the person appointed under subsection (8).

(10) By the determination of a reference under subsection (7) the appropriate person may specify terms to be included in the proposed arrangement and may direct that it be proceeded with.

(11) A determination of a reference under subsection (6) may contain such directions (including directions as to payment) as the appropriate person considers appropriate to resolve the matter in dispute.

(12) The appropriate person may by the determination in relation to an NHS contract vary the terms of the arrangement or bring it to an end (but this does not affect the generality of the power of determination under subsection (6)).

(13) Where an arrangement is so varied or brought to an end—

(a) subject to paragraph (b), the variation or termination must be treated as being effected by agreement between the parties, and

(b) the directions included in the determination by virtue of subsection (11) may contain such provisions as the appropriate person considers appropriate in order to give effect to the variation or to bring the arrangement to an end.

2.2. The key differences between an NHS contract and other forms of NHS contracting are as follows:

a) The only organisations, companies or individuals who can be parties to an NHS contract are those listed in section 9 of the NHS or as a result of another

statutory provision[3] which entitles the parties to an arrangement between an NHS commissioner and a provider to enter into an NHS contract. Both parties to the contract thus have to have statutory authority to enter into an NHS contract. If only one of the parties is permitted to do so, the arrangement cannot take effect in law as an NHS contract. The most significant (and deliberate) omission from the list of bodies that can enter into an NHS contract is an NHS Foundation Trust. NHS Foundation Trusts were first set up by the Health and Social Care (Community Health and Standards) Act 2003 ("**the 2003 Act**"). No provision was made in the 2003 Act for the new form of NHS bodies to be permitted to contract on the basis of an NHS Contract. That remains the position under the NHS Act and accordingly all contracts between an NHS commissioner and an NHS Foundation Trust are required to be in the form of legally binding contracts[4];

b) Section 139 of the NHS Act provides that an individual or body corporate which wishes to enter into a pilot pharmaceutical service contract can apply to the Secretary of State to0 be treated as a "health service body" and thus to contract on the basis of an NHS Contract;

c) An NHS contract can be for any goods or services which a commissioner reasonably requires for the purposes of its functions. This form of contract is almost invariably used for services to be provided to NHS patients (often in primary care) but there is no limitation to patient services in the legislation and thus this form of arrangement could be used for the supply of a wide range of goods or services;

d) Section 9(5) of the NHS Act provides that an NHS Contract gives rise no right to legal liabilities that can be enforced in the civil courts. The effect of section 9(5) was considered by the Court of Appeal in *Pitalia & Anor v The National Health*

[3] There are provisions in the GMS and PMS Regulations for general practitioners allowing NHS contracts.
[4] However the dispute resolution provisions in the NHS Standard contract mean that an NHS Foundation Trust contract cannot usually be enforced by way of standard court action.

*Service Commissioning Board* [2014] EWCA Civ 474[5] which emphasised that an NHS contract must not be regarded as giving rise to enforceable rights "*for any purpose*". It follows that it was, so the court held, wrong for the District Judge to have held that an NHS contract (as the court found it to be) in that case could be interpreted as an arbitration clause. Such a clause could only be found in a legal contract and an NHS contract must not be regarded as a legal contract for any purpose;

e) Parties to an NHS Contract have the right to refer a dispute to be determined by the Secretary of State, since such a dispute cannot be litigated in the courts. However for acute care NHS contracts (i.e. those outside primary care, dental care and community pharmaceutical NHS contracts), this provision has become less important in recent years because the NHS Standard Contract has complex dispute resolution provisions which take the place of a reference to the Secretary of State. However for those contracting areas where disputes are referred to the Secretary of State, the Secretary of State has made a series of directions to require the Family Health Services Appeal Unit[6], which is part of the National Health Service Litigation Authority, to make determinations on behalf of the Secretary of State; and

f) Section 9(7) provides that, where health service bodies are "*in the course of negotiations intending to lead to an arrangement which will be an NHS contract*" but cannot agree on the proposed terms, either health service body "*may refer the terms of the proposed arrangement to the Secretary of State for determination under this section*". Thus, in effect, the Secretary of State is given a power to impose contractual terms on the parties to a proposed contract.

2.3. NHS contracts have a far greater impact in primary care commissioning than in acute care arrangements because acute care contracting is undertaken using the NHS Standard Contract. This provides for dispute resolution provisions which require

[5] See http://www.bailii.org/ew/cases/EWCA/Civ/2014/474.html
[6] See http://www.nhsla.com/FHSAU/Pages/Home.aspx

expert determination as opposed to referring issues to the Family Health Services Appeal Unit.

## 3. The NHS Standard Contract

3.1. Following the 1990 Act, the Department of Health developed a standard contract for acute commissioning between primary care trusts and NHS trusts. This form of contract evolved over the years and got gradually more complex. Although the form of contract was only contained in Guidance, primary care trusts and NHS trusts almost invariably contracted on the basis of the standard contract (and could be directed by the Secretary of State to do so if they attempted to use a different form of contract). When CCGs were created by the 2012 Act, a decision was made that they should not be NHS bodies that could be subject to directions made by the Secretary of State. As a result, many of the governance issues that were set out in guidance for primary care trusts (and were backed by the Secretary of State's direction making power) were included in the 2012 Regulations as statutory duties imposed on CCGs and on the newly created NHS England.

3.2. One of areas where NHS commissioners were affected by this change of legal structure was the requirement to use the NHS Standard Contract in acute care contracting. Under the 2012 Regulations, the expression "relevant body" is defined in Regulation 2 as follows:

> ""relevant body" means a CCG or the Board"

3.3. The term "commissioning contract" is widely defined in Regulation 2 as follows:

> ""commissioning contract" means a contract, other than a primary care contract, entered into by a relevant body in the exercise of its commissioning functions"

3.4. The width of this definition should be noted. A "*commissioning contract*" is any arrangement put in place by a relevant body' in the exercise of its commissioning

functions. The expression "commissioning functions" is defined in Regulation 2 as follows:

> ""commissioning functions" means the functions of a relevant body in arranging for the provision of services as part of the health service, but it does not include, in relation to the Board, its functions in relation to services provided under a primary care contract"

Thus any arrangement put in place by a CCG or NHS England which results in the provision of services which can be used by one or more NHS patients amounts to an exercise of commissioning functions, otherwise than services provided under a primary care contract.

3.5. Part 5 of the 2012 Regulations is headed "*Standing rules: commissioning contract terms*". Regulation 16 of the 2012 Regulations provides some technical requirements to ensure that providers under acute commissioning contracts are licensed by Monitor under the 2012 Act and appropriately regulated by the Care Quality Commission. It provides:

> "(1) A commissioning contract entered into by a relevant body must contain terms and conditions that ensure that the health service provider complies with all the duties imposed upon a registered person by regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (duty of candour) ("the 2014 Regulations"), as modified by paragraph (1B), irrespective of whether—
>
> (a) the health service provider is a registered person; or
>
> (b) the health service provider is carrying on a regulated activity.
>
> (1A) A commissioning contract entered into by a relevant body must contain terms and conditions that ensure that the health service provider—
>
> (a) co-operates with—
>
> (i) the LETB for each area in which it provides such services; and
>
> (ii) any LETB which represents that provider by virtue of arrangements made by HEE under paragraph 2(4)(c) of Schedule 6 to the Care Act 2014,

in such manner and to such extent as the LETB in question may request, in planning the provision of, and in providing, education and training for health care workers; and

(b) provides the LETB in question with such information as it may request.

(1B) For the purposes of paragraph (1), regulation 20 of the 2014 Regulations is modified as follows—

(a) for "Registered persons" in paragraph (1), substitute "Health service providers";

(b) for "registered person", in each place it appears, substitute "health service provider";

(c) in paragraph (1), omit "in carrying on a regulated activity"; and

(d) in paragraphs (8) and (9) for "a regulated activity", substitute "health care services".

(2) In this regulation—

. . .

"LETB" means a local education and training board appointed by Health Education England under section 103 of the Care Act 2014;]

. . .

"registered person" has the same meaning as in regulation 2(1) of the 2014 Regulations (interpretation);

"regulated activity" means an activity prescribed as a regulated activity for the purposes of section 8(1) of the Health and Social Care Act 2008 (regulated activity) by regulation 3 of the 2014 Regulations (prescribed activities)"

3.6. Regulation 17 of the 2012 Regulations then provides for the NHS Standard Contract to be drafted by NHS England as follows:

"(1) The Board must draft—

(a) terms and conditions making provision for the matters specified in regulation 16; and

(b) such other terms and conditions as the Board considers are, or might be, appropriate for inclusion in commissioning contracts entered into by a relevant body.

(2) The Board may draft model commissioning contracts which reflect the terms and conditions it has drafted pursuant to paragraph (1).

(3) A relevant body must incorporate the terms and conditions drafted by virtue of paragraph (1)(a) in commissioning contracts entered into by it.

(4) The Board may require CCGs to incorporate the terms and conditions it has drafted pursuant to paragraph (1)(b) in commissioning contracts that a CCG enters into.

(5) If a CCG is required by the Board to incorporate terms and conditions pursuant to paragraph (4), it must do so"

3.7. NHS England has complied with this obligation by publishing a variety of NHS Standard Contracts. The forms of these contracts are revised on annual basis and published on the NHS England website. As from April 2017, there is a "shorter form" contract, which runs to a mere 70 pages as opposed to the full form of the contract which is over 300 pages. The full length NHS Standard Contract falls into 3 parts[7]:

a) The Particulars;

b) The Service Conditions; and

c) The General Conditions.

3.8. The Shorter Form contract is also in 3 parts, with the same division as the full length NHS Standard Contract. It is beyond the scope of this book to describe every aspect of the NHS Standard Contract but it contains numerous provisions governing the relationship between the NHS commissioner and the provider, and setting out the quality standards that the provider must adhere to.

[7] See https://www.england.nhs.uk/nhs-standard-contract/17-18/

3.9. NHS England has exercised the power in Regulation 17(4) to require CCGs to use the NHS Standard Contract (or the shorter form contract), as confirmed in the NHS England Technical Guidance. The NHS Standard Contract 2017/18 and 2018/19 Technical Guidance document ("**the Technical Guidance**")[8] sets out the legal obligations on NHS bodies to use the NHS Standard Contract as follows:

> **"7 When should the NHS Standard Contract be used?**
>
> 7.1 The NHS Standard Contract exists in order that commissioners and providers operate to one clear and consistent set of rules which everyone understands, giving a level playing field for all types of provider and allowing economies in the drafting and production of contracts, for example in respect of legal advice.
>
> 7.2 The NHS Standard Contract must be used by CCGs and by NHS England where they wish to contract for NHS-funded healthcare services (including acute, ambulance, patient transport, continuing healthcare services, community-based, high-secure, mental health and learning disability services). The Contract must be used regardless of the proposed duration or value of a contract (so it should be used for small-scale short-term pilots as well as for long-term or high-value services). Where a single contract includes both healthcare and non-healthcare services, the NHS Standard Contract must be used.
>
> 7.3 The only exceptions are:
>
> - primary care services commissioned by NHS England, where the relevant primary care contract should be used; and
>
> - any primary care improvement schemes agreed by CCGs with GP practices (with contractual arrangements, involving a variation or supplement to existing general practice contract, agreed between local NHS England teams and CCGs). Such Local Improvement Schemes (LIS) involve payments for improving the quality of services provided under an existing GP contract, not the commissioning of additional services.
>
> 7.4 CCGs must use the NHS Standard Contract for all community-based services provided by GPs, pharmacies and optometrists that were previously commissioned as Local Enhanced Services. This will apply where the CCG is commissioning services which expand the scope of services beyond what is covered in core primary care contracts or LIS agreements"

[8] See https://www.england.nhs.uk/wp-content/uploads/2016/11/7-contract-tech-guid.pdf

3.10. It follows that CCGs are under a public law duty to use the NHS Standard Contract whenever they were commissioning "NHS funded healthcare services" unless the services were exempted because they came within the type of services set out in paragraph 7.3 of the Technical Guidance (as set out above).

3.11. The legal obligations on CCGs to use the NHS Standard Contract has the following implications:

a) There is no exemption from the legal duty to contract using the NHS Standard Contract where the proposed contract is of low value. The legal duty to use the NHS Standard Contract arises regardless of the value of the contract;

b) There is no exemption from the mandated duty to use the NHS Standard Contract where the commissioning decision has been made by an Individual Funding Request panel; and

c) There is no exemption from the duty to use the NHS Standard Contract where services are being commissioned by a CCG for a single patient as opposed to being commissioned for cohorts of patients.

3.12. This means that a CCG is under a legal duty to use an NHS Standard Contract when, for example, commissioning a care home place for a patient who is eligible for NHS Continuing Healthcare or a placement for a patient who requires mental health in-patient treatment. There has been a practice amongst CCGs of using an informal form of contract, called a "spot purchase" arrangement, without using the full form NHS Standard Contract to set up these types of arrangements. There is even NHS England Guidance which appears to endorse the use of such an arrangement[9]. However, the Technical Guidance is clear that CCGs are under a legal duty to use the NHS Standard Contract for commissioning all services for NHS patients save for the exceptions set

[9] See the discussion at paragraph 9.18 in the Patient Choice Chapter.

out above. This is confirmed at paragraph 12.1 of the Technical Guidance which provides:

> "We expect the NHS Standard Contract to be used where an NHS commissioner is fully funding an individual's NHS Continuing Health Care (NHS CHC) placement in a care home or package of home care"

3.13. The Technical Guidance gives the following advice about when NHS commissioners are entitled (and should) use the Shorter Form NHS Contract:

> **"When to use the shorter-form Contract**
>
> 9.1 The shorter-form Contract must not be used for contracts under which acute, cancer, A&E, minor injuries, 111 or emergency ambulance services, or any other hospital inpatient services, including for mental health and learning disabilities, are being commissioned.
>
> 9.2 Restricting use of the shorter-form Contract in this way significantly reduces the number of detailed requirements which it has to include, and these providers (that is, providers of those services for which the shorter-form Contract must not be used) tend to be larger organisations.
>
> 9.3 Subject to the restriction around national prices above, commissioners may use the shorter-form Contract for all other services for which the NHS Standard Contract is mandated – for non-inpatient mental health and learning disability services, for any community services, including those provided by general practices, pharmacies, optometrists and voluntary sector bodies, for hospice care / end of life care services outside acute hospitals, for care provided in residential and nursing homes, for non-inpatient diagnostic, screening and pathology services and for patient transport services.
>
> 9.4 In response to feedback, however, we are amending the shorter-form Contract so that it can now be used for diagnostic, screening and pathology services, including where the National Tariff guidance sets a mandatory national price. We recognise that this will allow the shorter-form Contract to be used in a wider range of appropriate situations. Including the provisions relation to mandatory national prices adds to the length of the Contract, so we strongly recommend that commissioners use the e-Contract functionality, to ensure that this additional wording only appears in those contracts where it is required.

9.5 Within the parameters set out in this Guidance, it is for commissioners to determine when they wish to use the shorter-form version of the Contract, as opposed to the longer form.

9.6 We have not set a specific financial threshold for use of the shorter-form contract, but we strongly encourage commissioners to use it for appropriate services (as described in 9.3 above) with lower annual values, which will tend to include the great majority of contracts held by the smaller provider organisations which this new contract form is particularly intended to assist. The end result of this approach should be that the shorter-form Contract is used for most contracts with smaller providers, including voluntary organisations, hospices (where grant agreements are not being used – see paragraph 11 below), care home operators and providers of enhanced services such as general practices, pharmacies and optometrists.

9.7 However, in deciding whether to use the shorter-form Contract to commission services for which it may be used, commissioners should consider carefully the differences in the management process and other provisions between the shorter-form and full-length Contracts. If the "lighter touch" approach of the shorter-form is not thought appropriate to the services, the relationship or the circumstances, the full-length Contract may be used. Also, if the provider is providing other services under the full-length Contract, it may be more appropriate to keep all services on this form.

9.8 Note that when services are being tendered (whether competitively or under AQP) the same form of contract must be offered to all potential providers of those services. The form of contract offered (whether shorter-form or full-length) should be made clear in the Prior Information Notice, advertisements and other communications with potential providers"

3.14. **Multiple Commissioners under a single contract**: The NHS Standard Contract can be used by multiple CCGs to commission services from a single provider of NHS services. This is particularly useful for services of a fairly specialised nature (but which do not fall to be commissioned by NHS England[10]). The Technical Guidance explains the way in which the NHS Standard Contract can be used for multi-party contracting as follows:

**"13 Collaborative contracting**

13.1 The NHS Standard Contract may be used for both bilateral and multilateral commissioning i.e. for commissioning by a single commissioner or by a group of

[10] See the Responsible Commissioner Chapter to see the distinction between services commissioned by NHS England and those commissioned by CCGs.

commissioners collaborating to commission together, with one acting as the co-ordinating commissioner.

13.2 Clearly, it is for commissioners to determine the extent to which they choose to adopt the co-ordinating commissioner model – but it is an approach which NHS England strongly encourages. There can be great benefits for commissioners from working closely together to negotiate and manage contracts with providers. Using the co-ordinating commissioner model enables a consistent approach to contracting and is more efficient for both commissioners and providers, avoiding a proliferation of small, separate contracts.

13.3 In particular, we would encourage commissioners to work together to use, where they can, consistent contract metrics for the same provider – local quality and reporting requirements, local agreements, policies and procedures, Activity Planning Assumptions or Prior Approval Schemes. This will help to reduce the administrative burden which providers face.

13.4 Where commissioners choose to contract collaboratively, they should set out the roles and responsibilities that each commissioner will play in relation to the contract with the provider, and how they are to make decisions in relation to the contract and instruct the co-ordinating commissioner to act on their behalf, in a formal collaborative commissioning agreement (CCA). The CCA is a separate document entered into by a group of commissioners and governs the way the commissioners work together in relation to a specific contract. A CCA should be in place before the contract is signed and takes effect. However, a contract which has been signed by all the parties (as outlined in paragraph 15 below) is still legally effective and binding on all the parties without a collaborative agreement in place. The CCA should not be included in the contract (though the allocation of roles and responsibilities between commissioners which are party to a contract can, where necessary, be set out in Schedule 5C (Commissioner Roles and Responsibilities) to that contract).

13.5 Model CCAs are available on the NHS Standard Contract 2017/18 web page.

13.6 Where NHS England is the sole party to a contract, but the lead for commissioning of particular services from the provider is being taken by different NHS England teams, use of a formal CCA is not appropriate – NHS England is one legal entity. However, it is important to ensure that the different teams understand what role each will play in managing the contract and communicate this clearly to the provider"

3.15. **The period of an NHS Contract:** The period of an NHS Contract is not set out in the standard form contract. It is thus up to NHS commissioners and providers to agree between themselves how long a contract should last. The Guidance recommends that contracts starting in April 2017 should be for a 2 year period, thus largely avoiding the annual contracting round for April 2018. The Technical Guidance give the following advice about the period of an NHS Contract:

> "17.4 There is no nationally-mandated limit to contract duration, nor is there a central approval process for contract terms beyond a certain duration. It is for commissioners to determine locally, having regard to the guidelines below, the duration of the contract they wish to offer.
>
> - Commissioners will need to consider carefully what benefits they can expect from offering providers the increased certainty of a longer-term contract, setting this against the need to ensure that they are able to use a competitive procurement approach when this will be in patients' best interests, in line with regulations and guidance. Commissioners should consider patient choice, competition, the likelihood of technological and other developments affecting service delivery models, all relevant commercial and market considerations, in determining the appropriate length of contract. Contract length should be considered in conjunction with consideration of including any right to extend the contract (see paragraph 18) and/or the consequences of early termination (see paragraph 47).
>
> - Commissioners must ensure that they make clear the duration of the contract to be offered at the very outset of the procurement process.
>
> - Commissioners must ensure that the duration of any contract (and any proposed right to extend that period) is in compliance with their own standing financial instructions (SFIs) and other governance requirements, and that any approvals are obtained in line with those requirements. NHS England commissioners should note that, under NHS England SFIs, any proposal to let a contract with a potential duration of over five years (including any optional extensions) requires approval through the Efficiency Controls Committee prior to advertisement.
>
> 17.5 Alongside flexibility of contract duration, the Contract:

- includes an explicit acknowledgement of the parties' rights to terminate the Contract or any Service by mutual agreement (GC17.1); and

- continues to include provisions for early termination of the Contract or a Service on a no-fault basis, with flexibility as to notice periods (and note that different notice periods may be agreed for termination of the whole Contract or for a Service).

17.6 The Contract also continues to allow for National Variations to be mandated by NHS England, in particular to reflect annual updates to the NHS Standard Contract. Both commissioner and provider are able to propose other variations (for example to effect annual reviews"

3.16. The Technical Guidance also provides the following guidance on the need for both commissioners and providers to act fairly in their dealings with other. It provides:

"**29 Contracting fairly**

29.1 The contract is an agreement between the commissioner(s) and the provider. Once entered into, the contract is a key lever for commissioners in delivering high-quality, safe and cost-effective services. However, the contract in isolation will not achieve this. An effective working relationship between commissioner(s) and provider is a key element of successful contracting.

29.2 An effective relationship is unlikely to be a cosy one in which the partners are hesitant to address difficult issues for fear of upsetting each other – but nor will it be one where each party focusses, aggressively and continuously, on protecting what is perceives to be its own narrow, individual interests.

29.3 There is no perfect recipe, but an effective working relationship is more likely to be possible where commissioner and provider:

- have a shared vision for services, with the primary focus on what will produce the best outcomes for patients – but backed by a commitment to deal fairly with the consequences of this vision for individual organisations;

- are open and transparent in sharing information, ensuring early communication of new or changed intentions, emerging problems or potential disputes;

- take their contractual responsibilities seriously, but use contractual levers and processes in a reasonable and proportionate way; and

- tackle difficult discussions about financial pressures in a way which focusses on actions which will genuinely remove cost or increase efficiency in the local health system as a whole, rather than producing short-term, opportunistic gains for one party at the expense of the other"

3.17. This would be somewhat idealistic or even naive advice if the NHS operated in an entirely arms-length contractual manner, but that is not usually the overriding culture of the NHS. It remains to be seen how much this Guidance is followed in practice.

## 4. Non-contract activity: how commissioning arrangements work without a contract in place.

4.1. NHS commissioners will have contracts in place with their local providers of NHS services. However the patients for whom a CCG has commissioning responsibility will, in practice, be provided by NHS treatment by a vast variety of NHS providers, many of whom will not have a current contract in place with the responsible CCG. It would clearly be impracticable for CCGs to have contracts in place with every single NHS provider in the country just on the off chance that a patient from, say Newcastle, was treated by a hospital Trust in Devon. However where a patient who is resident in Newcastle falls ill whilst on holiday in Devon and is admitted to a Devon hospital, the Trust running the hospital needs to be able to charge the patient's home CCG in Newcastle for NHS treatment provided to the patient[11].

4.2. The NHS England "*Who Pays? Determining Responsibility for payments to providers" Guidance*[12] has the following guidance at paragraphs 38 to 46:

**"Non-contract activity**

[11] Other than accident and emergency treatment which should be billed to the CCG local to the hospital Trust. For more details on the division between different responsible commissioners, please see the chapter on the Responsible Commissioner

[12] See https://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf

38. Non-contract activity is the term used to refer to NHS-funded services delivered to a patient by a provider which does not have a written contract with that patient's responsible commissioner, but which does have a written contract with another commissioner or commissioners.

39. Written contracts, using the NHS Standard Contract format, should be put in place by commissioners with a provider where there are established flows of patient activity with a material financial value. Non-contract activity billing arrangements are not intended as a routine alternative to formal contracting, but are likely to be required in some circumstances, usually for small, unpredictable volumes of patient activity delivered by a provider which is geographically distant from the commissioner.

40. The responsible commissioner for non-contract activity will be established in the usual manner, using paragraph 1, irrespective of the location or status of the provider.

41. The following arrangements apply, within England, in terms of commissioner approval processes for non-contract activity:

a) No prior commissioner approval is required for emergency treatment on a non-contract basis.

b) No prior commissioner approval is required for consultant-led elective care where the patient has exercised choice of provider under the legal rights set out in the NHS Constitution. A GP, dentist or optometrist referral is required in such cases, however.

c) For non-emergency treatment where the NHS Constitution does not set out a legal right for a patient to choose their provider, referral by the patient's GP, dentist or optometrist nonetheless constitutes authority for the provider to see and (depending on the content of the referral) treat the patient, and commissioners must pay for activity undertaken in such circumstances.

d) In other circumstances than those set out in paragraphs a) to c) above, there is no presumption that a provider may see and treat patients, on a non-contract basis, and expect to be paid by commissioners. Commissioners have the right to determine which services they wish to commission and from which providers. Where non-emergency non-contract referrals are made other than by the patient's GP, dentist or optometrist, including self-referrals, the provider must seek prior authorisation from the responsible commissioner before assessing and treating the patient. Where prior authorisation is not granted, commissioners are under no obligation to pay for activity which is carried out by providers on a non-contract basis.

42. The same arrangements apply for commissioner approval processes in respect of UK cross-border non-contract activity, except that for all elective referrals, prior approval from the commissioner must be sought and obtained by providers. Referral by a GP or consultant does not in itself constitute approval.

43. Emergency treatment should never be refused or delayed due to uncertainty or ambiguity as to which CCG is responsible for funding an individual's healthcare. Commissioners and providers should work together in good faith to ensure that, where prior authorisation is required, this is sought, and a response provided, as quickly as possible.

44. It is good practice for providers to put in place administrative systems to identify elective non-contract activity at the point of booking. Providers should inform responsible commissioners of any planned treatment(s) for a patient likely to result in claim for payment in excess of £10,000 and to keep them informed as necessary throughout the patient's stay, for example, if it becomes apparent that a patient's length of stay is likely to exceed 50 days. These arrangements can help to ensure that commissioners are informed about high-cost cases at the earliest opportunity and are appropriately involved in planning care for patients with complex needs. These are expected behaviours of organisations, not a lever for purposefully withholding non-contract activity funding.

45. Non-contract activity is undertaken by the provider on the terms of the NHS Standard Contract in place between that provider and its host commissioner(s). A contract on those terms will be implied as between the patient's responsible commissioner and the provider. Note in particular that:

- services will be delivered in accordance with the service specifications and other terms and conditions of the provider's contract with its host commissioner;

- prices for services will be in line with National Tariff guidance (Payment by Results guidance in 2013/14), as applicable, or the local prices set out in the provider's contract with its host commissioner(s);

- arrangements for submission of activity datasets, invoicing and payment reconciliation should follow National Tariff guidance (Payment by Results guidance in 2013/14) and the terms and conditions set out in the NHS Standard Contract. Commissioners will be under no obligation to pay for activity where activity datasets and invoices are not submitted in line with these requirements;

- commissioners and providers should work together in good faith to minimise disagreements relating to payment for non-contract activity. However, any formal disputes over payment for non-contract activity should be resolved in accordance with the dispute resolution procedure set out in the NHS Standard Contract.

46. These arrangements may be applied to non-contract activity involving cross-border patient flows within the UK (e.g. cross border emergency treatment) under the arrangements set out in section C)"

4.3. This is all sensible, practical Guidance, but it does not explain the legal basis upon which payments are required to be made by a commissioner to a provider where there is no contract in place between an NHS commissioner and a provider. It also appears to ground the right of the patient to make choices in the NHS Constitution whereas the source of the patient's legal rights is under the 2012 Regulations and the duties on commissioners, as explained in the chapter on patient choice.

4.4. The Technical Guidance seeks to provide a legal basis for non-contract activity by applying either the terms of the contract or a model of an "implied contract" to non-contract activity by offering the following Guidance:

**"25 Acceptance of referrals and non-contract activity**

25.1 It is important for patients that providers of NHS-funded services accept referrals from all appropriate sources.

25.2 The Contract (full-length) includes a specific requirement on providers (SC6.6.2) to accept every referral, regardless of the identity of the Responsible Commissioner, where this is necessary to enable a patient to exercise his/her legal right of choice of provider. This applies whether or not the Responsible Commissioner for the patient affected is a party to a written contract with the provider. (Note, however, the new restrictions which will apply in respect of GP referrals not made via ERS from October 2018 – see paragraph 3.2 above.)

25.3 There is also an equivalent provision in relation to the acceptance of emergency referrals and presentations which are within the scope of the services it provides (SC6.6.3 of the full-length Contract). Again, this requirement applies whether or not

the Responsible Commissioner for the affected patient is a party to a written contract with the provider. There will be instances where a provider cannot safely accept an emergency referral, and the Contract wording makes provision for this.

25.4 These provisions can be enforced by the Responsible Commissioner of any affected patient, either through the co-ordinating commissioner for the provider's main contract or via GC29.1 (Third Party Rights).

25.5 Conversely, we also set out clearly (SC6.8 in the full-length Contract, SC6.3 in the shorter form) that the existence of a contract with one commissioner does not automatically entitle a provider to accept referrals in respect of, provide services to, nor to be paid for providing services to, individuals whose Responsible Commissioner is not a party to the contract, except (where appropriate) where such an individual is exercising their legal right to choice as set out in the NHS Choice Framework or where necessary for the individual to receive emergency treatment.

25.6 Guidance on non-contract activity (NCA) (including what form of referral constitutes authority to treat) is set out in *Who Pays? Establishing the Responsible Commissioner*[13]. Commissioners and providers should refer to this guidance for full detail, but it may be helpful to re-state certain key points here.

25.7 The guidance makes clear that "Written contracts, using the NHS Standard Contract format, should be put in place by commissioners with a provider where there are established flows of patient activity with a material financial value. Non-contract activity billing arrangements are not intended as a routine alternative to formal contracting, but are likely to be required in some circumstances, usually for small, unpredictable volumes of patient activity delivered by a provider which is geographically distant from the commissioner."

25.8 The concept of NCA is most relevant to acute hospital services, most of which are covered by national currencies and prices and where patients have choice of provider. As a guideline, we would strongly recommend that any CCG with activity of over £200,000 per annum with an acute provider should put in place a written contract, rather than relying on the NCA approach.

25.9 The guidance also explains that, where there is no written contract in place, there is nonetheless an implied contract (assumed to be on the terms of the NHS Standard Contract in place between the provider and its local commissioners). In particular, the guidance is clear that 'NCA' commissioners have the same rights to

[13] Please see the Responsible Commissioner chapter for a description of the system of allocating responsibility between commissioners. A degree of caution is needed because the "Who Pays" Guidance contains numerous statements that are at variance with the 2012 Regulations.

challenge payment as commissioners covered by written contracts, stating that "Arrangements for submission of activity datasets, invoicing and payment reconciliation should follow National Tariff guidance (Payment by Results guidance in 2013/14) and the terms and conditions set out in the NHS Standard Contract. Commissioners will be under no obligation to pay for activity where activity datasets and invoices are not submitted in line with these requirements."

25.10 We have heard of both commissioners and providers refusing to enter into written contract with their counterparts even where regular activity flows are substantially above the level referred to in paragraph 25.8 above, seemingly believing that it is in their interests to operate under NCA principles instead. We advise strongly against this sort of approach.

25.11 In practice, acute NCA will need to be reported via SUS, with invoices raised by providers in line with the timescale set out in SC36.35. It is essential that providers and commissioners comply with the requirements NHS England has published advice on access to personal confidential data for the purposes of invoice validation, *Who Pays? Information Governance Advice for Invoice Validation*, including the requirement for providers to submit detailed backing datasets to the same timescales as NCA invoices"

4.5. In practice the contacting provisions work by placing a contractual obligation on the NHS provider to accept a referral of a patient for treatment, even if the patient is not someone for whom the contracting CCG has commissioning responsibility. This is set out in Special Condition ("**SC**") 6.6 which provides:

**"Acceptance and Rejection of Referrals**

6.6 Subject to SC6.2A and to SC7 (Withholding and/or Discontinuation of Service), the Provider must:

6.6.1 accept any Referral of a Service User made in accordance with the Referral processes and clinical thresholds set out or referred to in this Contract and/or as otherwise agreed between the Parties and/or as specified in any Prior Approval Scheme, and in any event where necessary for a Service User to exercise their legal right to choice as set out in the NHS Choice Framework; and

6.6.2 accept any clinically appropriate referral for any Service of an individual whose Responsible Commissioner (CCG or NHS England) is not a Party to this Contract where necessary for that individual to exercise their legal right to choice as set out in the NHS Choice Framework; and

6.6.3 where it can safely do so, accept a referral or presentation for emergency treatment, within the scope of the Services, of or by any individual whose Responsible Commissioner is not a Party to this Contract.

Any referral or presentation as referred to in SC6.6.2 or 6.6.3 will not be a Referral under this Contract and the relevant provisions of Who Pays? Guidance will apply in respect of it"

4.6. Thus, if a provider has an NHS Standard Contract with one CCG, the provider has a duty to accept referrals from other CCGs. The words "referral" and "referrer" are defined in the General Conditions as follows:

"**Referral** the referral of any Service User to the Provider by a Referrer or (for a Service for which a Service User may present or self-refer for assessment and/or treatment in accordance with this Contract and/or Guidance) presentation or self-referral by a Service User

**Referrer**

(i) the authorised Healthcare Professional who is responsible for the referral of a Service User to the Provider; and

(ii) any organisation, legal person or other entity which is permitted or appropriately authorised in accordance with the Law to refer the Service User for assessment and/or treatment by the Provider"

4.7. General Condition ("**GC**") 29 relates to third party rights. It provides:

**"GC29 Third Party Rights**

29.1 A person who is not a Party to this Contract has no right under the Contracts (Rights of Third Parties) Act 1999 to enforce or enjoy the benefit of this Contract, except that, to the extent that it applies in its or their favour, this Contract may be enforced by:

29.1.1 a person who is the Provider's employee and is performing the Services for the Provider, if the matter to be enforced or the benefit to be enjoyed arises under GC5 (Staff), other than GC5.2, GC5.3.2 and GC5.15 to GC5.17 (Staff);

29.1.2 the Secretary of State;

29.1.3 a Regulatory or Supervisory Body

29.1.4 any CCG or Local Authority;

29.1.5 the NHS Business Services Authority;

29.1.6 a previous provider of services equivalent to the Services or any of them before the Service Commencement Date, or a new provider of services equivalent to the Services or any of them after the expiry or termination of this Contract or any Service, if the matter to be enforced or the benefit to be enjoyed arises under GC5.11 to GC5.14 (Staff);

29.1.7 the relevant NHS Employer, if the matter to be enforced or the benefit to be enjoyed arises under GC5.15 to GC5.17 (Staff).

29.2 Subject to GC13.2.2 (Variations), the rights of the Parties to terminate, rescind or agree any Variation, waiver or settlement under this Contract are not subject to the consent of any person who is not a party to this Contract.

4.8. Thus a CCG, or a person authorised to make referrals (such as a GP) can refer patients to any provider who has an NHS Standard Contract and, subject to the limited exceptions in SC6.6, the provider has a contractual duty to accept the referral and to provide appropriate NHS treatment to the patient who is referred. If the Provider refuses to accept the referral, the referring CCG has a contractual right under the Contracts (Rights of Third Parties) Act 1999 to enforce the obligation on the Provider to accept the referral and treat the patient by taking advantage of GC29.1.4.

4.9. That approach raises the question as to how the provider is entitled to bill the referring CCG for the activity that it has undertaken consequent upon that referral when the referring CCG has no contractual relationship with the provider. The answer provided by paragraph 25.9 of the Technical Guidance is that there is an "implied contract" on the terms of the NHS Standard Contract in place between the referring CCG and the provider under which the CCG agrees to remunerate the provider on the standard contractual terms. As a matter of law, this must be correct because the patient has been referred to the provider for NHS treatment against a clear

expectation that the provider will have the duty to provide the treatment and that the provider will be entitled to charge standard fees as a result of providing that treatment. The alternative is that the NHS Guidance creates a public law duty or a legitimate expectation for the provider to be paid by the CCG. The provider's right to be paid could be enforced either by private law proceedings or possibly by way of judicial review proceedings if a CCG failed to pay.

## 5. Payment for delivering NHS services and the NHS National Tariff: Introduction.

5.1. Over the years since the purchaser/provider was first created, the Department of Health developed a standard set of arrangements for paying NHS providers for providing services to NHS patients. The primary payment obligations in the NHS Contract are set out in the Special Conditions, starting at SC36 which provides:

> **"SC36 Payment Terms**
>
> **Payment Principles**
>
> 36.1 Subject to any express provision of this Contract to the contrary, each Commissioner must pay the Provider in accordance with the National Tariff, to the extent applicable, for all Services that the Provider delivers to it in accordance with this Contract.
>
> 36.2 To avoid any doubt, the Provider will be entitled to be paid for Services delivered during the continuation of:
>
> 36.2.1 any Incident or Emergency, except as otherwise provided or agreed under SC30 (Emergency Preparedness, Resilience and Response); and
>
> 36.2.2 any Event of Force Majeure, except as otherwise provided or agreed under GC28 (Force Majeure)"

5.2. Thus the payment obligation extends to "all Services that the Provider delivers to it in accordance with this Contract". The price is defined by SC36.3 which provides:

> **"Prices**

36.3 The Prices payable by the Commissioners under this Contract will be:

36.3.1 for any Service for which the National Tariff mandates or specifies a price:

36.3.1.1 the National Price; or

36.3.1.2 the National Price as modified by a Local Variation; or

36.3.1.3 (subject to SC36.16 to 36.20 (Local Modifications)) the National Price as modified by a Local Modification approved or granted by NHS Improvement,

for the relevant Contract Year;

36.3.2 for any Service for which the National Tariff does not mandate or specify a price, the Local Price for the relevant Contract Year"

5.3. The term "price" is defined by the General Conditions as:

"**Price** A National Price, or a National Price adjusted by a Local Variation or Local Modification, or a Local Price, as appropriate"

The lawfulness of NHS commissioners and providers agreeing a "Local Variation" to the price for a service specified by the National Tariff is considered below.

5.4. The existence of a standard set of prices for the delivery of NHS services was also intended to dissuade NHS commissioners from choosing to place contracts with a provider which offered the lowest price for the delivery of a service. Where prices were set by the PbR system, providers were supposed to compete on service quality and patient experience but not on price. The NHS Digital website explains the purpose of the PbR system as follows:

**"What is Payment by Results?**

The aim of Payment by Results (PbR) is to provide a transparent, rules-based system for paying trusts. It rewards efficiency, supports patient choice and diversity and encourages activity for sustainable waiting time reductions. Payments are linked to activity and adjusted for Casemix. Importantly, this system ensures a fair and

consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers.

PbR encourages stronger incentives to ensure that extra money being invested into the NHS results in improved performance and accountability. This involves making changes to the way health care is financed and the way funding flows are managed across the NHS.

Healthcare Resource Groups version 4 (HRG4) supports PbR by providing a classification framework that represents current clinical practice. In addition, HRG4 supports service planning, costing and commissioning between PCTs and trusts by providing reliable and consistent presentation of activity data to:

- support the focus on patient-centred care, to enable patient choice
- support the analysis of healthcare needs and monitoring of service provision, to inform service planning.

Data collected through HRG4 allows commissioners to develop transparent service level agreements with trusts and other service providers"

5.5. The PbR system has only ever covered a proportion of NHS services outside of primary care (where a PbR system has never operated). Prior to the introduction of the new rules in the 2012 act, NHS commissioners and providers signed "block contracts" to cover services that were not covered by prices defined within the PbR. These contracts defined the services that the provider would deliver and set quality and performance standards. However, the price to be paid was set for the contract as a whole rather than on a price per patient basis. There could be "caps and collars" which provided an increased price if the provider treated more patients than a defined number or possibly a reduction in payment if fewer patients were referred.

5.6. The underlying purpose of the PbR system is that the "money follows the patient". Thus providers get paid for the treatment they provide to individual patients, with the income dependant on the volume of patients treated by a provider. This approach has both policy advantages and disadvantages. As this is a legal rather than NHS policy book, it is not appropriate to dwell on the policy issues. However, the advantages and

disadvantages of a PbR system are explored in a Kings Fund Report[14] "Payment by Results: How can payment systems help to deliver better care?" which was published in 2012.

5.7. The 2012 Act put the non-statutory payment rules on a statutory footing. The rules for the operation of NHS commissioning arrangements are now set out in Chapter 4 of Part 3 of the 2012 Act. The "Explanatory Notes" to the Act explain the purpose of the Chapter as follows:

> "Chapter 4 makes provision for Monitor, in conjunction with the NHS Commissioning Board, to regulate prices for NHS services through a national tariff. It also makes provision for references to the Competition Commission to adjudicate over disputed changes to methodologies for determining prices under the national tariff"

5.8. Section 115 of the 2012 Act sets out the primary obligation on NHS commissioners to pay providers of NHS services according to the National Tariff. It provides:

> **"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"

5.9. The National Tariff is provided for by way of section 116 of the 2012 Act. This section places an obligation on Monitor to publish the National Tariff as a single document that sets out the prices for NHS services which are to be paid by NHS commissioners to providers. The relevant provisions state:

[14] See https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/payment-by-results-the-kings-fund-nov-2012.pdf

"(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"

5.10. Further provisions for the operation of the National Tariff are set out at section 117 of the 2012 Act, which provides:

"(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"

5.11. There is considerable disagreement between professional commentators about the meaning and effect of these provisions. NHS England, the Department of Health and Monitor (now part of NHS Improvement) have interpreted these provisions to permit the NHS to operate an internal market with a measure of price competition. However it is by no means clear whether their views are correct[15]. Further it is far from clear that the rules are followed in practice by NHS commissioners and providers. There are also considerable inconsistencies between the way that NHS England, the Department of Health and Monitor say payment provisions for the NHS now operate and assurances as to the effect of these rules given in parliament during the passage of the Bill which became the 2012 Act.

## 6. The meaning of a "health care service" in the National Tariff.

6.1. The starting point to understanding the potentially confusing set of provisions which govern how much an NHS commissioner should pay to an NHS provider for providing services to NHS patients starts by identifying the basic building block for the payment obligation, namely the provision of a "health care service". Although there is no definition in the 2012 Act of the meaning of the term "health care service" in the 2012

[15] At the time of writing this a judicial review challenge is being prepared to the terms of the Accountable Care Organisation draft contract which, if it comes to court, may assist in in resolving some of the issues in the following sub-paragraphs.

Act, any interpretation of the Act has to set it within the context that this Part of the Act was putting the existing PbR system onto a statutory footing. The NHS provides a wide range of health care services to individual patients and thus the natural meaning of the words "health care service" is an episode of medical treatment provided to an individual NHS patient by a provider of NHS services.

6.2. Different rules operate depending on whether the health care service is "specified in the National Tariff" or not. Section 115(1) of the 2012 Act sets pricing rules for services that are specified in the National Tariff. Section 115(2) covers those services which are not specified in the National Tariff and sets different rules which apply to determining payment schemes for such services. Paragraphs 31 and 32 of the 2017/18 National Tariff explain how the rules apply to those services that are specified in the National Tariff. They provide:

> "31. Under the Health and Social Care Act 2012 ('the 2012 Act'), the national tariff must specify certain NHS healthcare services for which a national price is payable. The healthcare services to be specified must be agreed between NHS England and NHS Improvement. The 2012 Act also provides that the national tariff may include rules for determining which currency applies where there is more than one currency and price for the same service.
>
> 32. We are using healthcare resource group HRG4+ currency design as the basis for setting national prices for admitted patient care, outpatient procedures and accident and emergency (A&E) attendances. We are using 'phase 3' of the currency design, which was used for the collection of the 2014/15 reference costs"

6.3. Section 117(1) provides that the National Tariff can specify services in 3 ways, namely (a) by reference to its components, (b) by specifying it as a service (a "bundle") that comprises two or more health care services which together constitute a form of treatment or (c) by specifying it as a service in a group of standardised services. The difference between these options is the extent to which a series of medical procedures are paid for under a single tariff payment. It would be possible for the NHS to remunerate providers for every blood test undertaken for a patient, every examination or every minute that a patient stays in hospital. Such a system would pay

providers by the "components" of health care. Alternatively, individual components could be "bundled" together and attract a single payment.

6.4. Finally, a course of treatment can be "grouped" from beginning to end under section 117(1)(c), so that a single payment is provided for each patient of a certain classification who requires a hip replacement, regardless of the number of tests done or length of stay in hospital. Such an approach has an element of "swings and roundabouts" because, across a cohort of patients, some will be more straightforward and some will be more complex (and thus incur additional bed days or additional clinical interventions). The National Tariff uses the third option. This is explained at paragraph 36 of the National Tariff as follows:

> "'Grouping' is the process of using clinical information such as diagnosis codes (in admitted patient care only), procedure codes (in admitted patient care and outpatient care), treatment codes (A&E only) and investigation codes (A&E only) to classify patients to casemix groups structured around healthcare resource groups. HRGs are groupings of clinically similar conditions or treatments that use similar levels of healthcare resources. The grouping is done using grouper software produced by NHS Digital.15 NHS Digital16 also publishes comprehensive documentation giving the logic and process behind the software's derivation of HRGs as well as other materials that explain and support the development of the currencies that underpin the national tariff"

6.5. The National Tariff uses the term "Currency" to mean a unit of healthcare activity such as spell, episode, attendance which is grouped together under a single National Tariff price. Paragraphs 37 to 39 of the National Tariff states:

> "37. A 'currency' is a unit of healthcare for which a payment is made. Under the 2012 Act, a healthcare service for which a national price is payable must be specified in the national tariff. A currency can take one of several forms. We use spell-based HRGs as the currency for admitted patient care and some outpatient procedures. The currencies for A&E services are based on A&E attendances.
>
> 38. The HRG currency design used for the 2017/19 NTPS is known as HRG4+ and is arranged into chapters, each covering a body system. Some chapters are divided into subchapters. The specific design for the 2017/19 NTPS is that used to collect 2014/15 reference costs.

39. The currency used for outpatient attendances is based on attendance type and clinic type, defined by treatment function code (TFC). This is explained in more detail in Section 3.2.4"

6.6. Thus, an NHS provider that provides medical treatment to an NHS patient that qualifies as a "currency" is entitled to claim a payment for the service which relates to that currency (which sum may then be adjusted as described below). There are different definitions of currencies that apply to different types of care. Hence, for example, the currency for out-patient appointments operates as follows:

**"3.2.5. Outpatient care**

83. National prices for consultant-led outpatient attendances are based on clinic type categorised according to treatment function code (TFC) There are separate prices for first and follow-up attendances, for each TFC, as well as for single professional and multi-professional clinics.

84. To incentivise a change in the delivery of outpatient follow-up activity, to encourage a move to more efficient models and to free up consultant capacity, we over-reimburse first attendances and under-reimburse corresponding follow-up attendances. This transfer in cost is set at a TFC level and ranges from 10% to 30%. There is a full list in Annex A.

85. The outpatient attendance national price remains applicable only to pre-booked, consultant-led attendances and in accordance with the service conditions in the NHS Standard Contract"

6.7. The term "HRG" in the National tariff is a reference to "**Healthcare Resource Group4+".** The NHS Data Dictionary[16] explains this term as follows:

"Healthcare Resource Groups offer Organisations the ability to understand their ACTIVITY[17] in terms of the types of PATIENTS they care for and the treatments they undertake. They enable the comparison of ACTIVITY within and between different

[16] See http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/h/healthcare_resource_group_de.asp?shownav=1

[17] Words in capitals in the NHS Data Dictionary are defined terms.

Organisations and provide an opportunity to benchmark treatments and services to support trend analysis over time.

Healthcare Resource Groups are currently used as a means of determining fair and equitable reimbursement for care services delivered by Health Care Providers. Their use as consistent 'units of currency' supports standardised healthcare commissioning across the NHS. They improve the flow of finances within - and sometimes beyond - the NHS.

For further information on Healthcare Resource Groups, see the NHS Digital website at: Introduction to Healthcare Resource Groups"

6.8. The NHS Digital website contains a further explanation of Healthcare Resource Groups as follows[18]:

**"What are Healthcare Resource Groups?**

Healthcare Resource Groups (HRGs) are standard groupings of clinically similar treatments which use common levels of healthcare resource.

HRGs help organisations to understand their activity in terms of the types of patients they care for and the treatments they undertake. They enable the comparison of activity within and between different organisations and provide an opportunity to benchmark treatments and services to support trend analysis over time.

HRGs are currently used as a means of determining fair and equitable reimbursement for care services delivered by providers. Their use as consistent 'units of currency' supports standardised healthcare commissioning across the service.

They improve the flow of finances within - and sometimes beyond - the NHS. HRG version 4 has been in use for reference costs since April 2007 (for financial year 2006/7 onwards) and for Payment by Results (PbR) since April 2009 (for financial year 2009 onwards).

HRG4 was a major revision that introduced HRGs to new clinical areas, to support the Department of Health's policy of Payment by Results (PbR). It includes a portfolio of new and updated HRG groupings that accurately record patient treatment to reflect current practice and anticipated trends in healthcare.

[18] See http://content.digital.nhs.uk/hrg

> Our aim is to ensure that HRG4 suits the needs of the NHS and meets the requirements of DH in implementing the policy of PbR"

6.9. The above definitions thus explain that, at least as far as services specified in the National Tariff are concerned, the term "health care service" in section 115(1) is a reference to a pre-defined (and "grouped") episode of medical treatment for an individual NHS patient provided by an NHS provider. There is no scheme under the 2012 Act which provides for a payment arrangement for the treatment of multiple patients other than as a multiplier of the National Tariff price for an individual patient.

**7. Is agreeing a changed price for a services specified in the National Tariff or "price competition" lawful as part of any NHS procurement or contracting arrangement?**

7.1. There is no definition of the term "price" in the 2012 Act. However, a "price" appears to be a sum of money which, by virtue of the statutory scheme under the 2012 Act, becomes payable by an NHS commissioner to a provider of NHS services for the provision of a health care service to an individual patient. Thus the term "price" in part 3 of the 2012 Act refers (and can only refer) to the sum of money payable by an NHS commissioner to a provider for the provision of a health care service to an individual patient.

7.2. One of the unanswered questions relating to the proper interpretation of the 2012 Act is whether any departure from National Tariff prices (for those health care services which are specified in the National Tariff) and/or whether any substantial element of price competition is permissible when undertaking a procurement exercise for NHS services. These 2 issues are obviously linked.

7.3. In the years since the publication of the 2012 Act, the NHS has embraced procurement processes with a focus on price competition in the years since the 2012 Act was implemented. However, the material set out below suggests strongly that the scheme of the 2012 Act was to create statutory procedures for fixing pricing mechanisms which meant that "prices" for the delivery of NHS services were determined on an

objective basis, and that any competition between providers was limited to quality and delivery issues. If that construction of the 2012 Act is correct, this is an area, like so many, where there may be a significant distance between the day-to-day realities as to how the NHS operates and the statutory scheme set out in the 2012 Act. A study of the parliamentary materials makes it very clear that one purpose of the Bill which became the 2012 Act was to rule out price competition in relation to NHS contracts, and that Parliament was continually assured that the Bill ruled out all price competition.

7.4. The Health and Social Care Bill, as originally published by the Department of Health, proposed market mechanisms for the NHS, including the potential for price competition. That fitted with the policies of the incoming government which sought to drive the NHS towards adopting market mechanisms, including price competition for NHS services. Paragraph 5.43 of the NHS Operating Framework for 2011/12[19] which was published in December 2010 stated:

> "The flexibilities set out in the 2010-11 NHS Operating Framework will remain largely in place for 2011-12. One new flexibility being introduced in 2011-12 is the opportunity for providers to offer services to commissioners at less than the published mandatory tariff price, where both commissioner and provider agree. Commissioners will want to be sure that there is no detrimental impact on quality, choice or competition as a result of any such agreement."

7.5. Clause 103(1) of the original Bill[20] (which subsequently became section 115 of the 2012 Act) proposed that the National Tariff price would be the "maximum price" the NHS could pay for the delivery of an NHS services, leaving it open to NHS commissioners and providers to agree the final price. It provided:

> "(1) If a health care service is specified in the national tariff (as to which, see section 104), the price payable for the provision of that service for the purposes of the NHS is—
>
> (a) the price specified in the national tariff for that service, or

[19] See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216187/dh_122736.pdf
[20] See https://publications.parliament.uk/pa/cm201011/cmbills/132/11132.pdf

> (b) where the national tariff specifies a maximum price for that service, such price not exceeding that maximum as the commissioner and the provider may agree"

7.6. Thus the proposal was that NHS commissioners could require all providers to compete to provide the best services at the lowest price. The intention to include regulated price competition as part of the NHS contracting environment was confirmed in an speech by the then Secretary of State, Rt Hon. Andrew Lansley, in January 2011[21] where he said:

> "In the future, Monitor will have a vital new role in ensuring effective competition and a level playing field, acting in the interests of patients and the taxpayer. They will also oversee the process of price competition, which is to be allowed only where it is deemed appropriate and where it will not harm quality of service"

7.7. This aspect of the Bill was the subject of considerable debate, especially at Second Reading in the House of Commons on 31 January 2011[22]. On 18 January 2011, the then Chief Executive of the NHS, Sir David Nicholson, told the Public Accounts Committee that he was very cautious about price competition. Speaking before the Public Accounts Committee[23] he said:

> "The international evidence seems to show that, if you introduce price competition, you can get to a place where quality suffers. In a sense, people reduce quality in order to deliver. But it's not necessarily the case because the issues are first of all: have you got measures of quality? So, can you say what you expect from them? Have you got real good measures? Have you got real good measures of monitoring quality, and have you got patients who have the knowledge to be able to work out whether the service that they're getting themselves is the kind of quality that they'd expect? If you've got those three things in place, I think it's possible to start talking about price competition. But it seems to me, until you have that, it's a very dangerous thing to do"

[21] See http://webarchive.nationalarchives.gov.uk/20120503092949/http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_123744

[22] See for example David Miliband MP at column 618: https://www.publications.parliament.uk/pa/cm201012/cmhansrd/cm110131/debtext/110131-0002.htm

[23] See https://publications.parliament.uk/pa/cm201011/cmselect/cmpubacc/741/11011802.htm

7.8. The essential concern was that procurement exercises based on price competition would lead to a "race to the bottom" on price because the public body paying the price for the services, namely the NHS commissioner, was not the person receiving the services (NHS patients). Hence there was a concern that financially stretched commissioners would accept an unrealistically low offer price from a provider who was desperate to secure the contract, and patients would suffer when the provider failed to deliver services to an acceptable quality. Expressions of concern about price competition were not confined to Labour MPs, as the Kings Fund Report[24] noted in its account of the history of the Act. It said:

> "The academics attacked the operating framework, warning of a "race to the bottom on price that would almost certainly threaten quality" – a concern that was echoed by the NHS Partners Network, the trade body for private and voluntary providers of NHS care, which declared itself "very nervous about the idea".
>
> Zack Cooper, the LSE health economist, said: "I am about as pro-competition in health care as you are going to find. But price competition would be a hugely retrograde step. To introduce it is not to learn the lessons from the NHS's own experience and from abroad."
>
> Julian Le Grand, another advocate of choice and competition in the NHS as Blair's health adviser, echoed the concerns. Shortly afterwards, in a letter to *The Times*, the leaders of six health service unions expressed their "extreme concerns" over price competition. The Government had managed to unite reformers and opponents, and it floundered. It took weeks finally to rule out price competition over services covered by the NHS tariff."

7.9. The government came under increasing pressure and decided to make a virtue out of the fact that it would prevent price competition in NHS services. The change was explained by the then Secretary of State, Rt. Hon. Andrew Lansley explained to the Financial Times on 4 March 2011. The report in the Financial Times said:

> **"Lansley U-turn over NHS price competition**

[24] See page 81 at https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/never-again-story-health-social-care-nicholas-timmins-jul12.pdf

> Andrew Lansley is to amend his NHS bill to remove the right of the new health regulator to set "maximum" prices for NHS care. …
>
> In a statement to the Financial Times on Wednesday, Mr Lansley said it was simply "wrong" that he wanted "to introduce price competition into the NHS".
>
> "Our modernisation plans have always been about competition on quality, not on price," he said. "We want the tariff to be a nationally regulated price, not a starting point for price competition. These amendments will put our intentions beyond doubt."
>
> Fixed prices were originally introduced by Labour with the aim of getting hospitals to compete on quality, not on price. They cover about 60 per cent of hospital care, but are set to be extended to other parts of the NHS. Health economists and others warned that both UK and international evidence suggest that allowing price competition would lead to a "race to the bottom" that would damage quality.
>
> Health economists and others warned that both UK and international evidence suggest that allowing price competition would lead to a "race to the bottom" that would damage quality"

7.10. However, Mr David Bennett, who was then Chair of Monitor, was quoted in the same article giving a slightly different view. He is quoted as saying:

> "…. as measures of quality improve, there could be a role for price competition. Ruling it out entirely is "neither necessary nor sensible" since it can help improve NHS productivity" In spite of the tariff remaining at a fixed price, Mr Lansley made clear that where services were not covered by the tariff, GP commissioners would still be able to put them out to tender. Speaking at a health summit run by the Nuffield Trust, he said it would still be possible for hospitals to offer spare capacity to commissioners at the financial year end at lower than the tariff price when commissioners could not afford the full price"

7.11. The freedom that Mr Bennett sought to retain for price competition was only in respect of those prices not fixed by the National Tariff. However his view of the operation of the Bill was not consistent with the message that Ministers gave to parliament. The Health Service Journal[25] reported on 18 February 2011 as follows:

[25] See https://www.hsj.co.uk/topics/finance-and-efficiency/lansley-u-turn-on-price-competition/5025934.article

**"The government has performed a significant U-turn on allowing price competition between NHS trusts and independent providers.**

A letter to senior staff from NHS chief executive David Nicholson on February 17 said there was "no question of introducing price competition" – contradicting the Health Bill which refers to the tariff being only "a maximum price for that service".

The Department of Health is denying the comment represents a ministerial U-turn, saying in a statement today: "There is no U-turn because we never intended to introduce price competition. There has been incorrect reporting around this and Sir David's letter simply sets that straight"

7.12. Amendments were thus drafted to the Bill. The policy position of the government was set out by the Minister, Simon Burns, carefully explained the government's policy to the Bill Committee on 3 March 2011[26] in a letter sent to members of the committee[27]:

"We are writing to notify fellow Committee Members of amendments we have today tabled regarding Monitor's function to set prices, and how this relates to competition. As colleagues are aware, we have already spent a significant amount of Committee time discussing the Bill's provisions on competition. Unfortunately, not all of these discussions have been fully informed of the Government's intentions in this area. The amendments tabled today are designed to clarify our policy and close loopholes left by the previous Government. The amendments, if accepted, would:

a. clarify our position on the tariff by removing the ability of Monitor to set maximum prices; and

b. clarify that Monitor is not able to set differential prices on grounds of ownership.

Our policy on competition in the NHS is, and always has been, that it should be based on quality rather than price. We are fully aware of the academic evidence in this area; indeed, it was the Department that commissioned some of the key studies, for example the recent work led by Professor Carol Propper.

Under the existing legislative framework, Ministers have had complete freedom to introduce price competition should they so wish; the Bill as currently drafted continues to allow for the possibility of tariffs to be set as maximum prices, rather than set solely as fixed prices.

[26] See https://publications.parliament.uk/pa/cm201011/cmpublic/health/110303/pm/110303s01.htm
[27] This letter does not appear to be anywhere accessible.

However, while the Government's intention not to introduce a general policy of price competition is clear, it is none the less a possibility that Monitor could in future seek to pursue a different approach, subject to agreement with the NHS Commissioning Board. This is not a scenario that we have considered to be at all likely; and in the Operating Framework, we made clear a range of safeguards and conditions that had to be met before prices could be treated as a maximum. However, to ensure clarity in this area, the amendments we have laid will remove the possibility of Monitor setting maximum prices.

The Bill also allows for some further national flexibility in price setting. Monitor can specify different prices depending on whether the service is designated (under Monitor's powers to preserve continuity of services), or due to different descriptions of the provider. The latter power was designed to allow prices to adequately reflect the higher unavoidable costs some providers face compared with others; for example, the differential costs based on location. It is important that we maintain such flexibility in the future.

It has never been the Government's intention to use this power to pay certain providers an increased tariff by virtue of their ownership status. We are not, for example, at all in favour of the approach adopted under the previous Government's Independent Sector Treatment Centre (ISTC) programme of paying providers a higher tariff.

However, this is another area where our proposals have been misinterpreted. To put the matter beyond doubt, the amendments laid remove Monitor's ability to vary prices by reference to whether a provider is in public or private ownership.

We look forward to debating these amendments with colleagues at the appropriate moment in Committee proceedings."

7.13. The government then moved the amendments in committee on 22 March 2011. The Minister said[28]:

"The amendments aim to clarify the provisions on pricing. The amendments in my name clarify that we do not want Monitor to have to specify every possible price payable for every service included in the national tariff. Instead, Monitor will set a national price, agreed with the NHS commissioning board, for the services covered by

[28] See https://publications.parliament.uk/pa/cm201011/cmpublic/health/110322/pm/110322s01.htm

the national tariff and set an adjustment that will be applied in certain circumstances. Rules will be included to specify how the final price to be paid is calculated.

Under the amendment, Monitor will specify a base price for the service and a series of adjustments, based on, for example, location, the complexity of treating the patient or any other factors deemed to be appropriate. The provider would then be able to calculate the prices that it would receive for treating its patients by applying the rules and adjustments. For example, a specialist provider in central London would add the London uplift and specialist additional cost to the base price to easily calculate the price it will be paid for the service. The final price paid to providers will be transparent and simple to calculate. The need for Monitor to specify all prices in all circumstances for all providers is unnecessary.

Amendments 555, 559 and 562 ensure that the national tariff includes rules governing the application of variation to the national price. Such rules will be transparent, legally binding and enforceable by Monitor. Rules on variations in tariff will specify when the price set in the national tariff changes, which may include when adjustments are made to it to take account of volume—with a marginal rate being applied when fixed costs are covered—complexity of treatment and the location of provision.

The provisions are different from those outlined in clause 104(2), which provide a legally binding framework, within which the provider and commissioner may agree to vary the specified service and price. This measure will enforce rules that must be followed by commissioners and providers on services that are specified in the national tariff.

7.14. The Minister said at column 978 that the purpose of the amendments was:

"To put it beyond any doubt, misrepresentation or misunderstanding, we intend to have competition based on quality, not price"

7.15. Thus the amendments 551 to 557, 559, and 561 to 574[29] were agreed to, removing the references to maximum prices in clause 103 and to introduce the form that now appears at section 115(1). However the amendments also sought to introduce the following to clause 104 (which is now section 116) to provide as follows:

"Monitor must publish a document, to be known as "the national tariff" which:

[29] See https://publications.parliament.uk/pa/cm201011/cmbills/132/amend/pbc1321703a.421-427.html for the text of the amendments.

(a) specifies certain health care services which are or may be provided for the purposes of the NHS,

(b) specifies the method used for determining the national prices of those services,

(c) specifies the national price of each of those services,

(d) provides rules for the variation of the national price of service according to such aspects of the provision of the service, and such other matters, as are specified in the national tariff,

(e) provides rules for determining the price payable for the provision for those purposes of health care services which are not specified under subsection (1)(a)"

7.16. However by the date of the next published version of the Bill on 18 July 2011[30], this clause was re-named clause 119 and sub-clauses (d) and (e) had been removed from the Bill. On 12 July 2011 the Minister said in committee[31]:

"The hon. Member for Pontypridd asked whether the Bill prevents price competition. It most certainly does, ensuring that services covered by national tariffs have a fixed price attached to them that cannot be altered for the same service delivery. That is an important element, and I look forward to further discussion on the matter on Report"

7.17. The Minister then moved amendments to clause 115 (now section 116) to remove sub-clauses (d) and (e) which were agreed without further debate in the light of the assurances that the Minister gave that the Bill prevented price competition.

7.18. When the Bill came back to the House on Report stage[32] the Secretary of State moved an amendment to add a sub-clause (d) to (what is now) section 116. This added the following as a mandatory requirement of the National Tariff:

[30] See https://publications.parliament.uk/pa/bills/cbill/2010-2012/0221/cbill_2010-20120221_en_14.htm#pt3-ch5-l1g119
[31] See https://publications.parliament.uk/pa/cm201011/cmpublic/health/110712/pm/110712s01.htm at column 745.
[32] See https://publications.parliament.uk/pa/cm201011/cmhansrd/cm110906/debtext/110906-0002.htm

> "(d) the method used for deciding whether to approve an agreement under section 122 and for determining an application under section 123 (local modifications of national prices)"

7.19. The consistent message from Ministers was thus that price competition was ruled out for National Tariff prices and that prices for services outside the National Tariff had to be fixed in accordance with rules made under the National Tariff. Speaking in the House of Commons on 20 March2012[33], the Minister introduced a series of amendments and continued to advance this explanation of the effect of the Bill. He said:

> "The Bill makes sure that in future there can be no scope for sweetheart deals to incentivise new entrants into the NHS**, it ensures that there cannot be price competition of the sort that was allowed under the 2006 Act**, and it ensures a protection for commissioners to decide when and if it is appropriate to use competition" [*emphasis added*]

7.20. Ministers repeatedly assured Parliament that prices would be set nationally so as to rule out local competition based on prices. This was repeated in the Impact Assessment[34] published by the government which said at paragraph B82:

> "As now, competition between providers of NHS services will be on the basis of quality, not price. There will be additional safeguards against price competition and cherry picking (where a provider accepts only the easier lower cost cases)"

7.21. For example, Earl Howe said on 6 March 2012 at column 1714[35]:

> "It is important to remember that Monitor will work with the Commissioning Board to design tariffs which best incentivise high-quality patient care, including through integration. That brings me to the point made by the noble Baroness, Lady Meacher. The Bill addresses the situation where a private provider could cherrypick the most profitable services to deliver, leaving an NHS hospital with the most complex procedures. It requires Monitor and the NHS Commissioning Board to take account of variations in the range of services provided by different providers, and the complexity

[33] See https://publications.parliament.uk/pa/cm201212/cmhansrd/cm120320/debtext/120320-0003.htm
[34] See https://www.parliament.uk/documents/impact-assessments/IA11-038.pdf
[35] See https://hansard.parliament.uk/Lords/2012-03-06/debates/12030640001354/HealthAndSocialCareBill

> of the needs of patients treated, to ensure a fair level of pay for providers. As a result, providers undertaking only the more simple interventions would be paid a suitably lower price. We are not seeking to stop providers choosing which services to deliver; the issue is making sure that they are paid a fair price for each of them. If prices accurately reflected the cost of services, private providers simply would not have the incentive to cherry-pick and damage the viability of other providers"

It therefore seems very clear that parliament was repeatedly assured that price competition, at least for services covered by the National Tariff, was supposed to be prevented in NHS by the 2012 Act.

7.22. However, if Parliament intended to rule out the possibility of NHS commissioners and providers agreeing cut-price deals for less than National Tariff prices and wanted to rule out price competition, that raises the question as to the true meaning of section 116(2)(b)? Section 116(2) of the 2012 Act provides:

> "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"

7.23. An initial reading would appear to suggest that, provided NHS commissioners and providers followed the rules of the National Tariff when determining prices, they could "vary" the price to, say, 75% or 50% of the National Tariff price for a health care service. Thus a simple reading of the section appears to deliver precisely what Ministers said was outlawed by the Bill.

7.24. The answer appears to be that a "variation" to a National Tariff price is something that is an initial agreed between the NHS commissioner and the provider, but it only becomes an effective change to the terms of the contract between the parties if the variation becomes a Monitor approved "modification" in accordance with sections 124 and 125. The draftsman has used the words "variation" and "modification" in

Chapter 4 of Part 3 to the 2012 Act to refer to a change in a price from the price that would be fixed in accordance with the National Tariff. However, in this context, if both a "variation" and "modification" had contractual effect, the words mean the same thing. They both refer to a change to the amount of money that becomes owing for the provision to an NHS patient of a health care service specified in the National Tariff. Thus either:

a) The 2 words should be interpreted to have the same meaning, in which case any variation has to be approved by Monitor under section 124; or

b) A "variation" is the first stage of agreeing a price which departs from the National Tariff price but that change does not have contractual effect unless approved by Monitor under section 124.

7.25. This interpretation would be consistent with the wording of section 115(1) which provides a single method by which a provider of NHS services can be paid a different price to a price payable, namely by an application to Monitor approval under sections 124 or 125. In all other cases, the price payable has to be "*on the basis of … the national price*". The reference to "on the basis of" allows changes to the national price caused by factors such as the Market Forces Factor which adjusts prices between regions of England to reflect differing underlying costs. NHS England and Monitor have construed the 2012 Act to provide 2 different methods of changing a national price, namely under either section 124/5 or by an agreement under section 116(2). However, if this construction was correct, section 115(1) ought to have referred to both methods of changing prices. Section 115(1) did not do that. It only gave one method of departing from a National Tariff, and provided that this was to be a payment "*on the basis of … the national price*", not on the "*on the basis of … the national price as varied under section 116(2)(b)*".

7.26. The proposed construction of section 116(2) which suggests a second method of varying National Tariff prices also makes the Monitor process under section 124 largely redundant. Section 124(1) means that an application to Monitor to approve a

change to a national price under section 124 can only be made (a) where there is agreement between the commissioner and the provider, and (b) where that agreement has been reached after following the rules of the National Tariff. However, if the term "variation" in section 116(2)(b) prescribes a different process to a "modification", then:

a) the section 124 process becomes entirely redundant since the commissioner and the provider can agree an increase or decrease in the price without going to Monitor; and

b) the protections build in by Parliament which allow upward only price changes and, even then, only in defined circumstances become meaningless because a commissioner and a provider could agree a price reduction without reference to those protections.

7.27. Hence, interpreting the words "variation" and "modification" to mean different things brings back the possibility of NHS services which are specified in the national Tariff being subject to price competition when Parliament was specifically assured that government amendments to the Bill which became the 2012 Act would prevent price competition.

7.28. It follows that if the Bill had the effect that was explained to Parliament, the proper interpretation of the words "variation" and "modification" in Chapter 4 of Part 3 to the 2012 Act is that they mean the same thing. Thus, any commissioner and provider that wish to change the price paid for a service which is specified in the National Tariff. If that is right, both Monitor and NHS England have misunderstood the price determination provisions in the 2012 Act by suggesting that NHS bodies are entitled to agree "local prices" between themselves for health care services which are specified in the National Tariff which are less than the rates set out in the National Tariff.

7.29. It also means that NHS commissioners are fully entitled to run a competitive process to select a provider but cannot do so on the basis of price for services which are specified in the National Tariff. Thus, as Ministers repeatedly explained to Parliament,

where services are specified in the National Tariff, competition can only be on the basis of quality and not on the basis of price.

**8. How can prices for health care services be lawfully determined under the 2012 Act?**

8.1. There are potentially 4 different ways in which a price payable by an NHS commissioner to a provider of NHS services for the provision of a "health care service" can be determined under the statutory scheme required by the 2012 Act. These are:

a) If the health care service is specified in the National Tariff, the price payable can be the National Tariff set by Monitor for that service (referred to as "**Method A**" below);

b) If the health care service is specified in the National Tariff and Monitor has agreed a modification to that price under sections 124 or 125, the price payable for that service will be the National Tariff as modified by Monitor (referred to as "**Method B** below);

c) If the health care service is not specified in the National Tariff, the price has to be determined between the commissioner and the provider following the rules set out in the National Tariff for determining prices for health care services that are not specified in the National Tariff (referred to as "**Method C**" below); and

d) If, contrary to the arguments advanced above, the health care service is specified in the National Tariff and the commissioner and the provider agree to "vary" the National Tariff price, the price payable is the National Tariff price set by Monitor for that service as varied by agreement between the commissioner and the provider (referred to as "**Method D**" below).

8.2. **Method A: Paying the National Tariff price**: If the health care service that the provider is specified in the National Tariff and no other arrangements operate, the price payable by an NHS commissioner to the provider for any NHS patient who is provided with that service will be the National Tariff price. The prices for a wider

range of different services that are "grouped" into HRGs are published annually by Monitor in the "Workbook"[36].

8.3. NHS bodies code their activity and submit returns via the Secondary Uses Service ("SUS"), operated by NHS Digital[37]. The NHS Digital website explains the purpose of SUS as follows:

> "The Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.
> When a patient or service user is treated or cared for, information is collected which supports their treatment. This information is also useful to commissioners and providers of NHS-funded care for 'secondary' purposes - purposes other than direct or 'primary' clinical care - such as:
>
> - Healthcare planning
> - Commissioning of services
> - National Tariff reimbursement
> - Development of national policy
>
> SUS is a secure data warehouse that stores this patient-level information in line with national standards and applies complex derivations which support national tariff policy and secondary analysis.
>
> Access to SUS is managed using Role-Based Access Control (RBAC) which grants appropriate access levels to identifiable, anonymised or pseudonymised data based on the users job role"

8.4. Thus data on patients who are treated by NHS providers is channelled to SUS, which then passes it on to commissioners who use the data to pay providers at National tariff prices.

8.5. The actual amount payable is not the National Tariff price itself, but the National Tariff price as varied by the rules of the National Tariff. There are 4 types of national variations to national prices within the National Tariff as published by Monitor:

[36] See https://www.gov.uk/government/publications/nhs-national-tariff-payment-system-201617
[37] See http://content.digital.nhs.uk/sus

a) variations to reflect regional cost differences;

b) variations to reflect patient complexity;

c) variations to help prevent avoidable hospital stays; and

d) variations to support transition to new payment approaches.

8.6. The most widely used variation is the "Market Forces Factor" ("MFF") which reflects the underlying cost differences between hospitals operating in different areas. The National Tariff explains the operation of the MFF as follows:

> **"5.1. Variations to reflect regional cost differences: the market forces factor**
>
> 266. National prices are calculated on the basis of average costs and do not take into account some features of cost that are likely to vary across the country. The purpose of the market forces factor (MFF) is to compensate providers for the cost differences of providing healthcare in different parts of the country. Many of these cost differences are driven by geographical variation in land, labour and building costs, which cannot be avoided by NHS providers, and therefore a variation to a single national price is needed.
>
> 267. The MFF takes the form of an index. This allows a provider's location-specific costs to be compared with every other organisation. The index is constructed to always have a minimum value of 1.00. The MFF payment index operates as a multiplier to each unit of activity. The example below explains how this works in practice.
>
> A patient attends an NHS trust for a first outpatient attendance, which has a national price of £168.
> The NHS trust has an MFF payment index value of 1.0461.
> The income that the trust receives from the commissioner for this outpatient attendance is £176 (£168 x 1.0461).

8.7. Paragraphs 273 to 279 of the National Tariff explain the adjustments that are made to the National Tariff for a comparatively small number of providers where the case-mix is significantly more complex than the average case-mix. These are mostly teaching

hospitals with predominantly tertiary referrals where the "average" payment does not recognise the complexities of the types of patients who are referred to these hospitals.

8.8. The third marginal variation is the "Marginal Emergency Rate Rule". The first part this tariff change, in effect, penalises A & E departments that treat too many patients. The full text of the rule is as follows:

> **"5.3. Variations to help prevent avoidable hospital stays**
>
> **5.3.1. Marginal rate emergency rule**
>
> 280. The marginal rate emergency rule was introduced in 2010/11 in response to a growth in emergency admissions in England that could not be explained by population growth and A&E attendance growth alone.74 It was made up primarily of emergency spells lasting less than 48 hours.
>
> 281. The purpose of the marginal rate emergency rule is twofold. It is intended to incentivise:
>
> a. lower rates of emergency admissions
>
> b. acute providers to work with other parties in the local health economy to reduce the demand for emergency care.
>
> 282. The marginal rate emergency rule sets a baseline monetary value (specified in GBP) for emergency admissions at a provider. A provider is then paid 70% of the national price for any increases in the value of emergency admissions above this baseline. Further guidance for commissioners on investing retained funds can be found on our website[38]"

8.9. The second part of this rule applies a marginal rate to penalise re-admissions of patients within 30 days (see §302ff).

8.10. The final change is in §5.4 concerning variations to support transition to new payment approaches. §313 of the National Tariff provides:

[38] See www.nhsimprovement.nhs.uk

> **"5.4. Variations to support transition to new payment approaches**
>
> 313. New or changing payment approaches can alter provider income or commissioner expenditure. For some organisations, the financial impact can be significant and could be difficult to manage in one step"

8.11. However the only area of clinical practice where the rules can be varied under this part concerns "Best Practice Tariffs" for hip and knee replacements (see §313ff). Thus, at least under the 2017/18 version of the National Tariff, this does not permit wider variations to the prices paid for services specified in the National Tariff to support new payment approaches.

8.12. It is beyond the scope of this book to attempt to describe every aspect of the rules of the National Tariff. In any event, these rules change on an annual basis. However, the essential purpose of the National Tariff is to provide a rules based system which ought to ensure that NHS providers in different organisations are paid the same price for delivering the same type of care for cohorts of NHS patients. That does not mean that an NHS provider is compensated precisely for the cost of treatment to each individual patient because, across a cohort, there will be clinical variations. However the system is designed to operate in a "swings and roundabouts" manner, under which the provider is provided with a fixed payment for carrying out a procedure which, given the variation in complexities across different patients, will provide a reasonable level of remuneration to compensate the provider for the costs of delivering the service.

8.13. **Method B: Modifying the price under sections 124 and 125 of the 2012 Act**: Section 124 enables NHS commissioners and providers of NHS services to agree that a provider should be paid a higher price for a service than the price set out in the National Tariff. Section 124 provides:

> "(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).

(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—

(b) the modification, and

(c) 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"

8.14. Section 116(1)(d) provides that the National Tariff should set out rules for such applications. The key limitation is in section 124(5) which provides that Monitor is only entitled to approve a modification if it is satisfied that, without a modification to the price, "*it would be uneconomic for the provider to provide the service for the purposes of the NHS*". This means that, in practice, this provision only allows upward price increases. However the wording of the test suggests that Monitor ought to ask

itself whether it would be uneconomic for this particular provider to provide the service for the NHS at the National Tariff price. This could be because, for example, the provider will only see a limited number of patients with a particular condition, and therefore will not have the advantage of economies of scale available to larger providers. However, it could also be an economic for the provider to provide services at the National Tariff rate because its cost base is particularly high. That could be due to any number of different factors, but the test appears to focus on the objective costs to the provider as opposed to benchmarking that provider's costs against the average (which of course is the purpose of the National Tariff). However, Monitor has discretion to decide whether to approve a proposed higher price, even if the test in section 124(5) is met. The exercise of discretion allows Monitor to refuse to agree a higher price, even if the test is met, if the higher price is not considered by Monitor to be objectively justifiable.

8.15. Section 125 covers a situation where an NHS commissioner is seeking to require a provider to provide a service but the provider considers that it would not be economic to provide that service at National Tariff rate, but where there is no agreement between the NHS commissioner and the provider about the price. It allows either the NHS commissioner or a provider of NHS services to apply to Monitor to set a price for a health care service specified in the National Tariff which is higher than the price that would be payable applying the rules of the National Tariff. Section 125 of the 2012 Act provides:

> "(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"

8.16. The power for Monitor to impose a higher price on a commissioner where the commissioner and the provider cannot agree a price between then can only be exercised by Monitor if it is satisfied that "*it would be uneconomic for the provider to provide the service for the purposes of the NHS*" at the National Tariff price. It is thus the same test as where the parties are agreed that a higher price should be paid. However if Monitor exercises its powers to set a higher price, the provider is entitled to be paid the higher price. However, just as under section 124, Monitor has discretion to exercise to decide whether to approve a price rise, even if the statutory test met.

8.17. If Monitor does approve the higher price, there does not appear to be any provision to entitle an NHS commissioner refusing to enter into a contract with the provider at this price.

8.18. **Method C**: **Determining prices for health care services that are not specified in the National Tariff**: There are a substantial number of health care services which are either not specified in the National Tariff or where the health care service is specified in the National Tariff but no "price" has been specified for the provision that service[39]. Section 115(2) of the 2012 Act provides:

> "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"

8.19. It follows that the absence of a national tariff price does not permit NHS commissioners and providers a free hand to set prices at a purely market rate where there is no National Tariff price. The NHS commissioner and the provider are required to follow the rules of the National Tariff to work together (and with both clinicians and the public) to determine a fair price for the services that are to be provided.

8.20. The relevant rules are explained at paragraph 449ff of the National Tariff which provides:

> "449. For many NHS services there are no national prices. Some of these services have nationally specified currencies, but others do not. In both cases, commissioners and providers must work together to agree prices for these services. The 2012 Act confers on Monitor the power to set rules for local price-setting of such services, as agreed with NHS England, including rules specifying national currencies for such services. We have set both general rules and rules specific to particular services. There are two types of general rule:
>
> a. Rules that apply in all cases when a local price is set for services without a national price. See Section 6.4.1.

[39] The services where there is a "national currency" which specifies the services but no national price are described at paragraph 453 of the National Tariff.

b. Rules that apply only to local price-setting for services with a national currency (but no national price). See Section 6.4.2.

450. As well as the general rules, there are rules specific to particular services. See Sections 6.4.3 to 6.4.7"

8.21. Paragraph 452 then provides:

"452. Rules 1 and 2 apply when providers and commissioners agree local prices for services without national prices. The rules apply irrespective of whether or not there is a national currency specified for the service.

**Local pricing rules: general rules for all services without a national price**

**Rule 1: Providers and commissioners must apply the principles in Section 6.1 when agreeing prices for services without a national price.**

**Rule 2: Commissioners and providers should have regard to the efficiency and cost uplift factors for 2017/18 and 2018/19 (as set out in sections 4.7 and 4.8 of this document) when setting local prices for services without a national price for 2017/18 and 2018/19, respectively"**

8.22. The requirement to "*apply the principles*" in Section 6.1 means, in effect, that NHS commissioners and providers are required to follow the procedures set out at that part of the National Tariff when fixing prices. However the requirement to "*apply the principles*" suggests that there may be an element of discretion to permit NHS commissioners and providers to decide precisely how they are going to follow the procedures set out in the National Tariff and could depart from the precise form of the procedures specified in the National Tariff without acting unlawfully. The further the NHS commissioners and providers depart from the procedures specified in the National Tariff, the more that there is a danger that their prices will be subject to a later challenge (either by one of the contracting parties or by a third party).

8.23. The procedures specified in Section 6.1 of the National Tariff are as follows:

**"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, and

c. the provider and commissioner(s) must engage constructively with each other when trying to agree local payment approaches.

327. These principles are explained in more detail in sections 6.1.1 to 6.1.3 and are additional to other legal obligations on commissioners and providers. These include other rules set out in the national tariff, and the requirements of competition law, procurement law, regulations under Section 75 of the 2012 Act, and NHS Improvement's provider licence.

**6.1.1. Best interest of patients**

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

a. Quality: how will the agreement maintain or improve the outcomes, patient experience and safety of healthcare today and in the future?

b. 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?

c. 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?

d. 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?

**6.1.2. Transparency**

329. Local variations, modifications and prices must be transparent. Increased transparency will make commissioners and providers more accountable to each other, patients, the general public and other interested stakeholders. Transparent agreements also mean that best practice examples and innovation in service delivery models or payment approaches can be shared more widely. In agreeing a locally determined price, commissioners and providers must therefore consider the following factors:

a. Accountability: how will relevant information be shared in a way that allows commissioners and providers to be held to account by one another, patients, the general public and other stakeholders?

b. Sharing best practice: how will innovations in service delivery or payment approaches be shared in a way that spreads best practice?

**6.1.3. Constructive engagement**

330. Providers and commissioners must engage constructively with each other to decide on the mix of services, delivery model and payment approach that deliver the best value for patients in their local area. This process should involve clinicians, patient groups and other relevant stakeholders where possible. It should also facilitate the development of positive working relationships between commissioners and new or existing providers over time, as constructive engagement is intended to support better and more informed decision-making in both the short and long term.

331. In agreeing a locally determined price, commissioners and providers must therefore consider the following factors:

- Framework for negotiations: have the parties agreed a framework for negotiating local variations, modifications and prices that is consistent with the existing guidelines in the NHS Standard Contract and procurement law (if applicable)?

- Information-sharing: are there agreed policies for sharing relevant and accurate information in a timely and transparent way to facilitate effective and efficient decision making?

- Involvement of relevant clinicians and other stakeholders: are relevant clinicians and other stakeholders, such as patients or service users, involved in the decision-making process?

- Short and long term objectives: are clearly defined short and long term strategic objectives for service improvement and delivery agreed before starting price negotiations?

**6.1.4. Guidance on applying the principles applying to all local variations, local modifications and local prices**

**Record-keeping**

332. Providers and commissioners should maintain a record of how local payment approaches comply with the principles. The content and level of detail of this record will vary depending on the circumstances. For example, more information is likely to be required for high value contracts than for lower value contracts. Further (non-exhaustive) examples are provided in the box below.

**Examples of what information a record might contain**

Providers and commissioners should consider whether to include the following in their record:

- reasons for choosing to use a local payment approach
- details of any engagement with patients, community groups, carers and other third parties and how their views have been taken into account before agreeing the approach
- reasons for specifying the services in a particular way
- rationale for combining payment for several different services as a bundle and the composition of that bundle, if applicable
- analysis of how the services will be delivered in a way that is co-ordinated from the perspective of patients alongside other healthcare, health-related and social care services
- details of the due diligence applied to the information used to inform the local payment approach
- rationale for key terms of the agreement, for example, prices, quality requirements that the provider must satisfy, how performance will be

assessed during the contract, the consequences of breaches, and the duration of the contract.

**How we will assess whether local payment approaches are in the best interests of patients**

333. When assessing compliance with the requirement to apply the principle that local payment approaches must be in the best interests of patients, we will examine whether providers and commissioners have considered all relevant factors. The extent to which, and way in which, the four factors listed in Section 6.1.1 need to be considered will differ according to the characteristics of the services and the circumstances of the agreement.

334. To have considered a relevant factor properly, we would expect providers and commissioners to have:

a. obtained sufficient information

b. used appropriately qualified/experienced individuals to assess the information

c. followed an appropriate process to arrive at a conclusion.

335. It is up to providers and commissioners to determine how to consider the factors set out above based on the matter in hand.

**Evaluation and sharing of best practice**

336. We encourage commissioners and providers to use the rules for locally determined prices as a basis for considering how they can improve the payment system, especially where care is being delivered in a new way. We are interested in learning from commissioners and providers that are implementing new payment approaches to enhance system-wide incentives: for example, to focus on prevention, integration of care, improved outcomes and improved patient experiences. Such payment approaches might include pathway, capitation or outcomes-based payments.

337. To determine whether local payment approaches have achieved their desired objectives and inform future decision-making, we recommend that commissioners and providers plan to evaluate the success of new payment approaches. We encourage commissioners and providers to share the results of any evaluation processes.
Guidance on a framework for constructive engagement

338. We believe that the principles will be consistent with existing practice for many providers and commissioners. However, we recognise that this will not always be the

case, particularly where providers and commissioners do not have existing contractual relationships.

339. Below we set out a framework that could be used as a guide to facilitate constructive engagement where commissioners and providers do not already have a framework. It has been designed with local payment approaches agreed through negotiation rather than competitive procurement in mind. It includes four stages, which are explained in more detail below. In summary, to implement the framework in full, providers and commissioners would have to:

a. **establish a working group** for contract negotiations in relation to locally determined prices

b. **define roles and responsibilities** for members of the working group, including relevant clinicians and other stakeholders, where appropriate

c. **agree objectives, timescales and rules** for the working group, including rules on information sharing, deadlines and the responsibilities of each party when providing or handling information for contract negotiations

d. **document progress and outputs** for the working group and contract negotiation, including any planned evaluation, if appropriate"

8.24. Thus NHS commissioners and providers who follow the above rules are entitled to reach mutually agreeable "prices" under a contract which requires the provider to provide health care services that are not specified in the National Tariff to NHS patients. Once a "price" for a health care service has been agreed following the above procedures, section 115(2) means that the NHS commissioner is under a statutory duty to pay the provider the agreed price every time the provider provides a health care service of the type defined in the contract to an NHS patient for whom the NHS commissioner has commissioning responsibility. If the provider provides a health care service to another NHS commissioner (with whom the provider does not have a contract), the Guidance set out above explains that this is "non-contract activity" and the provider is entitled to bill the relevant NHS commissioner for providing that service.

8.25. However what happens (as is regrettably the norm) if an NHS commissioner and a provider agree prices for the provision of services to NHS patients without following the procedures set out in the National Tariff. There is a dearth of clear authority about the contractual effect of NHS bodies agreeing terms which breach the statutory requirements of the 2012 Act[40]. However, the House of Lords considered a similar issue in *Johnson v Moreton* [1980] AC 37 ("*Johnson*"). The question addressed in *Johnson* was whether a contract can be enforced if the parties had purported to contract out of a statutory rights. Mr and Mrs Johnson let a farm on an agricultural lease to Mr Moreton. The Agricultural Holdings Act 1948 gave security of tenure to tenant farmers. However, the agricultural lease had purported to contract out of that statutory right. The court was required to decide whether a contract which had been agreed in a manner which departed from statutory protections was nonetheless enforceable as a private law contract between the parties. Lord Salmon observed that:

> "Accordingly if clause 27 is enforceable the security of tenure which Parliament clearly intended to confer, and did confer upon tenant farmers for the public good would have become a dead letter"

8.26. The conclusion reached by the House of Lords was that parties to a private law contract could contract out of statutory processes and protections if these were introduced solely for the private benefit of the contracting parties. However, if Parliament intended these terms to operate in all relevant contracts and/or the statutory provisions existed for public good (as opposed to being solely for the private benefit of the contracting parties), a term seeking to contract out of the mandated statutory protections would be unenforceable. The same principle applies to the duty to pay workers the National Minimum Wage (under the National Minimum Wage Act 1998).

[40] The only occasion on which these provisions were considered (to the knowledge of the author) was an expert dispute resolution process relating to Corby Urgent Care Centre. The outcome was reported in the professional press but has not been formally published. However the expert found that the requirements in the National Tariff were mandatory and thus the failure by the Corby CCG to follow those requirements meant that a purported to agreement to pay the operators of Corby Urgent Care Centre a price that was below the National Tariff was unenforceable. The outcome was that the operators of Corby Urgent Care Centre were entitled to substantial back-payments based on the National Tariff rate.

8.27. The rules by which prices for the provision of NHS services which are not specified in the National Tariff are to be determined have a clear "public interest" purpose. The aim of the processes is to ensure that a price is fixed which is in the best interests of NHS patients. Price competition which constitutes a "race to the bottom" will almost always be not in the best interests of NHS patients and thus is unlikely to be the outcome of a National Tariff compliant process. Thus, it seems highly likely that any contractual agreement on price between an NHS commissioner and a provider of NHS services (which are not specified in the National Tariff) where the price has been fixed through a process which fails to comply with the rules of the National Tariff will be an unenforceable term of the agreement.

8.28. Unfortunately, NHS commissioners have generally failed to follow the procedures under the National Tariff set out above when seeking to agree prices for services which are not specified in the National Tariff. In principle, there seems no reason why a provider should not register a dispute about the "price" paid under the contract and seek to have this re-evaluated in accordance with the procedures which ought to have been followed at a point that the contract was originally signed.

9. **Are "block contracts" legally permissible under the 2012 Act statutory scheme**?

9.1. An NHS "block contract" is an arrangement under which an NHS commissioner pays a defined sum of money to an NHS provider in order to deliver defined NHS services to the patients for whom the NHS commissioner has commissioning responsibility. These are frequently used in mental health and community services contracts. A feature of these "block" contracts is that the payment is not linked to the number of patients treated by the provider or the complexity of the treatments provided. These types of arrangements existed before the 2012 Act was implemented and have largely remained unchanged.

9.2. One of the consequences of this type of contracting arrangement is that the provider cannot expand its services to meet additional demand because the amount of money

that is provided is fixed, irrespective of the number of patients. Hence, by way of example, there is an acute shortage of child and adolescent specialist inpatient mental health beds provided by NHS mental health trusts. Many of these trusts have block contracts with their commissioners and accordingly cannot increase the amount they charge their commissioners if additional services are provided. In contrast, an acute hospital providing hip replacement services to the same commissioners will increase its charges if more patients are referred to the acute trust for this type of operation.

9.3. It is very difficult to see how this type of contracting arrangement complies with section 115(2) of the 2012 Act. A "health care service" is the provision of a service or group of services to a particular, individual patient. Section 115(2) requires a price to be determined for that "health care service". The money is supposed to follow individual patients, so any arrangement which pays the same amount, regardless of the number of patients treated and/or the complexity of the treatment is failing to identify a price for each of the health care services provided by that provider to NHS patients. Further, the procedures which are required to be followed under the National Tariff before prices for health care services can be agreed are not followed prior to agreeing a "block contract".

9.4. In practice, block contract arrangements are followed by NHS commissioners and providers even though the statutory mandated rules have not been followed. However, as austerity continues to affect the NHS, groups representing patient interests may well challenge the lawfulness of any arrangements which fail to comply with the statutory provisions. Accordingly, maintaining block contracts or agreeing contracts prices for non-tariff services otherwise than in accordance with the rules of the National Tariff, gives rise to considerable legal risks for NHS bodies.

10. **How can the rules for determining prices be operated within a competitive procurement exercise**?

10.1. This is considered under the "procurement" chapter. However, the strong message from the parliamentary materials is that NHS procurement ought to be conducted on quality alone and not on a combination of price and quality.

## 11. The Dispute Resolution provisions within the NHS Standard Contract.

11.1. If there is a dispute between the commissioner and the provider who hold an NHS standard contract, the dispute resolution provisions in General Condition 14 provide for a 3 stage process, namely:

a) Escalated negotiation;
b) Mediation; and
c) Expert determination.

11.2. The terms of GC 14 provide as follows:

> **"GC14 Dispute Resolution**
>
> 14.1 The provisions of GC14.2 to 14.21 will not apply when any Party in Dispute seeks an injunction relating to a matter arising out of GC20 (Confidential Information of the Parties).
>
> **Escalated Negotiation**
>
> 14.2 If any Dispute arises, the Parties in Dispute must first attempt to settle it by any of them making a written offer to negotiate to the others. During the Negotiation Period each of the Parties in Dispute must negotiate and be represented:
>
> 14.2.1 for the first 10 Operational Days, by a senior person who where practicable has not had any direct day-to-day involvement in the matter and has authority to settle the Dispute; and
>
> 14.2.2 for the last 5 Operational Days, by their chief executive, director, or member of its Governing Body who has authority to settle the Dispute.

14.3 Where practicable, no Party in Dispute should be represented by the same individual under GC14.2.1 and 14.2.2.

**Mediation**

14.4 If the Parties in Dispute are unable to settle the Dispute by negotiation, they must, within 5 Operational Days after the end of the Negotiation Period, submit the Dispute:

14.4.1 to mediation arranged jointly by NHS Improvement and NHS England, where the Commissioners are CCGs and/or NHS England and the Provider is an NHS Trust; or

14.4.2 to mediation by CEDR or other independent body or organisation agreed between the Parties and set out in the Particulars, in all other cases.

14.5 Mediations under GC14.4.1 will follow the mediation process agreed between NHS Improvement and NHS England from time to time:

14.6 Mediations under GC14.4.2 will follow the mediation process of CEDR or other independent body or organisation named in the Particulars.

**Expert Determination**

14.7 If the Parties in Dispute are unable to settle the Dispute through mediation, the Dispute must be referred to expert determination, by one Party in Dispute giving written notice to that effect to the other Parties in Dispute following closure of the failed mediation. The Expert Determination Notice must include a brief statement of the issue or issues which it is desired to refer, the expertise required in the expert, and the solution sought.

14.8 If the Parties in Dispute have agreed upon the identity of an expert and the expert has confirmed in writing their readiness and willingness to embark upon the expert determination, then that person will be appointed as the Expert.

14.9 Where the Parties in Dispute have not agreed upon an expert, or where that person has not confirmed their willingness to act, then any Party in Dispute may apply to CEDR for the appointment of an expert. The request must be in writing, accompanied by a copy of the Expert Determination Notice and the appropriate fee and must be copied simultaneously to the other Parties in Dispute. The other Parties

in Dispute may make representations to CEDR regarding the expertise required in the expert. The person nominated by CEDR will be appointed as the Expert.

14.10 The Party in Dispute serving the Expert Determination Notice must send to the Expert and to the other Parties in Dispute within 5 Operational Days of the appointment of the Expert a statement of its case, including a copy of the Expert Determination Notice, the Contract, details of the circumstances giving rise to the Dispute, the reasons why it is entitled to the solution sought, and the evidence upon which it relies. The statement of case must be confined to the issues raised in the Expert Determination Notice.

14.11 The Parties in Dispute not serving the Expert Determination Notice must reply to the Expert and to the other Parties in Dispute within 5 Operational Days of receiving the statement of case, giving details of what is agreed and what is disputed in the statement of case and the reasons why.

14.12 The Expert must produce a written decision with reasons within 30 Operational Days of receipt of the statement of case referred to in GC14.11, or any longer period as is agreed by the Parties in Dispute after the Dispute has been referred.

14.13 The Expert will have complete discretion as to how to conduct the expert determination, and will establish the procedure and timetable.

14.14 The Parties in Dispute must comply with any request or direction of the Expert in relation to the expert determination.

14.15 The Expert must decide the matters set out in the Expert Determination Notice, together with any other matters which the Parties in Dispute and the Expert agree are within the scope of the expert determination.

14.16 The Parties in Dispute must bear their own costs and expenses incurred in the expert determination and are jointly liable for the costs of the Expert.

14.17 The decision of the Expert is final and binding, except in the case of fraud, collusion, bias, manifest error or material breach of instructions on the part of the Expert, in which case a Party will be permitted to apply to Court for an Order that:

14.17.1 the Expert reconsider his decision (either all of it or part of it); or

14.17.2 the Expert's decision be set aside (either all of it or part of it).

14.18 If a Party in Dispute does not abide by the Expert's decision the other Parties in Dispute may apply to Court to enforce it.

14.19 All information, whether oral, in writing or otherwise, arising out of or in connection with the expert determination will be inadmissible as evidence in any current or subsequent litigation or other proceedings whatsoever, with the exception of any information which would in any event have been admissible or disclosable in any such proceedings

14.20 The Expert is not liable for anything done or omitted in the discharge or purported discharge of their functions, except in the case of fraud or bad faith, collusion, bias, or material breach of instructions on the part of the Expert.

14.21 The Expert is appointed to determine the Dispute or Disputes between the Parties in Dispute and the Expert's decision may not be relied upon by third parties, to whom the Expert will have no duty of care"

11.3. The reference to "CEDR" is a reference to the Centre for Effective Dispute Resolution[41], 70 Fleet Street, London EC4Y 1EU. CEDR can be approached by either party and, for a fee, will appoint an expert to conduct the expert determination process. Once the expert is appointed, the expert will have a wide discretion to set the process and to issue directions to both parties as to the material that the expert needs in order to determine the dispute.

11.4. Once the expert has made his decision, the expert determination is generally binding. The recent case of *Walton Homes Ltd v Staffordshire County Council* [2013] EWHC 2554 (Ch) emphasised the very limited scope that the Court has to interfere with a decision by an expert. The fact that the expert may have made an error of law or fact in his determination is usually insufficient to get the determination set aside: see *Veba Oil Supply & Trading GmbH v Petrotrade Inc* [2001] EWCA Civ 1832. An expert determination will only usually be set aside if a party can prove on of the following:

a) **Material departure from instructions**, in a case such as *Shafi v Rutherford* [2014] EWCA Civ 1186;

[41] See https://www.cedr.com/

b) **Failure to state reasons**: If the expert does not adequately state the reasons for his decision, a court can direct an expert to do so (*Halifax Life Ltd v The Equitable Life Assurance Society [2007] EWHC 503 (Comm)*);

c) **Fraud or collusion:** If the expert has reached his determination due to fraud or collusion with one of the parties, then the determination can be set aside by the court (*Campbell v Edwards [1976] 1 WLR 403*) ;

d) **The certificate not being certain:** If an expert is determining a situation which requires the expert to produce a certificate (as is sometimes the case in accounting scenarios) then the certificate cannot be uncertain or qualified (*Shorrock Ltd v Meggitt plc [1991] BCC 471*);

e) **Partiality:** If an expert has shown actual bias or there is a real danger of injustice resulting from the alleged bias, then the court has the power to set aside the expert determination (*Hickman v Roberts [1913] AC 229*).

11.5. Thus, in practice, a NHS commissioner and provider has to live with the consequences of the expert determination. This high level of finality can be contrasted with decisions of the FHSAU where either party can issue judicial review proceedings to challenge the lawfulness of the decision: see *R (Hussain & Ors) v Secretary of State for the Health Department & Anor* [2011] EWCA Civ 800.