Dentistry

BDA | NHSE | Ronuk Vasant

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The day we took NHSE to court

Ronuk Vasant tells the story of how he along with three other dental practices took NHSE to court…and won.

Court rooms are almost designed to be intimidating. The formality, the wigs, the unfamiliar language and processes. Nobody really wants to find themselves standing outside a court room, right? However, that is exactly where we, a group of NHS principals, found ourselves in October 2018.

A quick background

To understand what happened, we need to go back the start of the current (2006) GDS contract. Back then, Primary Care Trusts (PCTs) in England could form unique contractual arrangements in different areas to meet local healthcare priorities.

In Croydon from 2006 onwards, the local hospital was struggling with ever-increasing waiting lists for oral surgery procedures. The vast majority of which were surgical extractions on medically well patients, who we could treat in practice settings. The PCT entered into contractual relationships with several local practices. The contract enabled practices to provide minor oral surgery (MOS), or intermediate minor oral surgery (IMOS), services to ease the pressure on the hospitals. The pilot contracts in 2007 and 2008 were successful in drastically cutting waiting lists and reducing NHS expenditure.

In April 2009, Croydon PCT, encouraged by this success, naturally wanted to continue with the concept. Croydon PCT chose three practices, followed by a fourth after a few months, for this. All four practices held existing GDS contracts, and these were amended by means of a contract variation. In common with the rest of GDS services, we all understood this to mean that we had the right to provide IMOS services in perpetuity. The system worked fairly smoothly, and seemed to be a very successful example of the power of local commissioning. But hitherto it was limited to one London borough (O'Neill, Gallagher and Kendall, 2012). In April 2013, PCTs were abolished, with a new body, NHSE, absorbing their legal functions.

'Flip-flops'

Fast forward to summer 2016. To replicate the successful model in Croydon that had saved money, NHSE embarked on a pan-London tendering exercise. Its aim was to establish IMOS services across all London boroughs. Initially, NHSE showed no interest in procuring services in Croydon, given that there were existing services there. We instinctively felt that this made sense. Why attempt to change arrangements in Croydon that had worked well for almost a decade?

However, NHSE changed its mind within a matter of weeks of the initial announcements. All for reasons that didn't seem to make sense. This was to be the first of several flip-flops by NHSE. It was clear that NHSE had put itself into a difficult and confusing position. It wanted new IMOS arrangements with time-limited contracts in every borough (including Croydon). But us 'Croydon four' were still carrying on providing IMOS services under what appeared to be permanent arrangements. Between the four practices, we were meeting the demands placed on us. So, what need was there to put any additional contracts in place? We did not understand how this was going to work in reality, with us permanent providers having uncapped arrangements, and a new provider entering the fray with a capped volume contract for a five-year period.

It rapidly became clear that NHSE wanted to terminate our arrangements to get itself out of this rather odd situation. NHSE employed several different strategies to achieve this. The first was to try to agree with each of the four practices to insert an end date into our contracts. Unsurprisingly, we all refused. Bizarrely, this letter stated that our IMOS services were being provided under GDS contracts. Something, which NHSE later argued, was categorically not the case in court. So this was the second flip flop.

Terminating contracts

After this attempt failed, the second NHSE tactic was to send another letter, saying that it had the right to terminate our contract with 28 days notice, and

asked us to sign this also. Again, unsurprisingly, we refused. The third tactic was to send a third letter, informing us that our IMOS arrangements would terminate in just over a year, without any need for our agreement whatsoever. This termination notice worried us immensely, and threw up all sorts of questions. Could NHSE effectively reverse a contract variation unilaterally? If so, what impact would this have on the apparent permanent nature of GDS more widely?

NHSE made repeated reference to a specific MOS contract dated 7 April 2009 a ‘third’ contract. None of the principals could recall such a contract and neither could we find any copies. To date, NHSE has produced no such contract, despite repeated requests. Was NHSE mistaken or was it simply making things up (interestingly, this ‘2009 contract’ was not referred to in the skeleton arguments or evidence bundles sent to the High Court – a point picked up by our legal team as well as the judge)?

Searching for help

During this period of uncertainty, we reached out for help to the BDA. Out of the four practices in the same boat, two of the principals were expert members. Whilst the initial advice was sound, unfortunately we became very disillusioned with the support. During our correspondence, the BDA asked us to produce the ‘third’ IMOS contract referred to by NHSE in some letters. We struggled to convince the BDA that the ‘third contract’ referred to by NHSE never actually existed. It was clearly fictional. Frankly, it was exhausting our patience trying to convince the BDA that we were in fact telling the truth, and it was NHSE that was wrong. We abandoned our hope of BDA support for the moment as we were getting nowhere and the clock was ticking. We decided to seek external help, and approached a barrister for advice.

Simultaneously, we were in contact with the Local Dental Committee (LDC). In contrast to the BDA, the LDC secretary grasped the issues quickly showing a great deal of interest and keeping abreast of the situation.

Our barrister advised that we pursue legal action against NHSE to confirm our position that we were providing IMOS services under GDS arrangements. If the court made a declaration to that effect, we knew that our arrangements were in perpetuity and therefore NHSE couldn’t terminate them.

We did approach the BDA PEC in February 2017 with a view to whether they would be able to help us with the legal costs. Unfortunately, we did not receive any actual response to that request.

An attempt to reach a mutually agreeable outcome at mediation unfortunately failed.

Going to court

The High Court heard our case in October 2018 and I am very pleased to say that we won the case. The former principal interlocutor of Croydon PCT (now defunct) who gave evidence to the trial, confirmed our position – that Croydon PCT entered into an arrangement with the understanding that it was on a permanent footing. NHSE was unable to produce any witness or documentary evidence that contradicted this.

The judge recognised that NHSE's policy changes had come into conflict with the law: 'I understand why NHS England concluded…that it was inappropriate to include the IMOS services under the GDS contract without separate application of a right to terminate the IMOS services on one month's notice. It creates a practical difficulty… Unfortunately, those policy considerations do not trump NHS England's contractual obligations.'

NHSE appealed to the Court of Appeal, but lost in July 2019. In the run-up to the appeal, we again turned to the BDA to see if it could assist us with the legal fees. The PEC wanted to see NHSE's skeleton arguments before deciding whether it should help us or not. It was disappointing that the BDA was asking us for documents that it ought to have known we could not share due to confidentiality concerns.

Major concerns

Several things seriously worried us about the whole affair. The shifting position of NHSE upon realising it was in a bind (of its own creation) and trying different tactics to get its way, often contradicting its own earlier statements. We didn't take any of this personally, but we did wonder what the rationale was.

The situation raises serious questions about accountability, competency and also the amount of legal oversight NHSE managers have. This therefore seems a very cavalier approach towards issues that have very serious financial, clinical and personal consequences for affected parties. We still have in our possession, a letter stating from 2016 informing us straightforwardly that NHSE will terminate our IMOS arrangements in 2017. Despite losing two court cases proving their stance being wrong in law, causing a great deal of stress and lost time, we have had no retractions or apology from NHSE.

In the procurement documents sent to potential bidders, there was no mention of the current IMOS services within Croydon – this is hardly a transparent approach.

Reflections

When we zoom out from this whole experience, we can see that in just a few short years, we have gone from public thanks: ‘The authors would like to thank the following…all the providers of the IMOS service,’ (O’Neill, Gallagher and Kendall, 2012) to spending hundreds of thousands of pounds trying to try and close our service down, without a legal basis. Against a backdrop of austerity, this has been an unnecessary waste of public resources.

Dentistry.co.uk approached NHSE but it refused to comment on this article.

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Reference

O’Neill E, Gallagher JE and Kendall N (2012) A baseline audit of referral and treatment delivered to patients in the intermediate minor oral surgery service in Croydon PCT. *Prim Dent Care* **19(1):** 23-8