HOUSE OF LORDS

SECONDARY LEGISLATION SCRUTINY COMMITTEE

National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013

Written Evidence

Contents

Lord Owen – Written Evidence

Though I understand the pressures under which the Legislation Scrutiny Committee has been put I cannot but record my concern that the consultation period has been so limited.

As to new NHS Commissioning Regulations SI 2013/500 I would like to question the following:

2(c) I am not convinced that the addition of the new wording makes it sufficiently clear that tendering is open not just for the purchasing of care pathways but also individual services. By emphasising the former as opposed to the latter, one is restricting the capacity of smaller non profit making organisations to tender, many of whom are already supplying services of high quality to the NHS but who have neither the financing capacity nor the personnel to tender for care pathways framed to mirror the integrated care model of the US private health insurance industry.

5(2) The deletion of the specific exceptions means that there is nothing at all to ascertain how the relevant body is satisfied that they are safe from action from any would-be provider and means that CCG Commissioners could feel that they would only be safe if they were advertising every service across the EU. I had hoped that the Government would have given specific rules so that Commissioners could prove that they had fulfilled this requirement and in addition give an indemnity against any action being taken under competition law or any other body of law against the CCG who have taken all reasonable steps according to their criteria. Commissioners need to feel confident that they can award contracts to a local hospital who in their judgement are capable of supplying the local service without having to go through complicated, expensive and an extensive process to ensure they are not challenged under competition law. Arguably this deletion will just make it harder for CCGs to be confident they are on the right side of competition law and safe from the consequences of being judged to have broken competition law by Monitor. I recommend wording more in keeping with Sole Source as operated in the US when, for example, in relation to a university it could be judged as acceptable not to use competition. (http://f2.washington.edu/fm/ps/how-to-buy/sole-source) Such wording stressing what is involved is a method of acquisition and has the term "insofar as practicable" and stating competitive bidding is not necessary where in some circumstances purchases are clearly and legitimately limited to a single (sole) source of supply or where the purchase price may be best established by direct negotiations. In summary, this Regulation does not have the flexible approach which in the Committee Stages of the Bill we were promised on the floor of the House of Lords. It still has more than a flavour of compulsion, the application of rigid rules with no reassurance for the CCG that wants to tailor their requirements to local circumstances and proven provision.

10(3) This clause has been removed for reasons which are not clear and which on the face of it makes the situation worse for people looking to have some safeguard when acting reasonably to restrict competition.

Yours sincerely

DAVID OWEN

Anthony Armond – Written Evidence

Please bear record that I wish parliament to legislate to prevent unnecessary and unfairly competative privatisation of the NHS.

Yours faithfully,

Dr. Anthony D. Armond

S Bailey – Written Evidence

the slight changes the government has made, have not changed the main aim of this legislation which is to effectively hand over a precious public service to private industry. I do not want my NHS to be destroyed, on ideological grounds by a government with no mandate to do so. I am aware that many members of your House have an interest in private health providers, but I will take the non-cynical view that this will have no effect on your blocking this legislation so that it can be properly debated as would be expected in a democracy.

Yours sincerely, S. Bailey

Geoff Barr – Written Evidence

I would like to object to the thrust of the regulations going before the Lords. It seems that they will have much the same impact as the proposals recently withdrawn. The committee should be aware of this and reject these changes.

Yours

Geoff Barr

British Medical Association – Written Evidence

The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors from all branches of medicine across the UK.

The initial regulations -- Statutory Instruments 257 on procurement practice in the NHS.

Government to clarify the intended impact and scope We are pleased that the Government has listened to the concerns expressed by the BMA and other organizations about the regulations. The redrafted regulations, on the commissioning process.

However, even with these revised regulations, For example, as these regulations are sharp end of clinical practice fear that these to support the NHS. Just before publication of the revised regulations, the Committee recognized that, in view of the widespread criticism of the original regulations, the Government will need to communicate clearly the purpose of these provisions.

Given the importance of these regulations, and the significance of the reforms taking place at the end of this month, we continue to call for a full Parliamentary debate, to provide absolute clarity that Clinical Commissioning Groups will have freedom to decide how best to secure high quality services for their local populations.

Yours sincerely

Dr Mark Porter

Chair of Council, BMA

Ginny Davies – Written Evidence

I am most concerned that the time allowed for scrutiny of the new S75 regulations is completely inadequate. This is fundamentally undemocratic and appears to allow for the continued march towards privatisation of the NHS. Outrageous!

Ginny Davies

Kevin Eady – Written Evidence

I am emailing you to protest that the newly re-drafted regulations regarding competition in the NHS have been issued too hastily and are not being given enough time for proper consideration, consultation and debate. If, as appears likely, they are still intended to enforce unnecessary competition via the backdoor, then they will be contrary to the intentions expressed by ministers in the Commons during the debates on the issue. As such they will be flouting the wishes of Parliament by an undemocratic bureaucratic procedure. This should not be allowed to happen. I hope that you will demand that these proposed new regulations again be re-drafted to explicitly state that this competition will not be compulsory and that the CCG's will have the power to decide, in all situations, whether or not it is appropriate to subject any particular service or function to competition.

This will not pass unnoticed amongst the general public. Parliament's activity is under scrutiny these days more than ever.

Yours

Kevin Eady

Sarah Flynn – Written Evidence

I notice that the Lords' Secondary Legislation Committee will be discussing the amended regulations laid by the Government under Section 75 of the new NHS Act 1 at their meeting on 19 March.

I should like to draw to your attention the radical nature of these regulations. During the passage of the Health

Sarah Flynn

Richard Grimes – Written Evidence

I would be very grateful if you would pass onto the Secondary Legislation Scrutiny Committee my concerns about the recently published regulations relating to sections 75, 76, 77 and 304(9) and (10) of the Health and Social Care Act 2012.

I am a twice elected Foundation Trust governor and a patient representative on the Patient Forum of my local Clinical Commissioning Group, I do not represent either group, and I am writing this letter in a personal capacity.

However, as a patient representative I hope that you recognise that I have regular contact with NHS patients and that the concerns I express are typical of the majority of the patients I meet.

As a Foundation Trust governor I am aware that my trust provides many services which are inter-connected, and the loss of one service for competition's sake could make other services unsustainable. The local commissioners are aware of this and commission accordingly for the benefit of patients, the SI 500 regulations will make it very difficult for the Clinical Commissioning Group to continue do this.

Throughout the passage of the Health and Social Care Act through parliament, patients were reassured that the bill would not privatise NHS services and that there would not be competition for competition's sake. Patients were also reassured that GPs (more accurately Clinical Commissioning Groups, but the term "GPs" was always used) would determine which providers would be contracted to deliver NHS services.

Even though the original regulations (SI 257) have been re-worded, I do not think that the current version (SI 500) live up to the reassurances that patients were given. The current regulations still makes competition the chief aim of commissioning, and competition for competition's sake is not in patients interests.

My main concerns are:

1) The phrase "in the interests of people who use health care services for the purposes of the NHS" should be defined. The problem with the regulations is that it treats each service as a separate transaction, whereas in most cases NHS services are inter-dependent and changing the provider of one service can have adverse effects on the provision of other services. In particular, there is a lot of cross-subsidy where surpluses from one service makes it possible for a provider to deliver another service. (In general, emergency care, which make up the bulk of the work carried out by NHS hospitals, generate a deficit and are subsidised by surpluses from elective work.)

The sections on procurement should make it clear that where the existing provider relies on surpluses from a service to cross-subsidise one or more services, all of these services should be taken into account when determining "in the interests of" patients.

2) Section 5. "where the relevant body is satisfied that the services to which the contract relates are capable of being provided only by that provider"

I am concerned that the phrase "only by that provider" will be very difficult to prove, since by definition, any provider making a complaint under this section will only do so because they think they can provide the service. The criteria should be broader and the emphasis should not be pro-competition. The section must look at all the services dependent upon the service related to the contract.

3) Section 10. There should be an addition exclusion in this section as outlined above, that is, if the service in question provides surpluses that cross-subsidise other services, or other services are dependent upon this service (for example, specialists are shared between services) then it is in the patients' interests that *all* services are considered together. A complaint under this section should only be allowed if changing provider has a net improvement of the services for that population. If changing providers could adversely affect other services then there will be a net deterioration of services and so "anti-competitive behaviour" should be allowed to prevent such a deterioration.

4) Section 13. Subsections (1) and (2) are unacceptable. It surely cannot be right that a single organisation can instigate an investigation, perform the investigation and then adjudicate? These are three separate functions and Monitor should be responsible for one, not all of these.

5) The Explanatory Notes to the Health and Social Care Act 2012 says:

"15 ... It is intended that these regulations will enshrine a full range of options for commissioners, including the ability to secure services without competition, where this would be in patients' interests."

The regulations in SI 500 fails to give a full range of options because it is clear that whatever commissioners do they will be subject to challenges, and since Monitor (whose primary aim is the curious double negative of "prevent anti-competitive behaviour" and therefore exists to ensure competition occurs) will always favour competition for competition's sake.

This will act as a constraint on the ability of commissioners to act in the best interests of patients.

6) Since the intention is to improve care for patients, then providers should not be allowed to make a complaint under these regulations. Instead, it should be patients, or an independent patient advocate, who have this ability. The advocate should not be an organisation that will tender for the service, but could be a charity, a patient group, a local council, or it could be local Healthwatch. This will make sure that "in patients'

interests" means patients not providers' interests.

7) Finally, I am concerned that these regulations will encourage vexatious complaints. This will lead to increased bureaucracy and cost to commissioners. Commissioners are responsible for public money for healthcare and will not want to spend that money on defending legal actions, the results is that they will employ "section 75 compliance officers" to ensure that all procurement is compliant, or will simply tender everything. To discourage vexatious complaints the regulations should say that if a complaint fails then the complainant should be liable for all the costs of the investigation: both the costs of Monitor and the legal costs of the commissioners. This would have the double benefit of making reducing the cost of Monitor and it would deter speculative and spurious claims.

The National Health Service (Procurement, Patient Choice and Competition) Regulations 2013 (No 2) go against all the reassurances given by ministers in Parliament during the passage of the Health and Social Care Act. I hope you will agree with me that these regulations are so far-ranging and will have such an effect on the public that they should not be brought about through secondary legislation, but should be subject to full parliamentary scrutiny and amendment by elected Parliamentarians.

Dr Richard Grimes

Ellen Hawley – Written Evidence

The revised regulations appear to be contradictory and poorly thought through. They will, if allowed to go into effect, invite lawsuits and leave CCGs acting out of fear of lawsuits rather than in the best interests of the patients.

Ellen Hawley

Help the Hospices – Written Evidence

Thank you for the invitation to comment on the revised NHS Procurement No.2 Regulations SI 2013/500.

The revised regulations are a significant improvement on the previous version. In particular, we welcome the emphasis on integration and quality within the revised regulations. For many years hospices have worked as part of a plural healthcare environment and in partnership with the NHS and other providers have delivered high quality integrated health and social care to patients. However, we still have concerns regarding how the regulations will be followed locally. This note seeks to outline these concerns.

The redrafted regulations still state that commissioners can only award contracts without competition if they are certain no other provider could offer the service. There also remains a presumption within the document that a change of provider will bring benefits. For example clause 3 (4) makes no reference to improvements in services being secured through work with existing providers, implying that such improvements will only be secured through new arrangements.

We would strongly recommend that the regulations should recognise that a new service, for example a change of provider, is not necessarily the most effective way to deliver improvements in all instances. We touched on this in our earlier response around the possible interpretation of 'anti-competitive behaviour'. For example, clause 5 refers to the award of a new contract. The exclusions in relation to what constitutes a new contract (5(2)) could mean that where current agreements with hospices are renewed and move, for example from a Service Level Agreement with the PCT to the NHS standard contract, that they will be considered to be new contracts.

Also to note, the regulations appear to be at odds with briefings on procurement issued by the NHS Commissioning Board in September 2012. These are available to view at: http://www.commissioningboard.nhs.uk/files/2012/09/procure-brief-2.pdf. For example, when providing guidance on whether to carry out a procurement process for healthcare services, the guidance states :

"The first step is to assess whether a new healthcare service is required. Where an existing service is not being delivered to the required quality or quantity, your first step will be to secure improvements through contract management, for example through payment mechanism, performance monitoring and/or dispute mechanisms. Only after these mechanisms have been exhausted should termination of the contract and its replacement with a new service be undertaken. Having established that a new healthcare service is required, you should first consider whether any existing contractual arrangements could be used to deliver the required services."

We are concerned that clause 5, as currently drafted, does not give sufficient confidence to commissioners as to the appropriateness of not undertaking competitive tendering. The restriction on awarding a new contract to a single provider only where the commissioner is 'satisfied that the services to which the contract relates are capable of being provided only by that provider' remains very restrictive on the options available to commissioners.

Our argument that commissioners should decide when and how to use competition (as per our comments on the previous version of the regulations) is still relevant. Commissioners should be able to make decisions based on local needs and circumstances, and be in a position to consider the economic case – the balance of costs against benefits of tendering particular services, and should have the support and the capacity to be able to make these decisions.

We would also recommend that there is further clarity within the regulations that value for money should not solely be determined by cost. Currently, the regulations refer to (section 3) ensuring that services are procured from providers that provide best value for money. All too often, in practice, value for money is interpreted as meaning the lowest cost, whereas it should be a proper reflection of cost and quality. It may be appropriate for the regulations to link here to the requirements of the Public Services (Social Value Act), as we mentioned in our comments on the previous version of the regulations.

Finally, we would welcome further clarity as to the interpretation of clause 4(4) ' A relevant body must secure that arrangements exist for enabling providers to express an interest in providing any healthcare service for the purposes of the NHS'. There is the potential this could lead to providers putting themselves forward to run services before they are even advertised. It is arguable this would make it even more difficult for Clinical Commissioning Groups to demonstrate that there is only one provider capable of running a service.

I hope that these comments are helpful, and I would be grateful if you could bring our concerns to the attention of their Lordships to aid their consideration of these important regulations.

Yours sincerely,

Jonathan Ellis

Director of Public Policy and Parliamentary Affairs

Help the Hospices

J Hill – Written Evidence

I am writing to you to register my protest at what is happening regarding privatisation of the NHS by stealth by this Government.

I am opposed to it. I ask the House of Lords to listen to all the ordinary people who depend on this service. Profits and Health care are a toxic mix, and usually it is the taxpayer who foots the bill when the private company fails.

J. Hill

Wendy Horler – Written Evidence

- 1. National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2-13 Part 2- Section 3 Procurement and requirements

How is "Best Value for money" assessed? Is there research showing which provision is most effective or does this have to be taken on trust? -

2. Conflicts of Interest - National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2-13 Part 2- Section 6 If this goes through, will current members of the National Commissioning Board who have connections with Private Health Care companies resign from the Board?

3. National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2-13 Part 3 Section 15 The power of Monitor given here to undo decision made and contracts purchased by commissioners is considerable, especially considering the fact that it has not yet consulted on its guidance, let alone published it.

4. Appendix One National Health Service (Procurement, patient choice and Competition) Regulations 2013(SI 2013/257 "Commissioning decisions must be in the best interests of patients," but nowhere does it describes or defines what best interests are. There may well be a conflict between a patient's needs and the improvement of quality and efficiency within the service overall. This is an inevitable consequence of developing the NHS on marketing principles.

5. It is still unclear how much authority for commissioning rests with the CCGs compared to the National Commissioning Board, especially as the term "relevant body" is used in many instances for either or both of them.

6. Given that the Government believes this act represents the best way forward for the NHS why is it pursuing the task with a speed that has led to shoddy legislation and poor information and guidance being given to the relevant organisations. At the present pace of progress it is more or less universally acknowledge that the process is likely to prove unmanageable and deeply damaging.

Wendy Horler

Lambeth KNOP

John Hully – Written Evidence

I would be very grateful if you would pass on to the Secondary Legislation Scrutiny Committee my concerns regarding the aforementioned regulations which relate to the procurement of NHS services.

Firstly, that this Instrument should be drawn to the attention of the House under (2)(a) of the Terms of Reference of this Committee for the following reasons:

This instrument is politically important, in that the regulations will impact every member of the public in England who uses the National Health Service; that the extent of debate inside Parliament together with the number of amendments offered, debated, and made to the Health and Social Care Act 2012 provides evidence of its political importance; that announcements by members of Her Majesty's Official Opposition subsequent to the passage of the aforementioned act strongly indicate continued political importance; that the continued existence and activities of individuals and organisations opposing the aforementioned act further demonstrates its political importance; that it makes changes in contradiction to statements and assurances previously made by Government Ministers and others in and outside of Parliament.

This instrument is legally important in that it introduces competition law into the procurement of NHS services for and on behalf of the public. (See also below, regarding (2) (c).

This Instrument gives rise to major issues of public policy, which must be of interest to the House in that it makes significant changes to the management, operation and services of the National Health Service in England, a service used by the overwhelming majority of the public; in a manner which will impact the ways in which such services are procured, delivered, and chosen by every such member of the public; and makes changes in contradiction to statements and assurances previously made by Government Ministers and others in and outside of Parliament.

Secondly, that this Instrument should be drawn to the attention of the House under(2) (b) of the Terms of Reference of this Committee for the following reasons:

Subsequent to the enactment of the Health and Social Care Act 2012 and immediately previous to the laying of this Instrument before Parliament, a report produced by a Public Enquiry under the Chairmanship of Sir Robert Francis and commissioned by the previous Secretary of State for Health was published. I submit the contents of this highly important document form changed circumstances. The Committee will be aware of the enormity of the events at the Mid-Staffordshire NHS Foundation Trust which are recorded in a previous report under the same chairman, and which prompted this report to be commissioned.

The Francis Report 2013 makes 290 recommendations (Vol 3 Chapter 27 Table of Recommendations). Her Majesty's Government has acknowledged the significance of the events and of the report; but is yet to respond in full. Nevertheless, it has laid this Instrument before the House and it seems highly likely that this Instrument may come into force before the Francis' report recommendations have been duly considered and responses proposed.

The Francis Report recommends inter alia a number of changes (for example, Recommendations numbers 124-127, 129-132 and others) relating to procurement, and other recommendations relating to the role of "Monitor". Manifestly, the passage of this legislation should not be completed before a full impact assessment of the Francis Report has been completed, detailed responses to his recommendations have been put forward, and these regulations duly amended by Her Majesty's government. Failure to do this will lead to additional costs and effort for the NHS to implement subsequent changes. Moreover the regulations in this Instrument may hinder or even prevent the implementation of Sir Robert Francis' recommendations: leading to more unnecessary and unnecessarily early deaths and unnecessary suffering.

Thirdly, that this Instrument should be drawn to the attention of the House under (2) (c) of the Terms of Reference of this Committee for the following reasons:

This Instrument may inappropriately implement European Union competition legislation, thereby eventually restricting or eliminating the ability of commissioning bodies to procure services as per the Health and Social Care Act 2012, or as per the Francis Report recommendations, or as per the will of the English people as expressed through Parliament.

Fourthly, that this Instrument should be drawn to the attention of the House under (2) (d) of the Terms of Reference of this Committee for the following reasons:

The Instrument may imperfectly achieve its policy objectives, or those of the Health and Social Care Act 2012 in that: The regulations could have wide-reaching implications with regard to the the mix of providers of NHS-funded services. The regulations ban "any restrictions on competition that are not necessary", which is a broad definition and one which may be subject to persistent legal challenge. Further, they state that contracts may only be awarded without tender for "technical reasons, or reasons connected with the protection of exclusive rights" or "reasons of extreme urgency".

The regulations are to come into effect simultaneous with significant changes brought about by the Health and Social Care Act 2012 and changes brought about by the programme of 'savings and efficiencies' under Sir David Nicholson. It is well known that attempts to implement multiple programmes of change concurrently inevitably creates unplanned and unexpected impacts on service and on each programme of work. Such impacts will increase costs, reduce both effectiveness and efficiency, cause delays, and increase resource requirements. In the NHS, where the service is health, such impacts will be - directly or indirectly - increase suffering and unnecessary (early) deaths.

Furthermore, - though I accept from lack of experience that this may be normal in the drafting of such instruments - there is no evidence of funding to cover the implementation and then ongoing costs of this Instrument. Beyond that, the Instrument is not supported as a major programme of change by a risk register, has no implementation timescales (it is assumed to be in effect from "Day 1" when it comes into force), has no statement of work or project plan, and no clarity of ownership of responsibilities and accountabilities for implementation or ongoing service. As someone who has been engaged in the governance of programmes of change, I am quite honestly aghast at this absence of information.

Over and above this, the Instrument demands that NHS management and General Practitioners - who are, after all, supposedly leading commissioning of services according to the Health and Social Care Act 2012 - will in practice have to focus on compliance with

these regulations relative to provision of best quality care to their patients. It is improbable that General Practitioners have adequate experience to accomplish this, and the Instrument makes no provision for training. The Instrument thus conflicts with policy and is inconsistent between its own Requirements and its Objectives.

It is arguable that this Instrument is in conflict with assurances given by ministers during the passage of the Health and Social Care Bill through Parliament that it did not mean the privatisation of the NHS and that local people would have the final say in who provided their NHS services, by creating requirements for virtually all commissioning done by the National Commissioning Board (NCB) and Clinical Commissioning Groups (CCGs) to be carried out through competitive bidding, which will have the effect of forcing through privatisation regardless of the will of local people. Moreover, these regulations contain legal powers for Monitor to enforce such privatisation spontaneously or at the request of private companies that lost bids.

It is also arguable that the General Requirements of this Instrument conflict with the Objectives of this Instrument, in that the results of competitive bidding may not, either generally or in individual cases, permit or secure any or all of the following (a) securing the needs of the people who use the services, (b) improving the quality of the services, or (c) improving efficiency in the provision of the services. The regulations as set out in this Instrument clearly conflict with promises and assurances made by the then Secretary of State for Health, Andrew Lansley on Feb 16th 2012 when he assured General Practitioners (and by implication, the general public regarding the expressed concerns of General Practitioners) that:

"You will have the freedom, with your new powers and responsibilities, to commissionservices in ways that meet the best interests of your patients. You will, for example, be able to determine where integrated services are required and commission them accordingly."

And

"You will be able to work with existing providers of health and care services to deliver better results for patients"

And

"I know many of you may have read that you will be forced to fragment services, or to put services out to tender. This is absolutely not the case."

This absolutely is the case, as set out in these regulations. For the reasons set out above, I request that this Statutory Instrument may be drawn to the special attention of the House. I would wish to recommend for the reasons set out above that this Statutory Instrument be set aside until a later date, or at least until the recommendations of the Francis Report have been fully considered and detailed actions agreed and planned: at which time the regulations should be drawn to the special attention of both Houses.

John Hully

Frances Jones – Written Evidence

I want to urge everyone to drop the ridiculous plans to change the nhs as is being so badly planned. Can this be debated again? Most people do not want the plans for the NHS
Frances jones

Keep Our NHS Public – Written Evidence

We write as co-chairs of the organisation Keep Our NHS Public and wish to make clear that we believe that these amended regulations are just as unacceptable as those issued on 13 February and then revoked on 11 March. We urge the Committee to signal to the House that these regulations are worthy of wider consideration, particularly a debate on the floor of the House. Parliament was told by various health ministers during the passage of the Health and Social Care Act 2012 that it was not their intention to privatise the NHS. The furore which erupted when the first set of Section 75 regulations were published on 13 February showed how many people from many backgrounds there were who believed that this was not the outcome which would be created by those regulations.

We applaud the clear and constructive report you produced following your consideration of the first set of regulations. We set out our detailed objections to the new regulations below, concentrating on the miss-match between the likely outcome of the regulations and the arguments put by ministers during the passage of the Act. We trust that you will apply the same forensic skills to the new regulations as you did to those which have been revoked.

1 General points

1i The explanatory note to the revised regulations repeats the misleading claim that "The

Previous regulations went no further than the set of procurement guidelines issued in March 2010."We note that the Committee said in its report on the first draft of the regulations, that where previously competition was 'encouraged' (ie, non-statutory), under these regulations, it was 'required'. The committee correctly surmised that this was 'a significant change'. It is worrying that the Department of Health has ignored the view of the committee on this point, despite claiming that "The Government has listened carefully to those concerns".

1ii We wish to place on record our concern that these regulations have been made to come into force on 1 April, leaving very little time for scrutiny and / or parliamentary debate and vote. In our view a more appropriate response to the continuing problems with these regulations would have been to revoke them and give the department time for proper consultation and consideration.

1iii We also consider that the fact the Department has yet to come back with a view on the Francis report is another good reason to revoke and reconsider. These recommendations dealt extensively with commissioning, values, the need for consensus, the importance of public accountability and engagement, the need for commissioners and not providers to prevail, patient safety and staff training standards. The Francis Report recommendations also looked at the role of some of the market based mechanisms, which were certainly seen to have been a factor in driving the problems in mid-Staffordshire. These regulations do not appear to have regard to these recommendations.

1iv We reject the argument that there is an urgent need for these regulations. CCGs due to take over on 1 April are more than capable of commissioning under the existing framework, using their clinical judgement, as they were promised, whilst the government considers what

further regulations if any are needed. CCGs have been extensively assessed on their commissioning abilities. We observe there seems to be a contradiction in the various statements from ministers that a) these regulations change little and b) they are urgent.

2 Regulation 5

2i Whilst clause (2), which defined the exceptionally tight conditions on the circumstances in which commissioners could award a contract without competitive tender, has been removed, in practice this will make little difference. 'Only one provider capable of delivering services' is a very high bar. The revised regulations will put this high bar, on a statutory footing for the first time.

2ii This will restrict commissioners' freedoms in a way that contradicts assurances (such as those given by Andrew Lansley MP in his February 2012 letter to CCGs). Proving there is 'only one provider capable', in a way that puts commissioners beyond fear of Monitor's interventions, will be extremely difficult. It would probably be necessary to conduct market research to show that they had attempted to discover other potential providers. Establishing such a burden of proof would likely be an even more onerous task than that of running a tender exercise, meaning that it is highly unlikely that CCGs would attempt it, except in those circumstances where it is clear that the private sector does not want to take over the services. Indeed, Lord Howe's various pronouncements including his letter of 18/2 to peers and MPs, make clear that this is exactly what he envisages.

2iii In other words, it is a test that has nothing to do with protecting patient rights and everything to do with protecting 'provider' rights. It will lead to increased tendering, despite the transaction costs involved and cumbersome nature of such exercises at a time when the NHS is already under a financial squeeze. Through provider 'cherry picking', the NHS will be stripped of the secure income streams that flow from elective procedures and community-based treatments, struggling to provide the acute and emergency services that the private sector may be content not to provide.

2iv Competition law and practice has been developed primarily in markets where there was less asymmetry of information between commissioner and provider than is the case with health. Where it is not possible for the commissioner fully to understand the outcomes achievable, there is a risk of opportunism by the provider, especially where, as in the case of a private provider, profits may be increased by such opportunistic behaviour. One significant counter to this problem within the 2012 Act was to ensure that most commissioning was done as they saw fit by local bodies with local knowledge and experience. To force such local bodies into a competition straitjacket, as the amended regulations still do, is to remove one of the key safeguards against opportunistic behaviour on the part of providers. Tendering or other forms of competition will be the 'default position'.

3 Regulation (10)(2)

3i The amendments to do not appear to us to make much difference, or even, much logical sense. The Regulation still contains very broad pro-competition requirements. We are particularly concerned that these remain couched in catch-all terms, which seem to sweep everything into a competition law framework. Currently, commissioners can decide what is best for patients, from a wide range of options, including (for example) an in-house arrangement between NHS bodies. The government confirmed such an arrangement was entirely legal a few months ago, but it would be outlawed under these regulations.

Regulation 10(2) gives the broadest powers to Monitor to intervene. It is this regulation, rather than Regulation 5, which would constrain commissioners most severely, and most in breach of the assurances given.

4 Chapter 3, including Regulation 15

4i The additional clause in Regulation 15 ('Monitor does not have the power to direct a commissioner to hold a competitive tender') does not reassure us. It appears to contradict other parts of the same Regulations. For example we note that Regulation 15(e), retains very broad powers for Monitor to do anything it likes, if it spots anything it judges to be 'anti-competitive behaviour'. Monitor's capacity to penalise will be a de fact power of 'directing' – just in a less visible and transparent way.

4ii We wonder why the inserted regulation does not say, 'Monitor does not have the power to direct a commissioner to use competition'. If this was the intent, why is that not stated? We are concerned that this regulation, as currently drafted, could be interpreted to mean that Monitor would have the power to direct a commissioner to use competition, just not to insist that the tendering route was the specific form of competition used. There are other forms of competition that commissioners could use, including Any Qualified Provider and Frameworks. If the regulation were to be interpreted in this way, this would clearly be against both the spirit and letter of assurances that were offered. It is far too open to this interpretation at present.

5 Chapter 3 , general

5i We note that ministers have asserted that these regulations do not change the current position.. We concur with your report that in fact the earlier draft did make a significant change, and it is clear that the revised regulations do the same. These regulations put the non-statutory guidance given to PCTs which enabled them to use competition, into a compulsory statutory requirement for CCGs to do so, thus in effect removing local discretion

5ii These regulations give Monitor time unlimited statutory powers to investigate any 'anti-competitive behaviour'. This is in stark contrast to the Public Contract Regulations 2006, which have a 30 day time limit for action., and therefore seems an excessive power which will in effect reduce local discretion

5iii The Department of Health has claimed that regulations are needed now to protect the NHS from lawsuits under wider competition law, where the OFT is the regulator, the implication being that extending Monitor's powers will be a protection against competition. But the existing Regulations have never been used by private companies for the purpose of challenging such procurement decisions. So the suggestion that there is a need for additional regulations, to avoid court challenges, does not stack up with the evidence. We suggest that this indicates that ministers are seeking to establish powers for Monitor to drive competition and subsequent privatisation through the NHS, in contravention of what was said by ministers in Parliament during the passage of the 2012 Act.

5iv We note that the Francis report into mid-Staffordshire made a number of recommendations in relation to Monitor. It is clear from the report that there were significant failings in Monitors role as a regulator, in relation to patient needs. Francis recommends amongst other things that Monitor be merged into a single regulator, to avoid

problems falling between the cracks of different bodies in future. More generally he recommends far-reaching changes to the role and structure of Monitor, to better deliver the effectiveness and transparency which was missing at Mid-Staffordshire. It seems extremely unwise to give Monitor strong statutory powers to focus on competition, before the Department of Health and the NHSCB has even responded formally to the `recommendations

Yours sincerely,

Wendy Savage & John Lipetz

Co-chairs, Steering Group

Keep Our NHS Public

Michelle de Larrabeiti – Written Evidence

I still have many doubts about both the intentions and the effects if this SI stands, even with the changes. Having read through the rewrite it strikes me that the emphasis is on "anti-competitive" behaviour, which seems to imply that there is a danger of litigation if the CCG is perceived to have commissioned within the NHS? As in sub section of section 10 which appears to contradict itself? Further it states that the only reason a CCG can award services without either issuing a tender or going to AQP is if there is only one provider in the first place. This seems to contradict the intention of the bill to give the CCG (ie GPs) the power to know what's best in their area by denying them the choice of provider based on their own assessments?

I still don't think these regs are in a fit state to pass into law. If the stated claim of the act is to increase local GP choice and power over their own commissioning then these Regs still need rewriting to make that point clear. Otherwise the representations by Lord Howe in the house look dishonest?

Many thanks

Michelle de Larrabeiti

Bill MacKeith – Written Evidence

We made a submission to your committee on the section 75 regulations relating to the Health and Social Care Act. I understand you are taking submissions on the revised regulations up to the end of today.

Our submission is brief mainly because we do not have the resources in this short timescale to make it longer. It is simply the following:

Our understanding of the revised regulations is that they still do not allow local commissioners to make decisions about local services in the way that ministers promised during the passage of the Health and Social Care Act. The regulations therefore need either further amendment to be consistent with those assurances, or to be scrapped altogether.

Bill MacKeith

Secretary, Oxfordshire Keep our NHS Public

David Margolies – Written Evidence

I write to ask you to send the revised regulations (SI2013/500) for reconsideration on the grounds that, like the now-revoked regulations, they fail to conform to Government public statements that the regulations will not require competition. I am particularly concerned about 10(2) which excludes 'competition which is not necessary'. My understanding of the EU use of the word 'necessary' in relation to contractual arrangements is that what is always intended is commercial necessity. Even with the sub-clauses (a) and (b), I think the commercial sense of 'necessity' remains.

The effect, then, is to make commercial competition the default state, which has the practical result equivalent to requiring competition. I urge that you require the regulations to be revoked.

Your sincerely,

David Margolies

Jim Pragnell – Written Evidence

The revised Section 75 Regulations issued yesterday have not changed the situation very much.

A paragraph has been deleted from Reg. 5 but the words in it were taken from the Public Contracts Regulations 2006, which remains in force and will have to be complied with by commissioners. So no change there. Reg 10 now gives two examples of what will not be considered anti-competitive behaviour but the position where a commissioner simply decides not to tender an existing NHS service is not covered. So in this important area no change again. I welcome the fact that Monitor will no longer be allowed to direct a commissioner to hold a competitive tender for a NHS service, but how Monitor will react should a commissioner decide not to do so remains as before. We simply do not know. Guidance in this important area is not complete.

The Regulations could have been made the situation absolutely clear by simply saying that commissioners can decide when and how to use competition (your words) and that the Regulations concerning commissioners will only apply when they decide to tender a service. However, the Government appears to have ruled out any consultation on the revised Regulations because they are still planned to come into force on 1 April.

In my opinion the Regulations should be revoked and time given to a proper consultation, which could include consideration of the recommendations in the Francis Report.

Yours faithfully,

Jim Pragnell

Martin Quinn – Written Evidence

I would like to make the following observations on the revised regulations - SI 2013/500 The NHS (Procurement, Patient Choice and Competition) (No 2) Regulations 2013.

1. It is disgraceful that only three working days have been allowed for views to be submitted on these revised regulations. The legislation was approved a year ago so the last minute nature of scrutiny of the regulations indicates a deliberate attempt by the government to avoid the detailed examination such important regulations merit. I would request significant further time is allowed for this exercise.

2. The regulations are a recipe for short termism. The NHS must be developed and managed strategically so that as well as meeting the needs of current patients, the long term sustainability of an integrated NHS for future patients is guaranteed. It is shocking that there is not a single mention to the role of strategy in commissioning/procurement in either the regulations themselves or in the Department of Health's memo on the to the Secondary Legislation Scrutiny Committee 28 February 2013 explaining the policy intention. It would appear the policy intention is to be deliberately non-strategic. The huge danger the regulations will create is that commissioners will take individual commissioning decisions which incrementally will change the NHS so that in 10 to 20 years time the NHS will be a much more fragmented service which the commissioners may not have intended and the public certainly do not want.

3. In the letter the Deputy Prime Minister and Baroness Williams sent to all Lib Dem MPs and peers about the Health and Social Care Bill in February 2012 they wrote '...we have made sure that private providers can only offer their services where patients say they want them'. There is no mechanism in the regulations to implement this pledge. The regulations must make it clear that CCGs can only open up NHS services to private providers when they have available robust evidence that a majority of patients have said they want private providers to offer their services.

4. A loss leader strategy is well established business practice and the changes introduced by these regulations will mean private providers bidding for NHS contracts are highly likely to take this approach. NHS providers are not in a position to adopt such a strategy and so are likely to lose out to private sector rivals who will seek to score highly on 'best value for money' criteria. Once a public NHS provider has been put out off business it will rarely be able to return to compete when the service is put out to re-tender. So for the sake of short term 'VFM', commissioners will create enormous long term risks to the service. Whether by accident or design, there is nothing in the regulations to protect the NHS from these dangers. There is already clear evidence that companies such as Virgin Care and Circle Holdings PLC are adopting this business strategy when bidding for NHS contracts.

I believe the regulations require a fundamental review and redrafting however I would offer the following few drafting suggestions to part 2 which indicate the type of changes required:

2a add '...now and in the foreseeable future'

2 final sentence add '...and ensuring the long term sustainability of the NHS'

3 (3) add (c) Demonstrate that they are not engaging in a loss leader approach.

4 (3) insert new (a) Robust and independently verified evidence that a majority of patients have said they want private providers to offer their services.

4 (3) insert new (b) The long term strategic plan for the service (covering at least four times the contract period), including its role in health research and education which the contractor must support.

5 (1) Delete '...capable of being provided..' replace with '...best provided...'

10 1 add (c) 'protecting the long term viability of NHS services'.

10 2 (a) add '...now and in the foreseeable future'

Yours sincerely,

Martin Quinn

Alan Ray-Jones – Written Evidence

I am trying, late on Thursday night, to comment on these regulations from the point of view of a patient with no axe to grind save that I want a good National Health Service. To put it as politely as I can, I think the time allowed for scrutinising the redraft of SI 2013 no 275 is very short, and that the government appears to be attempting, by sleight of hand, to open up the NHS to competition to a degree which should only have been attempted after a manifesto pledge followed by a win at a general election. Critics of the legislation are being virtually ignored, and the process is fundamentally undemocratic.

I have had a very hurried look through the text and note as follows, without having the Acts mentioned in places available to me:

3 (2) b) reads like an invitation to privatization, and the last three words as if the NHS, with its experience, counts no more and no less that some unknown organization entirely new to the health industry in the UK. This clause should be omitted entirely or the word 'experienced' inserted, so as to read 'any other similarly experienced provider'. I think it should be omitted.

3 (4) b) and c) as drafted conflict with 3 (3) 'from one or more providers; so both should be preceded by 'where relevant'.

6 (3) should have added e) a major shareholder with a share over ?% and f) a contractor assisting with the administration of the relevant body, or the organization of which the contractor may form a part.

7 (8) is meaningless to me and I think that an explanatory note should have been provided. I fear that the overall effect of 7 may be to involve relevant bodies in providing choice from organisations about which not enough is known or looking over their shoulders at Monitor or spending unnecessary money in researching bodies of dubious provenance.

9 (2) should have added: f) the full text of the contract. There is no place for secrecy about contracts to private or public organizations associated with the NHS.

Perhaps it is dealt with in another set of regulations, but I see nothing in 2013 no 500 about the regulation of members of CCGs or Boards who have shareholdings or directorships in organizations who may be potential providers or tenderers. This is an extremely important matter so I can only suppose that it is dealt with elsewhere.

Yours sincerely,

Alan Ray-Jones

Jim Rowe – Written Evidence

I made contact with you before about the original insertion of Section 75 at a very late stage.

I am therefore highly disappointed and appalled by the 'rewording' of the Section 75 regulations. It will in effect, put the CCGs in a cleft stick because the rules now seem to be very vague and contradictory.

This has the potential for legal challenges which will cause great distress to the CCGs trying to interpret the rules for commissioning services. It would also appear that Monitor could intervene by declaring that 'the arrangement for provision of health care services for the purposes of the NHS is ineffective.' In other words it can cancel any contract that could be deemed to be non-competitive and open all contracts to the private health companies and entry into the EU and US transnational markets with no hope of turning it back.

The cost to the taxpayer gets even greater if legal challenges have to be made and this will be on top of the resources that are already being spent on the changes within the Health & Social Care Act which will come into force on the 1st April.

Have we forgotten democracy?

Jean Rowe

Independent Public Health Specialist

Royal College of General Practitioners – Written Evidence

As Chair of the Royal College of General Practitioners (RCGP) I write with regard to the new version of the above regulations re-laid before Parliament on 11th March 2013.

As you know, the RCGP previously expressed concerns to the Committee that, contrary to assurances given by Ministers during the passage of the Act, these regulations would restrict the freedom of Clinical Commissioning Groups to decide not to put health services out to competitive tender. We therefore welcomed the Government's decision to revise and re-lay these regulations before Parliament.

Having looked closely at the new version of the regulations, we believe that whilst they are a step in the right direction, they do not go far enough in ensuring that commissioners are genuinely free to decide whether or not to expose services to competition. Our comments on the new version are as follows:

- We welcome the amendment made to Clause 2 (procurement objective) which now makes explicit reference to consideration being given to the integration of services in the definition of how commissioners of health care services must act.

- However, this change is, we believe, effectively negated by Clause 5. This still specifies that in order to let a contract for health services without competition commissioners must be: "satisfied that the services to which the contract relates are capable of being provided only by that provider". We remain concerned that this will give rise to circumstances in which CCGs feel they must put a service out to competitive tender because technically more than one provider is capable of delivering it, even if they feel it is not in the interests of patients to do so. Without clear evidence that there is genuinely only one provider that can deliver a service, it is likely that CCGs will err on the side of caution, effectively creating a presumption in favour of competition.

- We continue to have grave concerns about the broad definition of a "new contract" encapsulated within regulation 5(3), which appears likely to draw many existing services within the ambit of the regulations.

- The point has been made by Ministers (including during the debate in the House of Commons on 5th March) that these regulations mirror guidelines previously given to Primary Care Trusts (PCTs) in 2010. However, it should be noted that unlike these previous guidelines, the regulations currently laid before Parliament will have statutory force.

- We welcome the inclusion of a new Regulation 15(2) clarifying that "Monitor may not direct a relevant health body…to hold a competitive tender for a contract for the provision of health care services." However, despite this clarification the possibility remains that decisions made by CCGs under Clause 5 could be subject to legal challenge.

Whilst we welcome the removal of some section of the original version of Clause 5, we believe that to ensure that CCGs will have the freedom to decide not to put services out to competitive tender, the whole of this Clause should be removed.

We recognise and value the commitment that the Government has made to listening to the concerns raised by a number of health bodies in relation to these regulations. Whilst we welcome some of the changes made in the new version of the regulations, we feel more work is needed to ensure they fully implement the commitments made by Ministers during the passage of the Act.

It should be up to commissioners to do what they feel is best for their patients, using their professional and clinical judgment.

The RCGP is grateful that the Committee took into account concerns we and others raised about the original regulations and reflected them in your 30th Report of 2012/13 Session. I would appreciate the Committee's consideration of the above comments as you consider the new version of the regulations.

Yours sincerely,

Dr Clare Gerada

Chair of Council

Royal College of Midwives – Written Evidence

Thank you for forwarding the revised Procurement Regulations and for inviting the RCM to comment on these. Having considered the revised Regulations, we are of the view that these represent a distinct improvement on the original version. We particularly welcome the changes made to:

- Part 2, clause 2, which strengthens the requirement to take account of services being provided in an integrated way
- Part 2, clause 3, sub-clauses 5 (a) and (b), which adds references to the duty to promote integration
- Part 2, clause 5 which deletes the narrow definition of the circumstances in which commissioners opt not to tender as set out in the original sub-clause 2
- Part 2, clause 10, sub-clauses 1 (a) and (b) which clarifies the circumstances in which commissioners can engage in anti-competitive behaviour
- Part 3, clause 15, sub-clause 2, which confirms that Monitor cannot direct a commissioner to hold a competitive tender for a contract for the provision of health care services for the purposes of the NHS

In raising objections to the original regulations, our chief concern was the impact these would have on the ability of CCGs to commission maternity services on a whole pathway basis as opposed to being required to parcel out elements of the maternity pathway for competitive tendering. Our assessment of the revised regulations is that they should enable CCGs to commission maternity services from NHS providers on the basis that they are usually the only providers capable of providing the full range of maternity care for all women, regardless of medical and social risk factors.

Having said that, it would be helpful to test our assessment of the revised regulations and for this reason the RCM would still like to see the regulations being subject to full debate and scrutiny.

I hope you find our comments to be helpful.

Kind regards

Stuart Bonar

Royal College of Midwives

Royal College of Paediatrics and Child Health – Written Evidence

The RCPCH welcomes that the government has listened to the concerns of the College and others and has revised the regulations on Procurement, Patient Choice and Competition (SI No.257).

We do however remain concerned that the regulations in their current form are open to misinterpretation which may lead to adverse and unintended consequences on children's healthcare.

I would like to draw particular attention to revised Regulations 5 and 10.

Regulation 5 which relates to "award of a new contract without competition", "where the relevant body is satisfied that the services to which the contract relates are capable of being provided by only that provider" still risks constituting a significant burden of proof for commissioners. Further, the regulation does not clarify what needs to be done to ensure that the relevant body is "satisfied" and that they would be protected from action in line with European law. In practice, such proof that there is no other capable provider may only be achieved through a tendering process, placing additional bureaucratic and financial burden on commissioners.

With regard to Regulation 10, whilst we welcome the increased focus on integration and co-operation, such terms can be open to broad interpretation. Further, it does not clarify cases where tendering one service within an organisation which does not qualify for protection under Regulation 10 could damage another interdependent service in another part of the same organisation, thus disrupting complex care pathways.

So, while we feel that the revisions have moved the regulations in the right direction, we remain concerned that they may be implemented in a way that is not to the best interests of patients and which, despite the stated intentions, may lead to fragmentation of services.

I would appreciate the Committee raise these concerns in the House when reporting on the regulations and recommend that they be debated in full in Parliament to establish further clarity.

Yours sincerely,

Dr Hilary Cass

President, Royal College of Paediatrics and Child Health

Royal College of Psychiatrists – Written Evidence

I am writing as President of the Royal College of Psychiatrists about SI No.500, following our recent submission to your committee about The National Health Service (Procurement, Patient Choice and Competition) Regulations 2013 (SI No.257), which were laid before Parliament on 13 February 2013 and subsequently withdrawn by the government.

The College welcomes the fact that the government has listened to the concerns of our College, but is concerned about the potential effects of the new regulations. We consider that these are of an order of significance that they are 'politically and legally important [and] give rise to issues of public policy likely to be of interest to the House'.

There is no overall explicit commitment in the regulations that patients' interests must be put before the interests of competition. However, the balance would be shifted towards patients if in regulation 2 it were made clear that: clauses (a), (b) and (c) are in order of importance, and clause (a) were amended to include the statement 'including through the services being provided in an integrated way (including with other health care services, health-related services, or social care services)' and also clause (b)) from regulation 10 (1) (i.e. 'by co-operation between the persons who provide the services in order to improve the quality of the services').

We are very concerned that regulation 5 still requires a relevant body awarding a contract to be 'satisfied that the services to which the contract relates are capable of being provided only by that provider' if it is not to 'advertise an intention to seek offers from providers in relation to that contract'. The effect of the requirement to demonstrate that a service can be provided only by one single provider could be as onerous for Clinical Commissioning Groups (CCGs) as running a tendering process. There is thus a high risk that CCGs will be much more focused on reducing any potential for legal challenge on the grounds of anti-competitive behaviour than on what is actually best for patients.

This does not, as Earl Howe stated in a letter to the Academy of Medical Royal Colleges on 5 March 2013, 'put…beyond doubt that commissioners will not be expected to tender all services.'

Were clauses (a) and (b) in regulation 10 (1) to be included in regulation 5 as a justification for only using a particular provider, this would provide greater assurance in this matter.

In summary, we remain very concerned both about the continued likelihood of the use of competition where it may not be in patients' best interests, and the fragmentation of services to which this could lead, which would have a very detrimental effect on the care of mental health patients.

I am grateful that the Scrutiny Committee drew our original concerns the attention of the House and look forward to your report on the amended regulations.

Yours Sincerely

Professor Sue Bailey OBE

President, Royal College of Psychiatrists

Mike Sainsbury – Written Evidence

I would very much like to make a detailed and close response to these amendments but regret very much that insufficient time has been allocated to allow me to do so. I regard this as entirely unacceptable behaviour, profoundly anti-democratic and dismissive of this country's electorate. The process could not possibly be described as transparent.

Mike Sainsbury

Barbara Smith – Written Evidence

Please could you ensure that there is a full Lords debate on the undemocratic attempt to force privatisation on the NHS via the new CCG's.

The NHS is very precious to me & my family.

Thank you

Barbara Smith

Joan Stewart – Written Evidence

Thank you for your email requesting comments on the revised regulations SI 2013/500.

The deadline for responses (today) has not allowed time for sufficient consideration of the revisions. Given the misleading nature of the previous regulations, I would like more time to examine the revisions, moving beyond the rhetoric and repeated assurances, to determine whether CCGs will be able to exercise the autonomy they have been promised.

Yours sincerely

Joan Stewart

Paul Summers – Written Evidence

I'm not happy about the rewrite of 75

Paul Summers

Trade Union Council – Written Evidence

Thank you for the opportunity to submit a brief response to the revised regulations published under section 75 of the Health and Social Care Act.

The scale of the response from the general public and the medical establishment showed the deep concerns about the regulations published as SI 257. When the TUC contacted supporters inviting them to submit comments on the regulations we received well over 1,000 responses in under 24 hours.

Given the level of interest and concern, and the importance of the regulations, it is the TUC's view that the revised regulations must be fully scrutinised and debated in Parliament. We are concerned that the timetable for the revised regulations is very tight and that this will serve to constrain the necessary debate and scrutiny. The TUC would support a recommendation by the Committee that the regulations should be subject to a full debate in the House of Lords.

On the substance of the regulations, the removal of section 5(2), which would have imposed extreme constraints on commissioners' ability to decide not to put a service out to competition, is a welcome move. The revised wording on integration and co-operation is also welcome in terms of tone, but does not appear to significantly alter the overall effect of the regulations in practice.

However, the TUC is still concerned that the overall effect of the regulations is to impose an unreasonably stringent requirement on commissioners to prove that services can be delivered by a single provider without competition. This is still out of kilter with commitments made by Ministers that commissioners would have the freedom and responsibility to decide whether, when and how it was appropriate to use competition. We are also still concerned that, despite the addition of the specific point that Monitor may not direct a body to hold a tender, CCGs will feel under pressure to hold a competitive tender or open services to AQP due to the fear of legal challenge from private providers.

With kind regards

Alice Hood

Alice Hood

Senior Policy Officer (Public Services), Organisation and Services Dept, TUC

UNISON – Written Evidence

I am writing to you on behalf of UNISON, the largest health trade union representing more than 400,000 people working in the health service, in relation to the revised procurement regulations.

The regulation that UNISON was most alarmed by (regulation 5) has been improved with the restrictive references to "technical reasons" and "reasons of extreme urgency" (in the case of using a single provider) removed. However, UNISON still has concerns that the bar will be set unreasonably high for commissioners to have to prove that services are capable of being provided only by a single provider; there is still a presumption that competition should be the default position, with the use of a single provider only being permitted in exceptional cases.

UNISON notes the comments of Dr Michael Dixon in this regard. As interim president of NHS Clinical Commissioners, Dr Dixon was one of those who championed the reforms in the first place and his members will be at the sharp edge of implementing the reforms. He said:

"There is a danger that it still leaves open the possibility that a clinical commissioner who wants to contract with a good local provider with a strong track record, who is signed up to the aspirations of the commissioner, and is providing a good service close to people's home, might still have to offer that service to someone else as part of a competitive tender or part of AQP. If CCGs are having to act in a way that makes them more cautious in respect to their local patients that will be a bad thing… I would be very worried if doubts about Section 75 will change their behaviour."

The other changes to the regulations provide welcome language around integration and cooperation (new regulations 2, 3 and 10), but do not seem to add anything substantive; they merely correct the imbalances of the previous set of regulations that had neglected the references to delivering services "in an integrated way" contained at various points within the Health and Social Care Act.

Likewise, while it is welcome that regulation 15 makes explicit that "Monitor may not direct a relevant body under paragraph (1) to hold a competitive tender", in practice the clinical commissioning groups are likely to feel under pressure to hold a competitive tender due to the fear of legal challenge from elsewhere.

To conclude therefore, the regulations are an improvement on the previous set and are more closely aligned with the Best Value for Patients consultation that preceded them. However, there is still a disparity between the regulations and the ministerial assurances that clinical commissioning groups will have unfettered freedom to decide whether to tender for services or not.

UNISON is also concerned at the timescale around the regulations, with them due to come into force on 1 April, giving politicians and public insufficient time to take appropriate advice or to consult on the ramifications.

UNISON calls for the Committee to ensure that the regulations are accorded a full debate on the floor of the House, to allow peers to raise ongoing concerns about the legislation and, ideally, to have them removed.

Yours sincerely

Christina McAnea

National Secretary – Health

UNISON

Steve Walker – Written Evidence

Dear Sir/Madam,

I understand that you are looking for submissions regarding the government's 'section 75' secondary legislation. The text below is from a blog article (http://ccgwatch.wordpress.com/2013/03/12/revised-section-75-regs-mire-ccgs-in-a-legal-minefield/) that I wrote following a careful reading of the government's revisions to SI257/2013 and identifies serious concerns with the legislation, which does nothing to change the substance of the original instrument - and in fact uses uncertainty as an additional tool to tie the hands of CCGs to include private bidders for health service contracts:

Minefield (n) /ˈmīnˌfēld/: an area laid with explosive devices, intended to prevent incursion or protect a valuable target

I've spent a pleasant couple of hours reading through the government's hurriedly-drafted amendments to its 'Section 75' (S75) regulations. These new rules, which the government tried to slip through Parliament without debate or vote, were designed to force the new Clinical Commissioning Groups (CCGs) to invite private providers to bid on any NHS contract, were blocked by Labour with the assistance of a brave LibDem MP (I know, there aren't many these days).

The government 'paused' its legislation with a promise to rewrite it to calm the fears of LibDem objectors, with health minister Norman Lamb claiming that the government took the objections extremely seriously and was committed to honouring its 2012 promises that CCGs would not be forced to include private providers unless they felt it best for the population they served.

In spite of this statement, many expected that the government would simply look for 'better' wording that would allow the LibDems to acquiesce while retaining its core aims.

They were right – and wrong.

The government has amended a few of the technical terms in its 'secondary legislation' – but it has also turned the regulations into self-contradictory mess that is designed to achieve its ends through fear of challenge and litigation rather than by plain fiat.

The new S75 regulations – a legal minefield designed to steer CCGs toward privatisation

The main change to the wording on competition looks ok on the face of it, albeit that the distinction is subtle. Instead of saying that CCGs must not engage in 'anti-competitive behaviour' that is

"not necessary for the attainment of intended outcomes which are beneficial for people who use such services"

Section 10 of the regulations says that CCGS

"must not engage in anti-competitive behaviour unless to do so is in the interests of people who use health care services for the purposes of the NHS"

So, you would think that, instead of having to show that they're declining a competitive process because there's no other way to meet the needs of patients, CCGs now only need to demonstrate that it's in their best interests. But a sub-paragraph of the same section still says:

"(2) An arrangement for the provision of health care services for the purposes of the NHS must not include any term or condition restricting competition which is not necessary for the attainment of-

(a) intended outcomes which are beneficial for people who use such services"

So the rules are contradictory. CCGs will still be extremely wary of limiting competition because the self-contradictory nature of the regulations results in a minefield of potential legal challenges.

A well-known NHS campaigner once told me that "the only thing the NHS is more afraid of than lawsuits is the risk of lawsuits" and the new regulations are designed (or turn out through sheer shoddiness and incompetence, or both) to be so self-contradictory that the only 'safe' decision a CCG can take is to include private bidders by default.

There are several 'mines' of this type in the minefield.

With regard to the inclusion of private bidders, the regulations still include the most critical provision:

"(2) The relevant body must—..(b) treat providers equally and in a non-discriminatory way, including by not treating a provider, or type of provider, more favourably than any other provider, in particular on the basis of ownership."

In other words, excluding private providers because they are privately-owned is strictly forbidden.

Section 3 of the regulations says that, in procuring services, CCGs must

"provide best value for money in doing so."

'Best value', by any genuine and rational definition, is not merely a question of 'lowest price'. Best value for an NHS service should take into account such factors as:

- the benefits of retaining expertise and infrastructure in public ownership
- avoiding the risk to services and skills if a private provider goes out of business or simply decides that it's no longer profitable to continue providing services
- preventing the fragmentation that must inevitably be a consequence of NHS services consisting of a series of private companies rather than a national, integrated body
- many other factors.

But by insisting that decisions 'in particular' cannot take account of ownership, the new regulations effectively strip all of these considerations out of the decision-making process – and turn 'best value' into 'lowest price'. Any attempt to do otherwise will be subject to overturning by Monitor or legal challenge by would-be private providers.

There are other provisions of the regulations which reinforce the right of private providers to be included in any bids, whatever other parts of the new rules might say:

"Award of a new contract without a competition

5.—(1) A relevant body may award a new contract for the provision of health care services for the purposes of the NHS to a single provider without advertising an intention to seek offers from providers in relation to that contract where the relevant body is satisfied that the services to which the contract relates are capable of being provided only by that provider."

So, the softening of one part of the regulations is completely offset by point 5, which says that the only reason a CCG can award services without either issuing a tender or going to the 'any qualified provider' (AQP) marketplace is if there is only one provider capable of providing the service in the first place. Since this would be true of almost no conceivable health services, in effect the regulations mean that all services must be competitively sourced – just without actually saying so in as many words.

Point 7 states:

"a relevant body may not refuse to select a provider that meets the criteria established by the relevant body for the purposes of that decision, except where to do so would mean exceeding a limit set by the relevant body on the number of selected providers."

So, CCGs cannot impose a selection criterion to exclude privately-owned companies – and cannot exclude any companies that meet their selection criteria. This is merely a long-winded way of saying 'private providers must be included'.

The regulations, in one stroke, still rip the NHS wide open to private providers and load the dice in their favour by making cost the only factor. As private providers will not be bound by the fair, national wage structures that NHS providers must adhere to, they will be free to cut wages and numbers to enhance profits while still undercutting NHS providers.

Once again, the government is creating a 'race to the bottom' whose only beneficiaries will be private shareholders.

As a sop to the LibDems and an attempt to deflect criticism and resistance, the new rules contain a new provision that completely contradicts the above regulations. Section 15 states that

"(2) Monitor may not direct a relevant body under paragraph (1) to hold a competitive tender for a contract for the provision of health care services for the purposes of the NHS."

But this is completely contradicted by the earlier points already mentioned and by section 14, which says

"Monitor may declare that an arrangement for the provision of health care services for the purposes of the NHS is ineffective"

if a contract does not meet the conditions outlined above. It goes on to specifically and separately state that contravening item 10.2 is a reason for Monitor to declare a contract award 'ineffective'. Item 10.2 is the section that says that:

"(2) An arrangement for the provision of health care services for the purposes of the NHS must not include any term or condition restricting competition which is not necessary for the attainment of—

(a) intended outcomes which are beneficial for people who use such services"

So, Monitor – the regulatory body – cannot insist that a CCG invites competition for a contract – but it can cancel any contract that is non-competitive (unless the CCG can demonstrate the strict 'necessity' of non-competition for the delivery of a service, which is basically impossible).

The government's original secondary legislation under S75 was criticised for being vague, shoddily written and for forcing CCGs to advance the privatisation of the NHS.

The only substantive change in the amended regulations is that the government uses shoddiness and vagueness to create a minefield that is designed to scare CCGs away from any course of action that does not include private providers – and to tip the scales in favour of those private providers.

Private providers will have deeper pockets than CCGs and will have far less fear of legal expenses. CCGs are intended to feel that their only course is to play safe and include private providers in every tender, because the various contradictions in the revised regulations make it impossible to be sure that any other decision won't be overturned either by Monitor, or in court at significant expense.

True to form, the government is resorting to weasel words, subterfuge and superficial changes to try to defuse opposition enough to get its way.

The intent and the threat of the original legislation has not changed one jot. This revised version is deceptive, unfit for purpose (if the purpose really is the good of patients and public) and must be blocked as a matter of urgency.

I look forward to a House of Lords scrutiny committee decision accordingly!

Yours faithfully,

Steve Walker

Charles West – Written Evidence

I remain seriously concerned by these regulations. In my view the rewrite does almost nothing to address the assurances given repeatedly by ministers from both Houses that Commissioning Groups will be free to commission services in the way that they consider best for their patients.

There continues to be a presumption in favour of putting every aspect of NHS care out to competition. (see clause 5). This will undoubtedly be costly even if no disgruntled providers challenge decisions, and could be catastrophic if some contracts are contested in the courts. (cf West Coast Main Line).

The assurance that it will be Commissioning Groups and not the Secretary of State, nor the regulator that determines how procurement is handled is contradicted by clauses 10, 13 and 15.

The basic drive of these regulations will be to bog down the commissioning process, and even if all the paperwork and negotiations were at zero cost, and even if every contract is let without any disagreement or error the process will inevitably lead to a degree of fragmentation of healthcare delivery.

I fear that these regulations do not deliver what ministers have promised, and if implemented will seriously harm the NHS.

Dr Charles West

Helen Wood – Written Evidence

I have been opposing these regulations as they first came out on the grounds that they do not allow GPs and CCGs to choose the providers on grounds of quality, and, indeed, to choose not to put a service out to tender. The revised regulations seem still to be primarily written to protect private companies in their efforts to make profit from the NHS rather than protecting GPs and CCGs from compulsory competitive tendering. And Monitor still seems to be being established as Big Brother with the CCGs being increasingly emasculated. Given the only honest reason behind the Act is to pass responsibility down to GPs, these regulations appear to show the true intention which is to privatise the NHS. And this from two parties that promised no re-organisation of the NHS, let alone a top down one, in their manifestos before the last election!

However, I have not had time to consider them in detail and believe the timescale given for the public to scrutinise them is absolutely insufficient.

Please take this e-mail as a formal complaint about the process of oversight that is being given to these regulations.

Helen Wood

Template # 1 – Sent by 56 people

I understand that you are looking for submissions regarding the government's 'section 75' secondary legislation. May I add my voice to those asking for a full Lords debate on this undemocratic attempt to force privatisation on the NHS via the new Clinical Commissioning Groups?

I do not intend to provide supporting arguments myself but instead would like to refer you to an excellent blog article – http://ccgwatch.wordpress.com/2013/03/12/revised-section-75-regs-mire-ccgs-in-a-legal-minefield/ – by Steve Walker, written following a careful reading of the government's revisions to SI 257/2013.

It identifies serious concerns with the legislation, which does nothing to change the substance of the original instrument – and in fact uses uncertainty as an additional tool to tie the hands of CCGs to include private bidders for health service contracts.

Template # 2 – Sent by 27 people

I notice that the Lords' Secondary Legislation Committee will be discussing the amended regulations laid by the Government under Section 75 of the new NHS Act 1 at their meeting on 19 March.

I should like to draw to your attention the radical nature of these regulations. During the passage of the Health & Social Care Act through Parliament ministers constantly uttered soothing remarks to the effect that there was no possibility of NHS services being forced to be put to the market, and that the health regulator Monitor would not have powers to enforce such a move. It followed that the NHS would not therefore be subject to EU competition law, and therefore no irrevocable change in its status was being made.

I understand that The Lord Owen has passed to you legal opinion obtained by 38 Degrees that if the Regulations are passed unamended they will break promises made by Ministers last year.

It has been suggested that an amendment along the following lines to Section 14 of the Health and Social Care Act 2012 would help clarify the situation.

"Each Clinical Commissioning Group may arrange for the provision of such services or facilities as it considers appropriate for the health service that relate to securing improvement in (a) the physical and mental health of the persons for whom it has responsibility, or (b) the prevention, diagnosis and treatment of illness in those persons."

This wording could be incorporated into Regulation 2, which should then state that the remainder of the Regulations applicable to CCGs would only apply when a CCG decides that it is appropriate to consider tendering a service or facility to more than one provider.

This amendment would make it absolutely clear that CCGs will be free to commission services int he way they consider best, without having to rely on obscure wording in the current Regulations, that we do not know how it will be interpreted by Monitor.

I hope it is within the terms of reference of your Committee to both recommend the present Regulation be withdrawn and suggest alternativewording for any new Regulation.

I hope you will be able to ensure their Lordships know that these regulations merit special attention so they do not just slip through on the nod.

Template # 3 – Sent by 53 people

I understand that the Lords' Secondary Legislation Scrutiny Committee will be discussing the amended regulations laid by the Government, SI 2013/500 National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013, at your meeting on 19 March.

I request that the Committee send these regulations for reconsideration. The reason is that, despite the amendment, there remains significant disjunction between the public statements of ministers and the content of the regulations.

Ministers said:

- Andrew Lansley MP: "There is absolutely nothing in the Bill that promotes or permits the transfer of NHS activities to the private sector." (13/3/12, Hansard[1])

- Andrew Lansley MP, 12.02.12, letter to Clinical Commissioning Groups: "I know many of you have read that you will be forced to fragment services, or put them out to tender. This is absolutely not the case. It is a fundamental principle of the Bill that you as commissioners, not the Secretary of State and not regulators – should decide when and how competition should be used to serve your patients interests.."

- Simon Burns MP: "...it will be for commissioners to decide which services to tender…to avoid any doubt—it is not the Government's intention that under clause 67 [now section 75] that regulations would impose compulsory competitive tendering requirements on commissioners, or for Monitor to have powers to impose such requirements." (12/7/11, Hansard, c442[2])

- Lord Howe: "Clinicians will be free to commission services in the way they consider best. We intend to make it clear that commissioners will have a full range of options and that they will be under no legal obligation to create new markets…." (6/3/12, Hansard[3])

- Nick Clegg: "That's why I have been absolutely clear: there will be no privatisation of the NHS. The NHS has always benefited from a mix of providers, from the private sector, charities and social enterprises, and that should continue... It's not the same as turning this treasured public service into a competition-driven, dog-eat-dog market where the NHS is flogged off to the highest bidder." 26/5/11[4]

The regulations say:

We would like to focus on three in particular.

10(2) An arrangement for the provision of health care services for the purposes of the NHS must not include any term or condition restricting competition which is not necessary for the attainment of—

(a) intended outcomes which are beneficial for people who use such services; or

(b) the objective referred to in regulation 2.

This is highly restrictive. It will be almost impossible for commissioners to demonstrate that avoiding competition is essential for patient benefit, or at least to feel confident that it can do so to the satisfaction of the unaccountable Monitor that will be interpreting these regulations

5.—(1) A relevant body may award a new contract for the provision of health care services for the purposes of the NHS to a single provider without advertising an intention to seek offers from providers in relation to that contract where the relevant body is satisfied that the services to which the contract relates are capable of being provided only by that provider.

This is also highly restrictive. There will be very few situations where only one provider could provide services or where commissioners feel able to demonstrate that this is so. It may be more helpful to add the phrase "…only by that provider, effectively, safely and in the public interest."

The effects of these clauses will be to ensure that CCGs, if they do not want to go through the competition route, will always be concerned that they will be attacked by Monitor or legally challenged by a private provider and therefore will lead to more competition and contradict assurances.

15(e) to vary an arrangement for the provision of health care services for the purposes of the NHS to remedy a failure to comply with regulation 10;

15(2) Monitor may not direct a relevant body under paragraph (1) to hold a competitive tender for a contract for the provision of health care services for the purposes of the NHS.

These appear contradictory. 15e gives wide powers to Monitor to enforce the "one provider" ruling. This could include, presumably, putting pressure of various kinds on a CCG to ensure a competitive tender was used. In addition, the term competitive tender appears to exclude the process of Any Qualified Provider which Monitor could still insist a CCG used – another way of enforcing competition. This is another way in which ministerial assurances are being contradicted.

The implications of ministerial statements is that CCGs will be free to choose which procurement route they decide is best – a permissive, positive approach. These regulations still constrain freedom of action to very unusual circumstances or very restricted activities or possibly those in which the private sector has no interest. This is quite the opposite of the intention as expressed by ministers.

This is the view of Dr Dixon, interim president of NHS Clinical Commissioners which represents over half of CCGs. He said of the amended regulations:

‘There is a danger that it still leaves open the possibility that a clinical commissioner who wants to contract with a good local provider with a strong track record, who is signed up to the aspirations of the commissioner, and is providing a good service close to people’s home, might still have to offer that service to someone else as part of a competitive tender or part of AQP.’

We urge you to require that the regulations be revoked and rewritten.