Securing best value for NHS patients

Annex: Analytical narrative and call to evidence for proposed changes to Commissioning Regulations

Introduction

This document is intended to inform our consultation on ‘Securing best value for NHS patients: Requirements for commissioners to adhere to good procurement practice and protect patient choice’ (‘‘the consultation document’’). It sets out the intended impact of our proposals and alternative options

The consultation document set out proposals for Procurement, Choice and Competition regulations to be made by the Secretary of State under section 75 of the Health and Social Care Act 2012 (‘‘the Act’’). The proposed regulations would impose requirements on the NHS Commissioning Board and clinical commissioning groups in relation to their commissioning of healthcare services.

The overarching aim is to ensure that NHS services are commissioned from providers best able to meet patients needs and to serve best value for taxpayer’s money.

The proposed requirements are, to a large extent, a transfer of the existing rules, requirements and guidance that apply to existing organisations - Primary Care Trusts (PCTs) - to those in the modernised health system – Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board.

While this is not a formal impact assessment at this stage, it follows the same structure – namely the reasons why Government intervention is necessary, what the proposed changes are (as well as options being considered), and what the likely impact will be. As part of the consultation process, it asks respondents to provide information to describe benefits, costs and risks in more detail, including quantification if possible. We will publish a full impact assessment in due course, after laying the regulations.

Next steps

The consultation closes on 26 October 2012. The primary purpose of this document is to inform responses to consultation by setting out the intended impact of our proposals and to invite views on that assessment as part of a ‘call for evidence’. The Government will then put forward final proposals in response to this consultation alongside a further impact assessment for Parliament’s consideration in the New Year.

Problem under consideration

As set out in 'Equity and Excellence: Liberating the NHS'1 the NHS Commissioning Board (NHSCB) and CCGs will be responsible for securing best value for NHS patients through their control of over £80 billion of annual public expenditure. They will need to use this finite funding as effectively as possible, and commissioners will need to respond to growing pressures on services. For example, with rising life expectancy, the proportion of older people will increase. The prevalence of long-term conditions is also increasing, partly as a result of increasing obesity levels and alcohol-related illnesses. New drugs, treatments and technologies can deliver huge advances but also additional costs. All of these factors, and more, contribute to the upwards demand pressures on the NHS.

As set out in the consultation document, it will be for commissioners to determine the service they require to meet the needs of their populations. They will have flexibility in how they secure services including managing providers' performance, extending and varying contracts, widening choice of qualified provider, and tendering for new contracts. Local conditions vary and there is no one-size-fits-all model for raising standards. However, the onus is on commissioners to be able to demonstrate the rationale for their decisions, in terms of best value for patients having considered all available options.

Although commissioners will have flexibility, we need to ensure commissioners operate within a framework of rules so that they secure the best services for patients and deliver best value from their £80 billion budget. This is because commissioners may not be under the same incentives as the whole system to ensure best value for patients and future patients2. In particular:

1) Commissioners will need to continuously review that the services they commission deliver best value for money for patients and taxpayers, rather than defaulting to existing contracts and providers.
2) Commissioners may have close working relationships with providers. This is certainly to be encouraged, for example to encourage innovation and new ways of working. However, commissioners should continue to ensure that the providers are delivering the best value for patients and for the taxpayer.
3) Commissioners may be under incentives to commission services from themselves as it helps to ensure financial balance or benefit, whereas this may not be in the best interests of patients and future patients.

Therefore, it is crucial commissioners carry out an objective assessment of different options and a rigorous evaluation of different providers in order to meet the challenges the NHS will face in the future. The Department also needs to ensure that commissioners act proportionately when procuring NHS services.

There is some evidence that this has not always been the case. For example, the NHS Future Forum drew attention to bureaucratic processes which failed to secure the best deal for patients. At best, this may result in unnecessary costs to providers participating in procurement

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
[2] including ultimately taxpayers

processes, but at worst it can skew decisions away from best value to the detriment of patients.

In addition, the Cooperation and Competition Panel's report into the implementation of Any Qualified Provider3 made clear that commissioners in the past have restricted patient choice and competition to the detriment of patient interests.4

The Department therefore needs to maintain minimum standards of transparency and governance in decision-making. The policy aims to ensure that commissioners of NHS services can be held to account for their decisions and can demonstrate that they have duly considered the available alternatives, based on objective criteria, and have then selected the best provider to meet the needs of their patients.

[3] This report is available at http://www.ccpanel.org.uk/content/cases/Operation_of_any_willing_provider_for_the_provision_of_routine_elective_care_under_free_choice/280711_AWP_Review_Final_Report.pdf. The policy was originally described as *'Any Willing Provider'*, hence the title of the report.

[4] For example, http://www.ccpanel.org.uk/cases/NHS_Wiltshire_Conduct_Complaint.html

Rationale for Government intervention

PCTs are currently subject to existing regulations, requirements and guidance about how they commission healthcare services to ensure best value for patients and to protect their interests.

In addition to the Public Contract Regulations with which PCTs are required to comply, existing sector specific requirements are set out in the Principles and Rules for Cooperation and Competition5 and within the Procurement Guide for commissioners of NHS funded services6. These form part of the NHS Operating Framework7. PCTs and Strategic Health Authorities (SHAs) are expected to follow the requirements, the guidance and the principles set out in these publications. The current rules provide commissioners with a health-specific framework to ensure they are compliant with wider EU and UK procurement law. These have been in place for several years and are well understood by commissioners and providers active in the system.

As set out in the Act8, PCTs are being abolished and commissioning functions will be undertaken by CCGs and the NHSCB. As the current arrangements only apply to the existing commissioning organisations, in the absence of any sort of intervention the existing regulations, requirements and guidance will cease to have effect in April 2013 when PCTs and Strategic Health Authorities (SHAs) are abolished. This would mean that the commissioning of services by CCGs and the NHSCB would no longer be subject to sector-specific oversight to ensure best value for patients .

We would consider this to be a retrograde step. This may lead to sub-optimal decisions, and would make it harder to hold commissioning organisations to account for decisions they make – this is set out in more detail below. Furthermore, without sector-specific safeguards that ensure decisions on expenditure for clinical services are transparent, proportionate and fair, commissioning may not be optimal or efficient, and public confidence in the system may be damaged.

[5]http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118221
[6]http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118218
[7]http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360
[8] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

Policy objective

Consistent with the Act, the specific aim for the proposed Procurement, Choice and Competition regulations is to ensure transparency and openness in assessing process and to promote best value for patients by:

- raising standards in procurement practice by commissioners, including requirements to act transparently, avoid discrimination and purchase services from the providers best placed to meet patients' needs;
- protecting patients' rights to choose as set out in the NHS Constitution;
- prohibiting commissioners from taking actions which unnecessarily restrict competition against patients' interests;
- ensuring that commissioners manage conflicts of interest, ensuring that particular interests do not influence their decision-making;
- conferring enforcement powers on Monitor so that action can be taken in the event the regulations are breached.

These are the criteria and the objectives against which the proposed policy options must be assessed.

Options appraisal

Three broad options have been considered to regulate commissioners' actions;

1) Do nothing
2) New principles and rules-based regulations – supported by substantive guidance (preferred option)
3) New explicit rules-based regulations – supported by minimal guidance

Discussion on impacts

1) Do nothing.

This would mean that the existing rules, requirements and guidance that apply to PCTs and SHAs would cease to exist as the organisations are abolished. We would consider this to be a retrograde step. For example, protections for patient rights to make choices, and prohibitions against anti-competitive behaviour would no longer be enforceable.

In addition, commissioners would potentially face higher costs associated with legal support services and compliance advice because the only regulations applicable would be procurement law and through the courts.

2) New principles and rules based regulations – supported by substantive guidance (preferred option)

The preferred position in the consultation document is to retain the existing principles and rules, to which commissioners are required to comply and place them on a firmer statutory footing. This corresponds to the Government's response to the recommendations of the NHS Future Forum. Monitor would enforce the rules and would have power to direct remedial action and, as a last resort, set aside contracts to address breaches of the regulations.

This option closely replicates the current position. It aims to give commissioners greater flexibility than simply a rules-based approach (as set out in option 3), whilst ensuring that commissioners can be held to account for their decisions.

This is the preferred option as it gives greater flexibility to commissioners to decide how best to use choice and competition as levers for improving services. It also gives more scope to address issues that are difficult to legislate for, or that have not yet been anticipated as problematic prior to the establishment of the new regulatory regime. In addition, to mitigate compliance costs the principles enshrined in the regulations will be supported by detailed guidance from Monitor on how to comply with the regulations and Monitor's approach to enforcement action. This would be more proportionate than a one size fits all approach, which could be overly bureaucratic and potentially undo the benefits of the regime.

The NHSCB has a statutory role under the Act to support commissioners in the procurement process. They intend to publish specific guidance on the regulations, for example on procurement practice and the management of conflicts of interest. By supporting the regulations with substantial guidance some additional compliance costs may be created, but this is anticipated to be offset by greater clarity expected behaviour and good practice . This approach is intended to give commissioners greater confidence in taking decisions and would allow for the NHS CB to update its guidance from time to time to reflect lessons learnt and promote developments in good practice.

It is possible that by putting rules on a firmer statutory footing, through secondary legislation, could effect behaviours among commissioners that may not have been the case with the existing rules, both with this option and for option 3. It is very difficult to quantify such

behavioural costs at this stage of engagement and the Department is aiming to present further analysis, including quantification of effects if possible, in the impact assessment after assessing relevant responses to this consultation. This will be published alongside the regulations.

3) Prescriptive rules-based approach – supported by minimal guidance

While option 2 is the preferred policy option at this stage, the alternative of more detailed regulations that relate to specific activity has also been considered. The benefits of this approach would be greater clarity for commissioners as to explicit obligations under the regulations as well as clarity on the costs associated with compliance. This may reduce the extent to which more detail guidance was required, but would significantly reduce the level of flexibility.

There are certain disadvantages to this approach First, it is anticipated that the compliance costs associated with this approach may be higher, especially in the short term. Although commissioners would have more certainty, they would also be relatively unfamiliar with this approach and one of the main benefits of the preferred option is that it is very similar to the current rules, requirements and guidance and is simply replicating this on a statutory footing.

It is also difficult, in practice, to draft more specific rules of this kind without increasing the risk of unintended consequences which may reduce the flexibility commissioners have to act to improve services for their patients. For example, one option we considered, is a more rules-based approach specifying a “blacklist” of anti-competitive behaviours which would always, given their nature, be against patients’ and taxpayers’ interests, for example where commissioners were to restrict the number of providers for patients in a geographical area. However, in most scenarios discussed during engagement, there was at least some scope for the behaviour to be justified in limited circumstances as patients could potentially benefit, for example where it was necessary to limit the numbers of providers to ensure efficient and sustainable provision of services. Therefore, an approach that relies on principles where the effect of commissioning decisions must be proved (as in option 2) has the potential to be the most cost-effective option. However, there is a balance to be struck, and the Department has sought views on this in the consultation.

Additional impacts

There are further impacts that are likely to result from the proposed changes. For example, commissioners searching for best value for money may result in more providers entering the market, which could have longer-term benefits through increasing incentives for providers' services to be high-quality and low-cost, otherwise patients will choose to go elsewhere. As with the benefits and costs previously described, these are not possible to quantify at this stage, if at all. Furthermore, these impacts are mostly across sector regulation policy in general – and it is unlikely to be possible to state the extent to which they apply specifically to this policy.

Groups affected

Commissioners: will be subject to the regulations and enforcement by Monitor. However under the preferred options the principles and rules would largely replicate what is currently in place for PCTs.

NHS providers: will benefit from greater transparency in commissioning and fairer procurement. Providers may also be affected by potentially increased competition.

Small and Medium Enterprises: voluntary sector organisations and private sector organisations: will also benefit from greater transparency in commissioning and fairer procurement. There will also be a more consistent approach to enforcement and regulations to avoid distractive and disproportionate procurement requirements.

Patients: should benefit from ensuring that services commissioned are those that are best capable of meeting their needs. Patient rights to choice are also protected.
The public: should benefit from a system which helps to ensure best value for money, and therefore best value for taxpayers.

Enforcement and deterrent effect

A regulator with statutory investigation and enforcement powers, as Monitor would be, can lead to greater benefits in terms of deterring unfair and exclusionary forms of procurement that result in deadweight loss to patients and the taxpayer. In the wider economy, for example, the Office of Fair Trading operates at least a 5:1 benefits ratio of its interventions, which could be viewed as analogous to the interventions of Monitor. Moreover, its independent evaluations have quantified this more recently as being of nearer 8 times the cost of its interventions. 9

[9] http://www.oft.gov.uk/shared_oft/reports/Evaluating-OFTs-work/oft963.pdf and http://www.oft.gov.uk/shared_oft/reports/Evaluating-OFTs-work/oft1428.pdf

Background material

The table below sets out the rules, regulations, requirements and guidance to which commissioners are currently subject. These are split into the 4 broad areas covered by the proposed regulations, and there is an additional section looking at enforcement. The third column in each table sets out what the proposed position is under the section 75 regulations, set out in the accompanying consultation document to which this IA relates.

Area	Current position	Proposed position under the Procurement, Choice and Competition Regulations
Choice	Requirements for PCTs to arrange patient rights to make choices set out in Directions from Secretary of State (SofS) and through the Principle and Rules for Cooperation and Competition (PRCCs)	Requirements for CCGs and NHSCB to arrange patient rights to make choices maintained through the Standing Rules. Enforced through the procurement, choice and competition regulations.
	Regulations setting terms of GP contract including requirements in relation to registering with a practice.	Regulations expected to continue in 2013/14. Requirements enforced through the procurement, choice and competition regulations.
Procurement	Public Contract Regulations 2006 apply to PCTs.	Public Contract Regulations 2006 apply to NHSCB and CCGs
	Sector specific requirements imposed on PCTs by SofS / DH through (non-legal) NHS Operating Framework, including the Principles and Rules for Cooperation and Competition (PRCC) and the Procurement Guide for commissioners of NHS funded services.	Sector specific requirements for NHSCB and CCGs set by SofS through regulations, and guidance on procurement from NHSCB to CCGs
Prohibitions on anticompetitive behaviour	Sector specific prohibitions for PCTs set out in the PRCC (Administrative controls – i.e. non-legal)	Sector-specific prohibitions for CCGs and NHSCB set out in regulations.
	Competition law –The Competition Act 1998 does not generally apply to purchasing	Competition law – The Competition Act 1998 does not generally apply to purchasing

Area	Current position	Proposed position under the Procurement, Choice and Competition Regulations
Managing conflicts of interest	SofS / DH imposed requirements to manage conflicts of interest when commissioning services through PRCC and Procurement Guide (Administrative Controls – non-legal)	Requirements for CCGs to manage conflicts of interest set out in the Health and Social Care Act 2012. Regulations provide for address by the regulator in an individual case
Enforcement action	Investigation by the Cooperation and Competition Panel (CCP) of potential breaches of the PRCC	Investigation by Monitor of potential breaches of the regulations
	Advice to SofS, and enforcement to comply with the PRCC by SofS and Strategic Health Authorities (SHAs)	Enforcement to comply with the regulations by Monitor

While some of these changes are nominally an increase in regulations to which commissioners will be subject, this is currently achieved through the NHS Operating Framework. While the Operating Framework does not have legal status, PCTs are required to comply with it and it is the key document for setting the rules for the system on performance and behaviour. Therefore, in practice commissioners comply with the Operating Framework requirements as they would do requirements set out in regulations. So, while this is nominally an increase in regulations on commissioners, who are public sector organisations, in terms of what commissioners will actually need to do as a result this is not considered to be an increase. Alternatively, the response by commissioners could be substantially different than that of PCTs and the behavioural impact will be greater.

Supporting evidence, and benefits, costs and risks of specific options (including administrative burden of each)

This section briefly summarises the proposed approach to each of the broad areas set out in the table above, describing the current situation and the preferred option, including what options have been considered (where appropriate).

Procurement

Specific Options	Main Costs	Main Benefits
Do nothing	• Uncertainty for commissioners through absence of sector specific requirements for healthcare procurements. • Increased costs as enforcement action could only be taken through the courts rather than by a sector specific regulator under the regulations.	• Lower compliance burdens on commissioners.
Broad principles, supported by specific guidance (preferred)	• The broader the regulations are, the higher the potential compliance costs and chance for poor compliance.	• Allows guidance to develop gradually and informs proportionate decisions by the regulator, to help ease compliance costs.
Prescriptive rules for health sector	• Combination of prescriptive rules and greater statutory basis for rules means higher compliance costs. • Prescriptive rules could be misplaced and build wrong incentives to system.	• Would give greater certainty to commissioners from day one.

Call for evidence

The Department is keen to receive more information on the impact of certain behaviours that may be considered poor procurement practice. For example, Commissioners may have constructed contracts to favour a particular type of supplier without objective rational. Specifically, commissioners may continually roll over annual contracts, instead of offering a longer more contestable contract to potential providers. This could reduce incentives to compete where competition is beneficial. On the other hand we are keen to understand where disproportionately large or costly tender exercises impacts on scarce administrative resources.

Competition

Specific Options	Main Costs	Main Benefits
Do nothing	• No direct enforcement mechanism to deal with anti-competitive behaviour. • Higher costs associated with a reduction of beneficial competition in appropriate services.	• Lower compliance burdens on commissioners
A broad principle, with patient benefits exemptions. Supported by specific guidance (preferred)	• The broader the regulations, the more compliance costs and chance for poor compliance.	• Allows guidance to develop gradually and inform proportionate decisions by regulator and ease compliance costs. • Provides a clear way for commissioners to demonstrate that restrictions on competition can be justified where indispensable to achieving desired patient benefits.
Prescriptive competition rules with “blacklisted” behaviours	• Greater statutory basis for rules means higher compliance costs. • Prescriptive behaviours could be misplaced and build wrong incentives to system. • Difficult issues to prescribe and subsequently exempt if necessary.	• Would give greater certainty to commissioners from day one. • Behaviours would be familiar to commissioners where previously addressed by the CCP.

Call for evidence

The Department is keen to receive more information on the impact of certain behaviours that may be considered anti-competitive. For example, commissioners may bundle individual contracts together for commissioning purposes. This may impact on smaller provider ability to compete with larger providers who have the scope to provide a wider scale and scope of services.

Choice

Specific Options	Main Costs	Main Benefits
Do nothing	• No direct enforcement mechanism for Monitor may lead to non-compliance/poor compliance. • Insufficient protection of patients rights to choice.	• None.
Specific requirement to protect patient rights to make choices. (preferred)	• No specific role to address lack of progress, against the interests of patients, in enabling the further choice.	• Protects core rights to choice while retaining greatest flexibility for commissioners to develop local choice offer.
Specific requirement to protect rights to make choices plus further requirements in relation to the extension of choice beyond these rights.	• Could impose additional bureaucracy and limit commissioners' flexibility to decide where to extend choice. • Could lead to confusion and overlap between statutory duties on CCGs to act with a view to enabling choice. • Duplication between the role of Monitor and the NHS CB in providing oversight of commissioners' duty as to choice. • It could also create perverse incentives not to introduce choice for fear of future challenge.	• Would allow focused action to be taken where commissioners were taking no action to develop the choices their patients have.

Call for evidence

The Department is keen to receive more information on the impact of certain behaviours that may be considered to prevent patient choice. For example, the extent to which commissioners may attempt to restrict the operation of choice where it is a constitutional right or the impact of commissioners failing to extend patient choice.

Managing conflicts of interest

Specific Options	Main Costs	Main Benefits
Do nothing	• Inadequate protection of patients and taxpayers through lack of independent investigation and enforcement action in individual cases.	• Commissioners may face some reduction in compliance costs
Provide a focused role for Monitor to take action where a contract has been awarded as the result of a conflict of interest. (preferred)	• Additional costs of compliance.	• Does not duplicate statutory governance requirements to manage conflicts. • Allows greater flexibility for commissioners supported by guidance by the NHS Commissioning Board. • Individual cases can be investigated independently and enforcement action taken.
As above but in addition introduce further specific governance requirements through the regulations.	• Likely to be duplicative with the existing statutory requirements and gives rise to additional compliance costs. • Reduces flexibility for commissioners to put in place robust governance arrangements tailored to local circumstances.	• Would provide greater clarity for commissioners on the specific actions they must take, for example in relation to services previously delivered through local enhanced service arrangements.

Call for evidence

The Department is keen to receive more information on the impact of certain behaviours that arise from conflicts of interest that clinical commissioning groups may have. In particular, where services are commissioned by CCGs whose members also provide those services as well as other providers.

Risks and assumptions

This IA covers a subset of the overarching changes to provision that were set out in the Act and its accompanying impact assessments. It provides more detail about the proposed changes to the regulations that apply to commissioners to ensure that they act in patients' best interests.
This does represent additional regulation for CCGs over and above what PCTs currently face. As set out above, this may be an increase in nominal regulation but in terms of the requirements on existing commissioners this is not expected to be an increase given PCTs expected compliance with the NHS Operating Framework.

The proposals put forward in the accompanying consultation documents only apply to the public sector organisations (i.e. the NHSCB and CCGs) and not businesses. The proposals maintain an approach to securing the best capable providers to deliver services to the NHS. The proposals, therefore, maintain opportunities for the best provider, whether from the public, private or voluntary sectors to succeed and strengthen incentives for providers to improve their service offer.