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Securing best value for NHS patients

*Requirements for commissioners to adhere to good
procurement practice and protect patient choice*

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1. Introduction

- 1.1. The reforms introduced by the Health and Social Care Act 2012 (the Act) place patients at the heart of the NHS and lay the basis for a health service which achieves world-class outcomes – one which provides better information, offers patients more involvement and greater choice, develops more responsive services and delivers higher safety, quality and value for money.
- 1.2. We are establishing a new NHS Commissioning Board (the Board) and empowering clinical commissioning groups - the professionals closest to local patients - to commission the best services for their populations. Within these groups, GPs and other experts will use clinical insight and local knowledge to improve services. They will decide how to use resources, where to give patients more say over their care and treatment through greater choice, where to harness competition, and how to develop more integrated care.

The challenges facing the health and social care system

- 1.3. The Board and clinical commissioning groups 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.
- 1.4. Commissioners will need to respond to growing pressures on services. With rising life expectancy, we need to support growing numbers of older people with long-term conditions. Changes in lifestyles including higher rates of obesity and alcohol consumption mean higher levels of diabetes, arthritis and liver disease. New drugs, treatments and technologies can deliver huge advances but also additional costs.
- 1.5. At the same time, patients have rising expectations regarding the range, quality and responsiveness of services. Patients rightly expect to have greater involvement in decisions about their care and increasing choice of treatments and providers.
- 1.6. Commissioners will need to tackle these challenges with limited budgets in a demanding environment. The NHS has always been a cash-limited system which, rightly, allocates resources in patients' overall interests and provides care based on clinical need rather than ability to pay. The Government has protected the NHS budget and is continuing to increase it in real terms. Nevertheless, given the current fiscal situation, the NHS is facing one of the tightest funding settlements in its history.
- 1.7. In short, commissioners' most important task will therefore be to secure best value from limited resources. Commissioners will need to find ways to do more with their budgets. Simply doing the same things in the same way will not be affordable in future. They will need to harness new ways of delivering care and secure the best value services from

the most efficient providers. Failure to meet these challenges would inevitably mean reduced access to services, poorer quality and growing dissatisfaction with the system.

Delivering best value

- 1.8. We want commissioners to have flexibility to decide how best to respond to these challenges. It will be for commissioners to determine the services they require to meet the needs of their populations. They will engage with patients and the public in developing commissioning plans for local services¹.
- 1.9. It will also be for commissioners to decide how best to secure and improve these services. Commissioners can use a range of tools, including managing providers' performance, extending and varying contracts, widening choice of qualified provider, and tendering. They will need to choose the right tools for different circumstances. Local conditions vary and there is no one-size-fits-all model for raising standards.
- 1.10. However, we need to ensure that 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. For example, we need to ensure that commissioners always carry out an objective assessment of different options and a rigorous evaluation of different providers. There is some evidence that this has not always been the case. For example, the NHS Future Forum pointed to missed opportunities to tender when this could have helped to secure better services for patients².
- 1.11. We need to ensure that commissioners act proportionately when procuring NHS services. For example, our engagement with stakeholders suggests that commissioners can sometimes set disproportionate or inappropriate criteria for evaluating different options. The NHS Future Forum also 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 processes, but at worst it can skew decisions away from best value to the detriment of patients.
- 1.12. We need to maintain minimum standards of transparency and governance in decision-making. Commissioners will be responsible for the use of substantial public funds. We want to ensure that they can be held to account for their decisions and can demonstrate that they have duly considered the available alternatives, based on objective criteria.
- 1.13. Our overarching aim for the procurement rules is to ensure that commissioners select the providers best able to meet these requirements. The rules will therefore primarily govern matters of due process in determining who should deliver services, rather than the clinical or other specifications of what is provided.

¹ Section 26 of the Act sets out requirements for commissioners to prepare commissioning plans. The NHS Commissioning Board is expected to provide guidance to support commissioners in developing their plans.

² ["Choice and Competition: A report from the NHS Future Forum"](#), June 2011

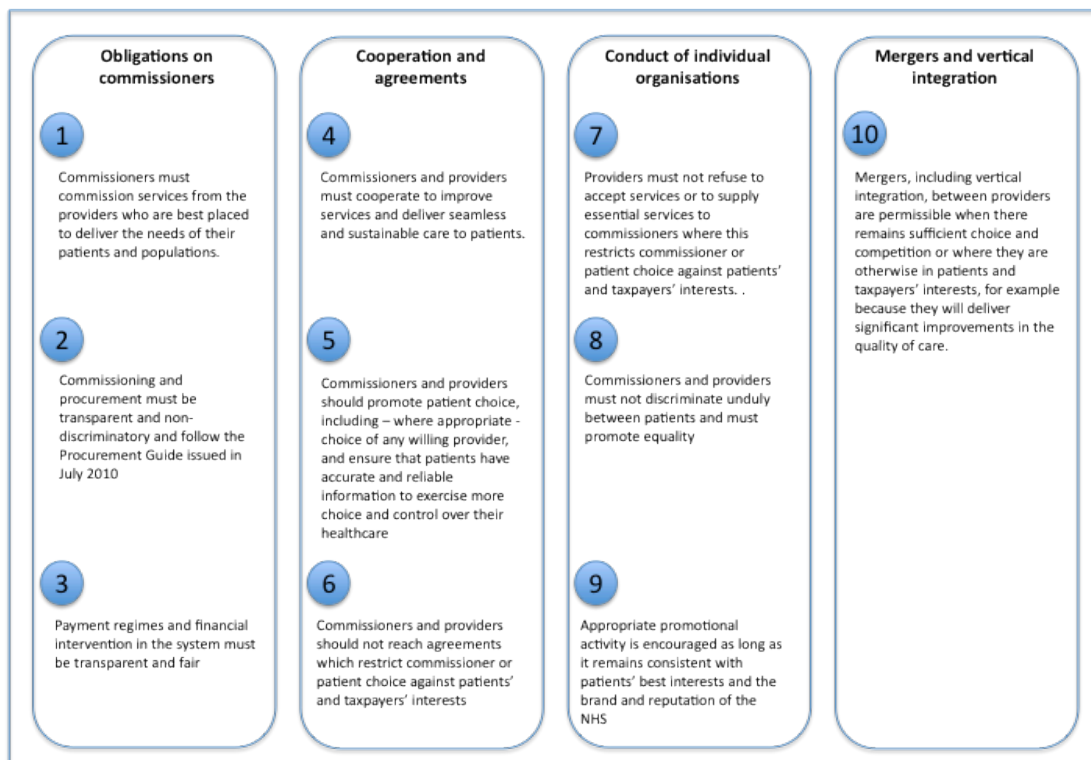
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- 1.14. We also need to ensure that commissioners deliver the rights that patients have to make choices, as set out in the NHS Constitution.

The current administrative rules

- 1.15. The previous administration recognised the need to set rules to ensure that commissioners secure best value services for their patients. Since 2007, the Department of Health has required commissioners to comply with a set of administrative rules, the *Principles and Rules for Cooperation and Competition*³, which include obligations to purchase the best services, to protect patients' right to choice and to use procurement, competition and other tools effectively to improve services.
- 1.16. Since 2009, commissioners have also been required to comply with the *Procurement Guide for Commissioners of NHS Funded Services*⁴, which includes more detailed requirements to ensure best practice in procurement. For example, it requires commissioners to engage with different providers and hold open tendering processes where appropriate, so that they can compare organisations and select the best possible services for patients.

Figure 1: Principles and Rules of Cooperation and Competition



³ [“Principles and Rules of Cooperation and Competition”](#), Department of Health, July 2010

⁴ [“Procurement Guide for commissioners of NHS Funded Services”](#), Department of Health, July 2010

Putting the rules on a firmer, statutory footing

1.17. The content of the current 'Principles and Rules' provide a reasonable framework for ensuring that commissioners work in patients' interests to deliver best value. However, we will not be able to enforce non-statutory, administrative rules in the reformed system, where commissioners and other organisations have greater autonomy within a legislative framework. We need to put the rules on a statutory footing so that they are binding on the new commissioning organisations. We also need to establish appropriate arrangements for investigating potential breaches of the rules and ensuring compliance. Failure to do so would be a step back, withdrawing important safeguards to protect patients' interests.

Our proposals for regulations

1.18. This consultation therefore invites comments on proposals for regulations for the Board and clinical commissioning groups under Section 75 of the Act. Like the current rules, they will establish minimum requirements for good commissioning, ensuring that commissioners are accountable for their decisions. We have grouped these requirements into four sections as follows:

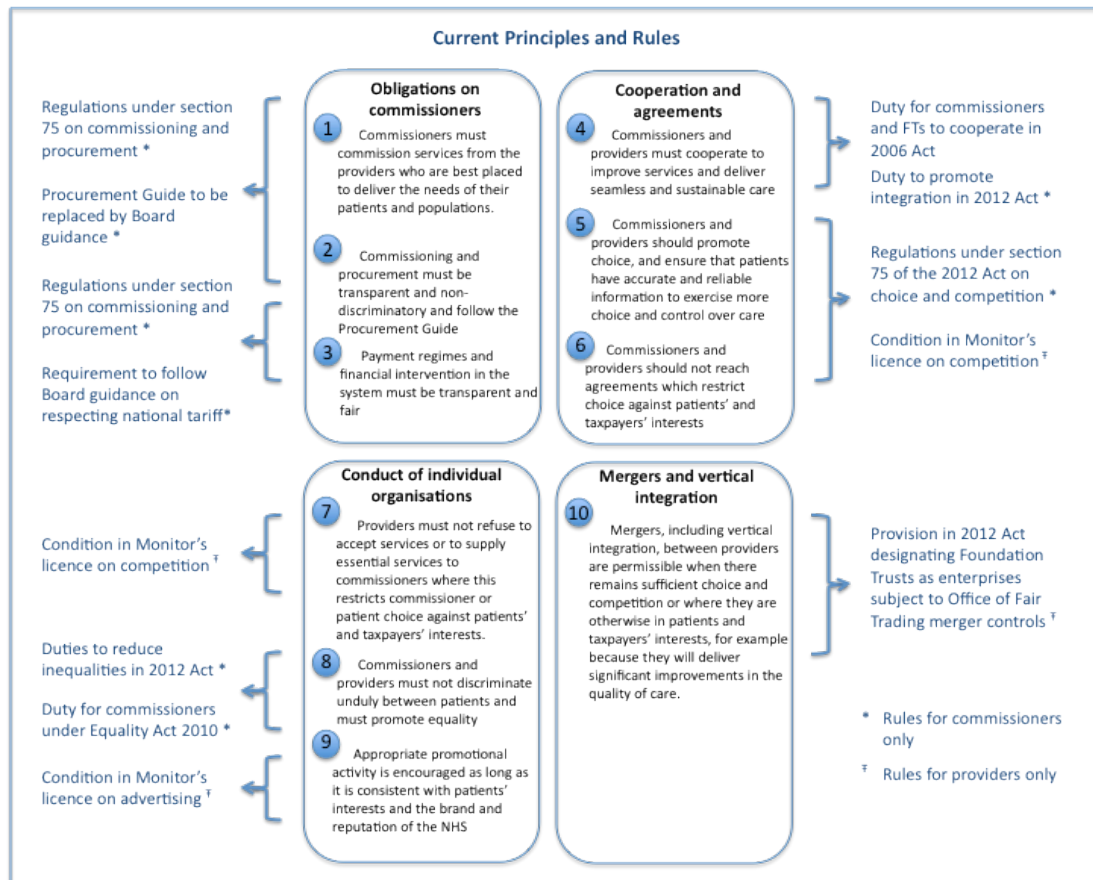
- Procurement
- Patient Choice
- Anti-competitive conduct
- Managing conflicts of interest

1.19. We have taken the existing Principles and Rules as our starting point rather than introducing fundamentally different obligations (see Figure 2 below). Like the current rules, we are proposing to set broad requirements for commissioners to secure best value for their patients, to use the best providers and to harness choice and competition, where appropriate, to raise standards.

1.20. Like the current rules, we are not proposing to prescribe the circumstances in which commissioners should introduce tendering, extend patient choice or harness competition. Commissioners need to decide how best to improve services rather than pursuing choice, competition or other levers as an end in themselves. However, commissioners should always follow transparent, rigorous processes as a necessary step in securing best value and they should always be able to objectively justify their decisions.

1.21. As now, commissioners must continue to take their decisions in accordance with the requirements of UK and EU procurement law.

Figure 2: Current and future rules on choice, competition and cooperation



Monitor's role

- 1.22. In the reformed system, Monitor will act as an independent regulator for the health sector, with a primary duty to promote the provision of economic, efficient and effective healthcare for the benefit of patients. As a specialist regulator, Monitor will have an in depth understanding of the unique features of health services, including the importance of cooperation through clinical networks and the benefits of integrating services to improve quality of care⁵.
- 1.23. Monitor will be responsible for enforcing the regulations, alongside its other functions including licensing providers, setting national tariff prices and protecting patients' access to services. Monitor's role will be to investigate potential breaches of the regulations and take action where commissioners are acting against patients' interests.
- 1.24. It would not be Monitor's role to dictate where commissioners should introduce competition or patient choice of any qualified provider locally. Instead, Monitor's role would be to investigate whether commissioners have respected due process,

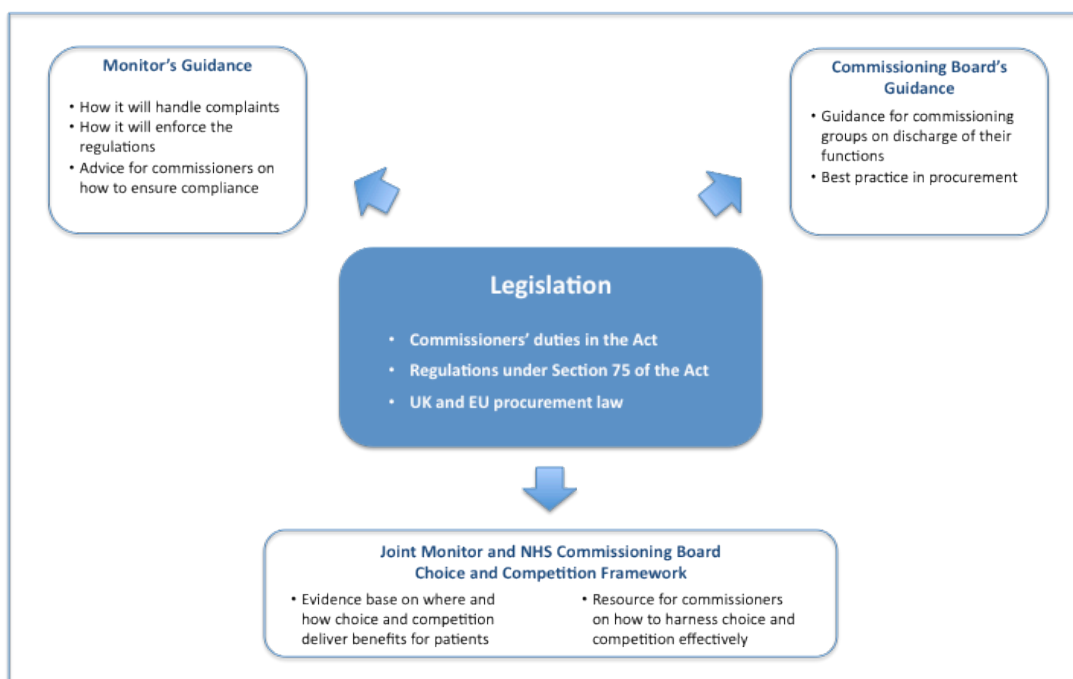
⁵ For more information on the new regulatory framework, see "[Sector Regulation: a short guide to the Health and Social Care Bill](#)", Department of Health, 23 February 2012.

considered the full range of options and made objective decisions on how to commission services in patients' best interests, including through using competition.

Guidance for commissioners

- 1.25. Under Section 78 of the Act, Monitor has a statutory duty to consult on and publish guidance on how commissioners can ensure compliance with the regulations and how it intends to exercise its investigative and enforcement powers. This will be an important source of information for commissioners on how to ensure that they comply with the regulations. It will provide much more detailed information on how commissioners should assess their conduct and the types of behaviour which are likely to be prohibited.
- 1.26. The Board will play a key role in supporting clinical commissioning groups to achieve excellence in procuring local services. While the regulations will set minimum requirements, the Board will provide separate guidance to clinical commissioning groups on best practice in procurement. The Board is currently working with Monitor to produce a choice and competition framework which will help inform commissioners' decisions.

Figure 3: Guidance to support commissioners



This consultation document

- 1.27. The purpose of this consultation is to invite comments on the five main sections of the future regulations:
- Section 2 sets out proposed requirements to ensure good procurement practice including requirements to act transparently, avoid discrimination and purchase services from the providers best placed to meet patients' needs;
 - Section 3 presents proposed requirements to ensure that commissioners enable patients to exercise their rights to choose as set out in the NHS Constitution;
 - Section 4 presents proposed requirements prohibiting commissioners from taking actions which restrict competition where this is against patients' interests;
 - Section 5 sets out proposed requirements to ensure that commissioners manage conflicts of interest, ensuring that particular interests do not influence their decision-making;
 - Section 6 outlines Monitor's proposed investigative and enforcement powers.

Next steps

- 1.28. We welcome responses to the consultation by 26 October 2012. We will take account of responses before developing regulations based on these proposals to be laid in Parliament in January 2013 and to come into force in April 2013. We will be publishing an impact assessment for the proposals early during the consultation period. Monitor will consult separately on its draft guidance on how it will enforce the regulations.
- 1.29. Further details on how to respond to this consultation are set out in the Annex: "How to respond to the consultation".

Full List of Consultation Questions

We would welcome responses to the following questions on the regulations as well as any additional comments that you would like to make:

Procurement

- Do you agree that we should establish broad principles for good procurement practice in the regulations, rather than setting more prescriptive procedural rules?
- Do we need to introduce any additional safeguards to ensure that commissioners comply with good procurement practice?
- Could the proposals have any perceived or potential impact on equality including people sharing protected characteristics under the Equality Act 2010?

Patient choice

- Do you agree that the regulations should protect patients' rights to exercise choice as set out in the NHS Constitution?
- Are there any further safeguards that should be established through the regulations or elsewhere to protect the extension of choice?

Anti-competitive conduct

- Do you agree that we should adopt an effects based approach to assessing restrictive conduct by commissioners, rather than assuming that conduct which restricts competition is automatically against patients' interests?
- What can the Department of Health, NHS Commissioning Board and Monitor do to ensure that commissioners understand the requirements so that they can effectively 'self-assess' whether or not their conduct falls within the rules?
- Are there particularly problematic behaviours which we should address specifically, for example in the requirements or in Monitor's guidance for commissioners?

Conflicts of Interest

- Do you agree that the Act and proposed requirements impose sufficient safeguards to ensure that commissioners manage conflicts of interest appropriately?
- If not, what additional safeguards could we introduce?

2. Ensuring good procurement practice

- 2.1. In the reformed system, the NHS Commissioning Board (the Board) and clinical commissioning groups will be responsible for spending £80 billion of the annual NHS budget. We want commissioners to decide how to secure the best services for patients. However, we also need safeguards to ensure that they use public funds effectively to deliver best value. This section invites comments on proposed requirements to ensure that commissioners respect minimum standards when procuring services, including carrying out tendering exercises.

Using procurement to deliver best value

- 2.2. Our intention in establishing procurement rules is to establish minimum requirements for NHS commissioners in determining *who* provides services to meet the needs of their patients.
- 2.3. As at present, the new commissioning organisations will be able to adopt a variety of strategies for securing services to meet the needs of their patients. For example, commissioners should monitor service standards and use contractual mechanisms to incentivise good performance. In many circumstances, this will be the most cost-effective way for commissioners to influence providers to identify ways of improving services, for example, to better integrate service delivery around patients' individual needs and preferences.
- 2.4. Commissioners may also seek to use competition as a means of securing value for money. For example, commissioners may procure services via a competitive tendering process to encourage providers to re-evaluate existing services, re-design pathways, consider whether to introduce new technologies, and improve efficiency.
- 2.5. Alternatively commissioners may establish qualification criteria that providers would have to meet in order to be 'qualified' to list services on a menu of choices to be made available to patients. This approach would facilitate competition driven by patient choice and may be particularly effective in strengthening incentives for providers to be more responsive to patients' preferences.
- 2.6. In each case, commissioners would be expected to make a balanced assessment of different options, based on objective criteria, and award contracts to the provider or providers best able to meet patients' needs based on objective criteria.

Assessing the trade-offs between different procurement options

- 2.7. Due to the scale of public expenditure involved – and the potential benefits of better value for money resulting in improved access, quality of care or health outcomes – procurement should always be cost beneficial. In other words, the potential value-for-money benefits to patients will significantly outweigh the costs incurred by commissioners and providers in participating in procurement processes.
- 2.8. However, commissioners will need to assess the trade-offs between different procurement options. For example, commissioners will need to assess the costs and benefits of tendering different bundles of services together. On the one hand, commissioners might be able to attract larger numbers of bidders and more rigorous competition by tendering individual services. On the other hand, they might be able to exploit greater economies of scale and scope, deliver more integrated care, or reduce tendering costs by tendering for a single provider to deliver a bundle of services.
- 2.9. Similarly, commissioners will need to consider the trade-offs between tendering for short-term or long-term contracts. With short-term contracts, commissioners retain the ability to re-tender services on a regular basis. This could allow them to harness renewed competition between providers, exploit new technologies as they are developed, or introduce more efficient delivery models. With longer term contracts, commissioners can reduce the transaction costs of tendering while allowing providers to recover capital investments in services. The Board is expected to provide guidance on these issues⁶.

The need for rules on procurement

- 2.10. There is evidence from across public services that, when tendering is done well, it increases value for money, spurring providers from all sectors to raise their game⁷. In its report on choice and competition, the NHS Future Forum gave examples of effective procurement to extend patient choice, reconfigure services and introduce innovation⁸.
- 2.11. There is also evidence that commissioners sometimes fail to use procurement effectively to secure best value. For example, the Future Forum identified cases where commissioners had decided not to run open tendering processes for services, even though this could have allowed them to secure better value for patients.
- 2.12. The Future Forum also identified cases where commissioners developed complex processes which excluded providers unnecessarily. For example, commissioners have imposed excessive requirements which prevent capable providers bidding to run services. These behaviours make it harder for commissioners to make objective comparisons and choose the best services for their patients.

⁶ For more information, visit the NHS Commissioning Board website at: www.commissioningboard.nhs.uk

⁷ See for example “[Public Services Industry Review](#)”, Dr DeAnne Julius, July 2008

⁸ “[Choice and Competition: A report from the NHS Future Forum](#)”, June 2011

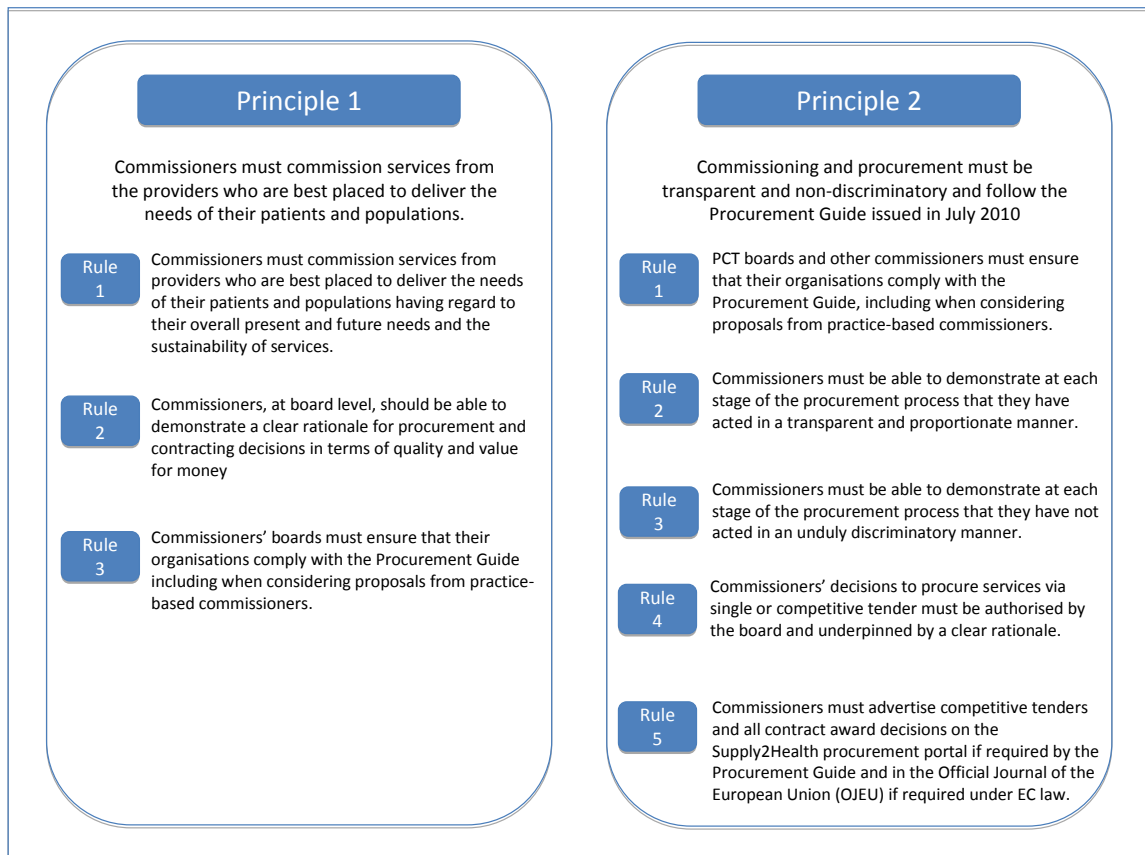
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- 2.13. We therefore need to ensure that commissioners carry out their functions within a framework of rules to ensure good practice. At a minimum, we need to ensure that commissioners make a broad assessment of different options and reach objective decisions in patients' interests. This will help commissioners deliver the best value and outcomes for patients whatever the circumstances.

The current principles and rules

- 2.14. The previous administration recognised the need for rules on procurement to ensure that commissioners deliver their functions effectively. The current Principles and Rules for Cooperation and Competition require commissioners to purchase from the best providers, carry out tendering processes transparently, proportionately and without discrimination, and be able to demonstrate a clear rationale for their decisions.
- 2.15. Since 2009, the Cooperation and Competition Panel has investigated complaints that commissioners have acted inconsistently with these procurement rules.

Figure 4: Current principles and rules on procurement



The proposed requirements on procurement

- 2.16. We have developed a set of requirements on procurement which are closely consistent with the current Principles and Rules. Like these existing rules, our proposals would establish broad principles to ensure good commissioning rather than prescribing the actions that should be taken in individual circumstances.
- 2.17. The proposed requirements are consistent with and will fall within the wider umbrella of UK and EU procurement law. As now, commissioners will need to ensure that they comply with these regulations, the Public Contract Regulations 2006 and EU Treaty Principles when tendering services.
- 2.18. There is some overlap between the proposed requirements and the Public Contract Regulations. For example, both would require public purchasers to act transparently and without discrimination. However, we see benefits in establishing sector-specific procurement regulations for healthcare, both to provide greater clarity for commissioners on expected behaviours and to provide scope for appeals to the healthcare regulator as an alternative to challenging procurement decisions in the courts.
- 2.19. The Board will play a key role in supporting clinical commissioning groups to achieve excellence in procuring local services. While the regulations will set minimum

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requirements, the Board will provide separate guidance to clinical commissioning groups on best practice in procurement.

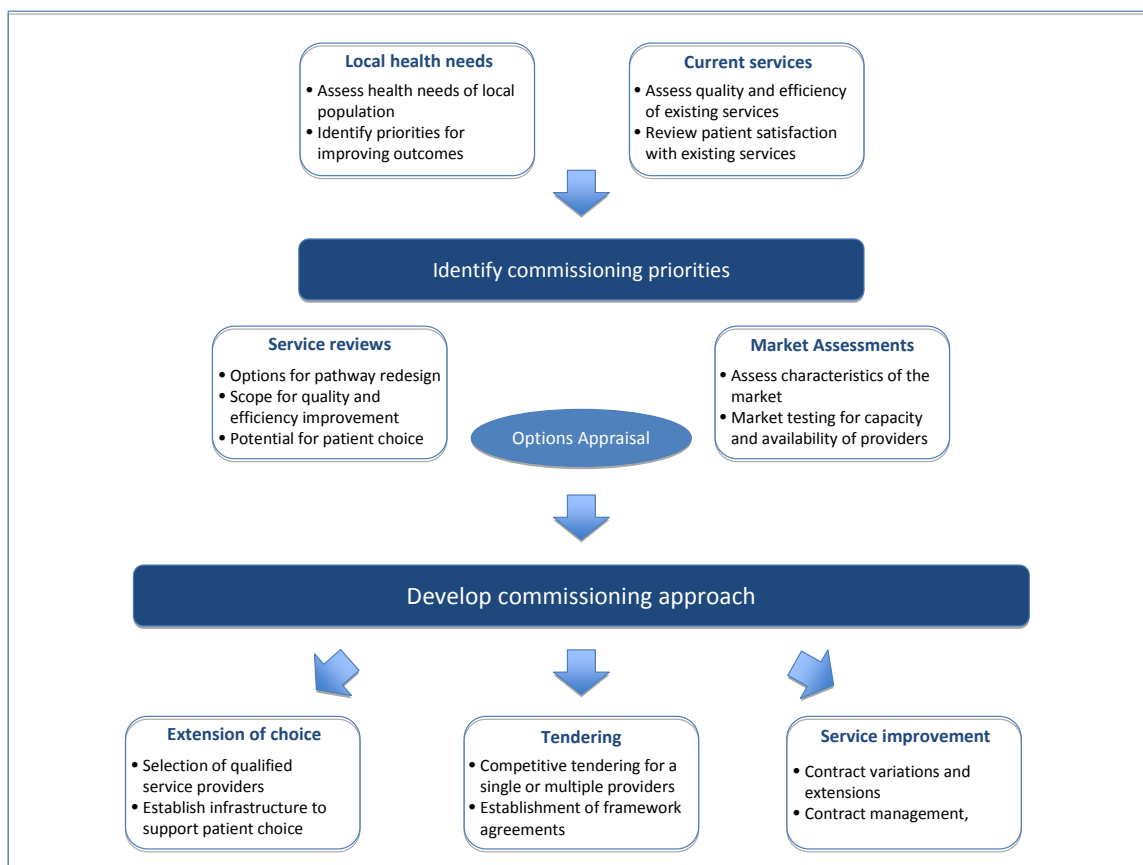
- 2.20. The Board is currently working with Monitor to produce a choice and competition framework which will help inform commissioners' decisions. They have already begun collecting data on the level and type of procurement and contracting methods being used. When finished this evidence base will be available to all commissioners.

General principles for procurement

- 2.21. As discussed above, commissioners will need to focus on securing the best value services in order to manage growing demands and rising patient expectations within their finite budgets. Like the current rules, we propose to enshrine as an overarching principle that commissioners should use the providers who are best capable of meeting patients' needs and delivering value for money, whether they are from the public, private or voluntary sectors.
- 2.22. We have made clear that commissioners have flexibility to decide whether, where and how to extend choice or use competition as means of improving NHS services. We have also made clear that commissioners will be expected to secure best value for patients and will be accountable for the outcome of their decisions. The draft proposals would therefore require commissioners to use choice and competition where appropriate to improve quality and efficiency. This does not mean that commissioners should pursue competition as an end in itself or seek to increase the market shares of particular providers, but rather that commissioners should be able to demonstrate that they have considered alternative options in determining which providers offer best value.
- 2.23. Consistent with the existing Principles and Rules, we are proposing to retain general requirements for commissioners to act transparently in the procurement of NHS services. We are also proposing a requirement for commissioners to keep appropriate records of the reasons why they have reached their decisions. Transparency is a fundamental principle of public accountability. Ensuring that procurement processes are transparent, and that there is a clear audit trail for decisions, are necessary pre-conditions for holding commissioners accountable for securing best value.
- 2.24. Similarly we also propose to retain requirements under the existing Principles and Rules for commissioners to act proportionately, non-discriminately and to treat providers equally in the procurement of NHS services. This reflects the overarching requirements of EU procurement law, which NHS commissioners will need to comply with in the future, as now. Moreover, these requirements are necessary for securing best value for patients. For example, to the extent that commissioners employ disproportionate or discriminatory criteria this could result in skewing of decisions away from best value to the detriment of patients' interests.

2.25. Commissioners will need to follow robust processes to be able to demonstrate that they have met these requirements. Figure 5 provides an illustration of a commissioning process to secure best value.

Figure 5: Robust decision-making on how to secure best value



Maintaining provider engagement

2.26. Commissioners need to engage effectively with current and potential providers to secure the best services for patients. Without this engagement, commissioners will not know which providers are capable of offering particular services or introducing new models of care. We therefore propose to establish a requirement that commissioners maintain transparent arrangements to establish providers' interest in delivering services.

2.27. One option would be to set out a requirement that commissioners must always advertise opportunities prior to committing expenditure (eg. above a *de-minimis* level). The practical implication of this is that commissioners would not be able to extend or vary existing contracts, or award new contracts, without prior advertisement. However, NHS commissioners will be facing vastly different circumstances and what is appropriate will vary in individual cases. This reflects the fact that the potential for competition will vary significantly between different services and in different

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geographical areas and, therefore, a 'one size fits all' approach would result in unnecessary bureaucracy.

- 2.28. We therefore propose to avoid prescribing the steps commissioners should take to engage with providers. Instead, commissioners would have flexibility to determine how to meet the general requirement to determine the level of provider interest in individual cases. Advertising opportunities case-by-case would be one way of meeting this requirement and will often be cost-effective, but this it is not the only way of determining provider interest, and may not always be necessary and proportionate. We would therefore expect the Board to provide guidance to clinical commissioning groups on when and how to advertise opportunities, including within the Official Journal of the European Union, and to arrange access to commissioning support services at local level.

Single and competitive tenders

- 2.29. The regulations do not specify the circumstances in which commissioners should tender services or extend patient choice of any qualified provider locally. Instead, commissioners must decide where it is appropriate to extend choice or use competition to improve services.
- 2.30. In many circumstances, it is appropriate for commissioners to run a competitive tendering process when carrying out procurements for services. This allows commissioners to compare the range of providers interested in delivering the service, and to choose the provider who offers best value for money and best meets patients' needs.
- 2.31. However, consistent with the requirements of the Public Contract Regulations 2006, we would not expect commissioners to have to carry out an open competitive tendering process for new contracts when there was only one provider capable of delivering the service or where there was an urgent unforeseen clinical need.
- 2.32. In these circumstances it would be acceptable for commissioners to contract with an individual provider rather than advertising and running a competitive tendering process. Commissioners should of course carry out sufficient analysis of the market and engagement with providers to inform such a decision.

Qualification of providers

- 2.33. As discussed above, we know that commissioners have sometimes established disproportionate or discriminatory criteria for deciding whether particular providers can deliver services or bid for contracts. If commissioners exclude particular providers unfairly, this could prevent them from selecting the best providers for patients. We have therefore included a requirement for commissioners to establish transparent and non-discriminatory criteria when determining whether providers qualify to offer services,

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appointing providers to frameworks and pre-qualifying providers to bid for contracts. It would be unreasonable and a breach of these requirements for a commissioner to refuse to qualify a provider that met such criteria.

Transparency, proportionality and non-discrimination

- 2.34. As explained above, we propose to establish a general principle that commissioners should act transparently, proportionately and without discrimination when securing healthcare services. In addition to this broad principle, we are proposing to establish some additional requirements to ensure good commissioning practice.
- 2.35. Under the current system, commissioners are required to publish up-to-date records of their contracts on the Government's "supply2health" procurement portal. This helps to maintain public confidence and commissioners' accountability for local services. It also allows providers to plan and express interest in offering services before contracts expire.
- 2.36. We propose to retain this requirement in the new system: the draft rules require commissioners to publish records of contracts above £10,000 including the scope of the services, contract value and expiry date. The Board will be required to maintain the "supply2health" portal, or a similar portal, in the new system. The requirements are in line with Cabinet Office rules for public procurement.
- 2.37. As the Future Forum explained, commissioners sometimes set disproportionate requirements which prevent capable providers bidding for contracts. This makes it harder for commissioners to make objective assessments and select the best providers.
- 2.38. We therefore propose to establish a requirement for commissioners' actions to be proportionate to specific requirements to meet patients' needs or improve quality and efficiency. The requirement would prohibit commissioners from imposing unnecessary costs by duplicating registration, licensing or other regulatory requirements.
- 2.39. We wish to ensure that commissioners do not discriminate unfairly between providers, for example, by preventing voluntary and independent providers bidding for contracts. This would make it harder to secure the best services for patients. We therefore propose to establish a requirement prohibiting commissioners from treating a provider more or less favourably than others, in particular on the basis of ownership, for example it is a public, voluntary or private organisation.

Commissioners' duties to promote equality

- 2.40. The Principles and Rules of Cooperation and Competition include a requirement for commissioners not to discriminate unduly between patients and to promote equality. In the new system, the Board and clinical commissioning groups will have a statutory duty

to reduce inequalities in the Act. They are also subject to the public sector equality duty under the Equalities Act 2010.

- 2.41. There is limited evidence about how sector regulation affects equality. We have therefore included a question seeking views as to the direct impact of the proposals in this document on equality for people with protected characteristics under the Equalities Act 2010, namely age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, or sexual orientation.

Proposed requirements on procurement

General Principles

Commissioners must secure services from providers who are best capable of meeting patients' needs and deliver best value for money, using choice and competition, where appropriate, as a means to improving quality and efficiency in the provision of services.

Commissioners must act transparently, proportionately, non-discriminately and with equality of treatment when securing healthcare services for the purposes of the NHS.

Commissioners must maintain appropriate records demonstrating why they have reached their decisions. In doing so, they must record how they have met their duties.

Commissioners must ensure that if they delegate commissioning activities, their agents also comply with the requirements of these regulations.

Maintaining provider engagement

Commissioners must maintain transparent arrangements for providers to express their interest in providing services to their populations.

Commissioners may award a new contract to a single provider without a competition where the commissioner is satisfied that the health care services are capable of being provided only by that provider.

Qualification of providers

Commissioners must establish transparent, proportionate and non-discriminatory criteria when:

- determining whether providers qualify to be able to list services on any menu of choices to be made available to patients;
- appointing providers to framework agreements; or
- pre-qualifying providers to bid for potential future contracts.

Subject to any limit on the number of providers necessary to ensure best value, a commissioner may refuse to award a contract to a provider only where the provider does not meet the criteria.

In the commissioning of services subject to patient rights to choice, a commissioner may not refuse to qualify a provider that meets the criteria.

In particular, commissioners must not duplicate requirements imposed by registration, licensing or other similar regulatory requirements that a provider would already be required to satisfy.

Non-discrimination and equality

When procuring health care services for the purposes of the NHS, commissioners must not treat a particular provider more or less favourably than other providers, in particular on the basis of ownership.

Transparency

Commissioners must maintain and publish up-to-date details of all contracts for the provision of healthcare for the purpose of the NHS above £10,000, including:

- Name and address of the provider
- Scope of services
- Contract value (£)
- Contract expiry date

The NHS Commissioning Board must maintain and publicise details of a dedicated website ('NHS Procurement Portal') for use by commissioners in advertising opportunities for providers to bid for new contracts.

Where a commissioner advertises an opportunity for providers to bid for a new contract, the advertisement must be published on the NHS Procurement Portal (eg. www.supply2health.nhs.uk) and must include a description of the service requirement and the criteria that will be used to evaluate any bids.

Consultation questions on the proposed requirements

We would welcome responses to the following questions on the proposed requirements as well as any additional comments that you would like to make:

- Do you agree that we should establish broad principles for good procurement practice in the regulations, rather than setting more prescriptive procedural rules?
- Do we need to introduce any additional safeguards to ensure that commissioners comply with good procurement practice?
- Could the proposals have any perceived or potential impact on equality including people sharing protected characteristics under the Equality Act 2010?

3. Protecting patients' rights to make choices

- 3.1. The Government's reforms will put patients at the heart of the NHS and enable patients to have far greater involvement in decisions about their care through more choice and control in line with the principle: 'no decision about me without me'. We want to give everyone more say in decisions about their care and more opportunity to make choices, supported by the right information, as a means of securing better care and better outcomes.
- 3.2. There is significant evidence demonstrating that patients want greater choice of treatment and provider. A British Social Attitudes Survey⁹ found that 95% of people feel that they should have choice over the hospital they attend and the kind of treatment they receive. The King's Fund found that 75% of respondents considered choice of hospital either 'very important' or 'important' to them¹⁰. More recently, a Department of Health commissioned survey¹¹ of 5,000 people in England, conducted in October 2011 found that:
- 81% of respondents want more choice in where they are treated;
 - 79% of respondents want more choice of how they are treated;
 - 75% of respondents wanted a choice of hospital consultant in charge of their care; and
 - 75% of respondents wanted a choice of hospital consultant in charge of their children's care.
- 3.3. Since May, we have been seeking further views from patients, the public, healthcare professionals and the NHS on proposals to allow patients to share in making decisions about their care and treatment. Greater choice and control is a key element of this and the proposals would further increase the range of choices that patients have¹². Further information on this consultation and how to respond is available at:
<http://consultations.dh.gov.uk/choice/choice-future-proposals>

⁹ British Social Attitudes survey, Natcen, <http://www.natcen.ac.uk/study/british-social-attitudes-25th-report/findings> (2009)

¹⁰ Dixon, A., Robertson, R., Appleby, J., Burge, P., Devlin, N., Magee, H., Patient Choice: How patients choose and how providers respond The Kings Fund (2010)

¹¹ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalassets.dh_131611.pdf (see page 26)

¹² "Liberating the NHS: No decision about me without me. Further consultation on proposals to secure shared decision-making", May 2012

Patients' rights to make choices

3.4. Our starting point in considering requirements to protect the rights that patients have to exercise choice over their care and treatment are the existing national rights set out in the NHS Constitution and its handbook. These are:

- the right to choose any provider in England for a first consultant-led outpatient appointment for most elective services;
- the right to request that a commissioner takes all reasonable steps to offer an alternative provider when waiting over maximum waiting times for treatment; and
- rights in relation to registering with a GP practice and expressing a preference to see a particular GP within a practice.

3.5. As the NHS Constitution and its handbook explain, the rights that patients have to make choices will develop, over time, as choice is extended into other areas. As set out in previous consultations on patient choice, the Government intends to increase the choices that patients have and, where appropriate, will look to see whether these increased choices should become rights so that they are available to patients wherever they live in England.

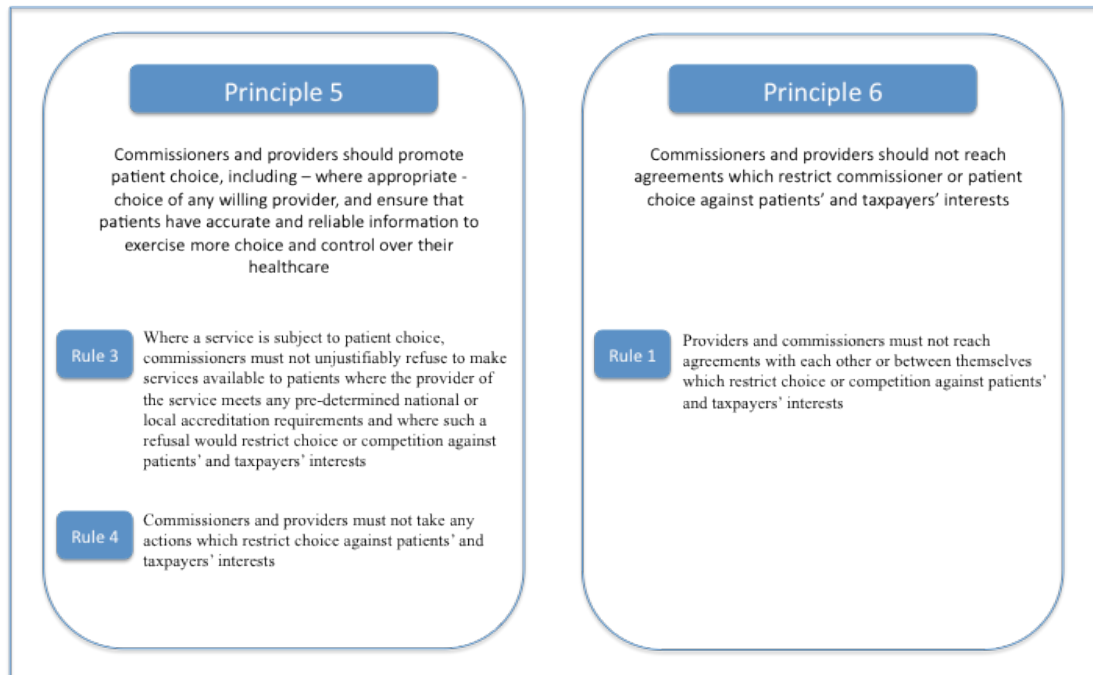
The current principles and rules

3.6. Commissioners are required to comply with rules to protect patient choice. The Principles and Rules for Cooperation and Competition require commissioners to promote choice and prohibit actions which restrict choice against patients' interests.

3.7. Since 2009, the Department of Health's Cooperation and Competition Panel has investigated complaints that commissioners have restricted patients' rights to exercise choice. In its report on the implementation of any qualified provider in elective care, for example, the Panel found that some commissioners had introduced restrictions through minimum waiting times, volume caps on activity, and restrictions on which providers could qualify to deliver services which restricted choice and competition while forcing patients to wait longer for treatment¹³.

¹³ ["Review of the operation of 'Any Willing Provider' for the provision of routine elective care"](#), Cooperation and Competition Panel, July 2011

Figure 6: Current principles and rules on patient choice



The draft requirement on patient choice

- 3.8. All patients must be able to exercise their rights to make choices in primary and elective care. These are national rights and patients should be able exercise them wherever they live in England.
- 3.9. We therefore propose to establish a similar requirement in the regulations to the current principles and rules safeguarding patients' rights to exercise choice. The requirement would prohibit commissioners from reaching agreements or taking any other actions which would be inconsistent with patients' right to exercise choice as set out in the NHS Constitution.
- 3.10. This means that, in future, Monitor would be able to consider complaints that a commissioner has taken action which is inconsistent with a patient's right to choose. Monitor will have powers to investigate and powers to direct commissioners to change their approach if they have breached the regulation (see section 6 below).

Patient choice beyond the rights in the NHS Constitution

- 3.11. The Government's ambition is for patients to have much greater choice and control in their care and treatment and, therefore, we have considered whether it would be appropriate to establish further requirements through the regulations over and above the national rights set out in the NHS Constitution.
- 3.12. For example, we could establish requirements in the regulations to extend patient choice, or establish safeguards against the inappropriate withdrawal of patient choice

where this has previously been introduced locally. However, we wish to retain flexibility for commissioners, who are best placed to take the lead in deciding where and how to extend patient choice in individual local services, taking account of patients' needs and local circumstances.

- 3.13. We also consider that there are other safeguards in place to protect the extension of choice. For example, the NHS Commissioning Board (the Board) and clinical commissioning groups have statutory duties to enable choice. Under the Act, the Board and clinical commissioning groups must act with a view to enabling patients to make choices with respect to aspects of health services. Commissioners, in exercising their commissioning functions, must act consistently with this duty.
- 3.14. The Board will play a key role in supporting clinical commissioning groups in the development of patient choice. From July until September, we are consulting on the Secretary of State's draft Mandate to the Board, which will set out its objectives for the year¹⁴. One of the Board's proposed key objectives is to put patients first, including promoting shared decision-making and choice, improving information and making services more integrated around individuals. Further information on this consultation and how to respond is available at <http://mandate.dh.gov.uk>.
- 3.15. During 2012-13, commissioners have selected at least three community and mental health services in which to extend patient choice of provider locally. The Government expects these choices to be maintained and that commissioners, in line with their duties, will continue to extend patient choice to more services from 2013 onwards informed by local priorities. We expect the Board to set clear guidance for clinical commissioning groups to help them take decisions on how best to extend patient choice in local services and the action it would take where commissioners are failing to meet their statutory duties, for example, by withdrawing choice against the interests of patients
- 3.16. In addition, and as set out above, the Government intends to increase the choices that patients have and so, over time, will consider whether there is a consensus that it would be appropriate for further choices to become rights, so that they are available to patients wherever they live in England. Monitor will also be able to carry out market studies to assess how patient choice is developing and make recommendations to the Secretary of State on where patients' rights to make choices could be extended over time.
- 3.17. On balance, we therefore believe it is preferable for the Board to oversee progress by clinical commissioning groups in enabling the further extension of patient choice in line with the objectives of the Mandate as an alternative to placing further requirements on commissioners through the regulations. Furthermore, there are potential risks in

¹⁴ [“Developing our NHS care objectives: A consultation on the draft Mandate to the NHS Commissioning Board”](#), July 2012

imposing additional requirements to extend patient choice in the regulations. It could impose additional bureaucracy and limit commissioners' flexibility to decide where to introduce choice, because individual decisions on these issues could be subject to regulatory appeals. It could also create perverse incentives not to introduce choice for fear of future challenge.

Proposed requirement to protect patient choice

Commissioners and their agents must not enter into agreements or take any other action that would be inconsistent with a patient's right to make choices as under the NHS Constitution.

Consultation questions on the proposed requirement

We would welcome responses to the following questions on the proposed requirements as well as any additional comments that you would like to make:

- **Do you agree that the regulations should protect patients' rights to exercise choice as set out in the NHS Constitution?**
- **Are there any further safeguards that should be established through the regulations or elsewhere to protect the extension of choice?**

4. Preventing anti-competitive conduct against patients' interests

- 4.1. In the new system, clinical commissioning groups will have considerable freedom to decide where to extend choice and use competition to improve services. As discussed in section 3, commissioners must ensure that patients can exercise their rights to make choices. Beyond this, it is for commissioners to decide where to extend patient choice or competition in line with their statutory duties and the Mandate.
- 4.2. Competition is not an end in itself, but just one of the tools that can be used to drive up standards and achieve world-class outcomes. However, there is growing evidence that competition is helping to improve services. For example, the NHS Future Forum found that a diverse range of providers can stimulate innovation whether from within the NHS, the third sector or independent organisations¹⁵. Academics have also found that competition is associated with lower mortality rates and better management practices¹⁶.
- 4.3. In these circumstances, we want to ensure competition is effective in strengthening incentives for providers to improve services. We want to ensure that providers compete on equal terms and that the best providers succeed. We therefore need to avoid restricting competition where this would erode best value by allowing poorer providers to maintain lower standards of care.
- 4.4. This section therefore invites comments on a proposed requirement to prevent commissioners restricting competition against patients' interests. Monitor will set out its approach to enforcing the regulation in its guidance (see section 6).

The current principles and rules

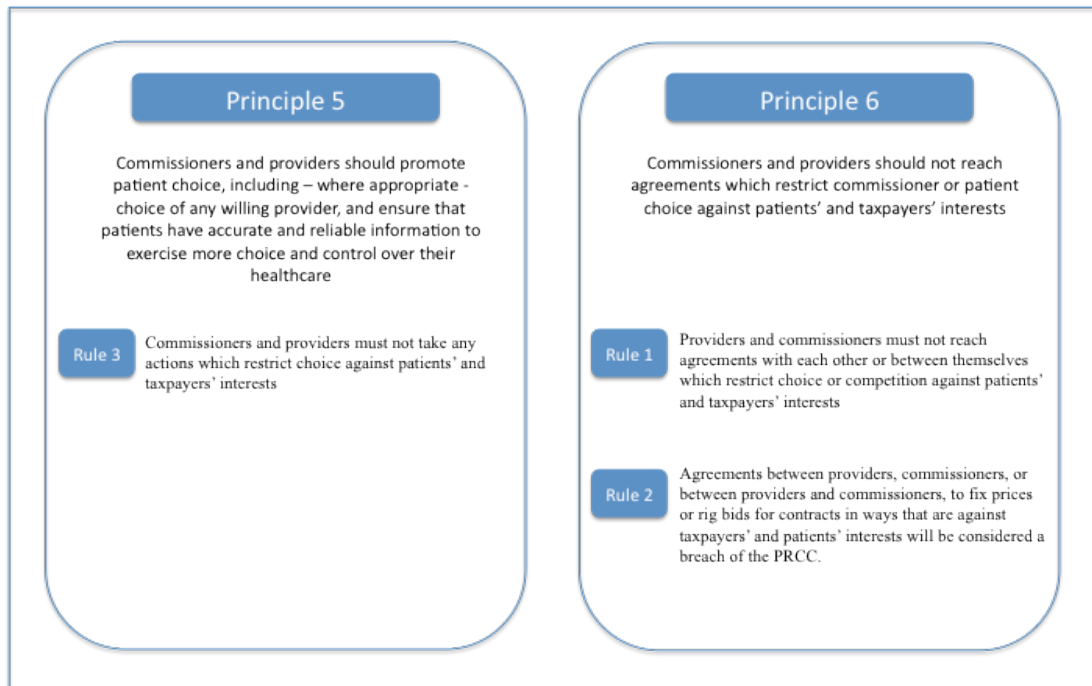
- 4.5. The previous administration recognised the need to establish rules to prohibit conduct which restricts competition in these ways. The current Principles and Rules for Cooperation and Competition prohibit commissioners and providers from taking actions which restrict competition against patients' interests.
- 4.6. Since 2009, the Cooperation and Competition Panel has investigated complaints that commissioners have breached the rules. As mentioned above, the Panel found that commissioners had introduced restrictions which undermined competition in elective care, including minimum waits and caps on patient volumes for some providers¹⁷.

¹⁵ ["Choice and Competition: A report from the NHS Future Forum"](#), June 2011

¹⁶ ["Death by market power: Reform, competition and patient outcomes in the National Health Service"](#), Martin Gaynor, Rodrigo Moreno-Serra and Carol Propper, August 2011

¹⁷ ["Review of the operation of 'Any Willing Provider' for the provision of routine elective care"](#), Cooperation and Competition Panel, July 2011

Figure 7: Current principles and rules on competition



The draft requirement on anti-competitive conduct

- 4.7. As at present, we know that commissioners in the new system could act in ways which have the effect of restricting competition against patients' interests. Our starting point must therefore be to retain the existing prohibitions on anti-competitive conduct by commissioners, as set out in the current Principles and Rules. Removing these provisions would be a step back, withdrawing an important safeguard to protect patients' interests.
- 4.8. However, we propose to simplify the current rules by consolidating them into a single requirement. The requirement prohibits commissioners from entering agreements or taking other actions which restrict competition to the extent that this is against the interests of people who use services.
- 4.9. This closely matches Monitor's draft licence condition prohibiting providers from engaging in conduct which restricts competition against patients' interests. Like the current rules, it therefore establishes equivalent safeguards for purchasers and providers.

A broad prohibition

- 4.10. The requirement establishes a broad prohibition of conduct which restricts competition against users' interests. This approach would capture any restrictive conduct irrespective of its nature, including informal agreements as well as formal contracts. Conversely, we do not propose to specify a list of conduct which is automatically

prohibited in all circumstances. This reflects the fact that we do not wish to prohibit specific behaviour *per se*, but only when it has restricts competition against patients' interests.

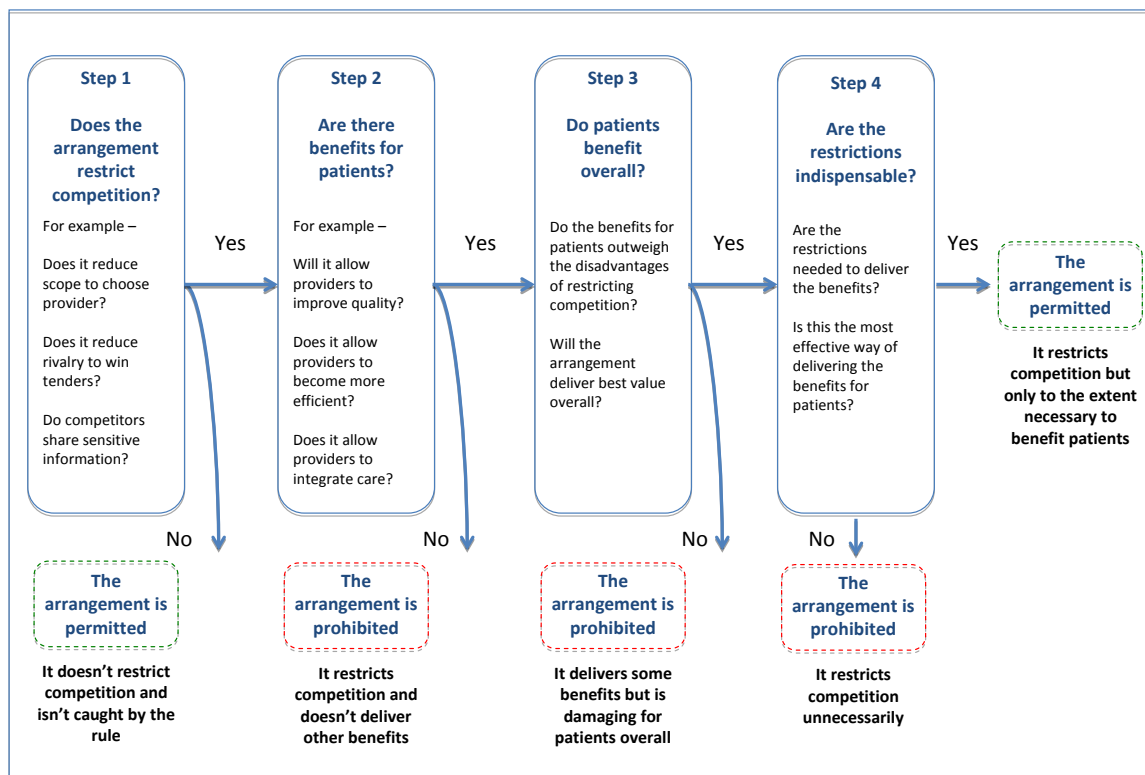
An 'effects-based' approach to assessing conduct

- 4.11. Like the current rules, we are proposing to maintain an 'effects-based' approach to assessing whether particular conduct operates for or against patients' interests. We recognise that there are circumstances where commissioners might legitimately seek to restrict competition, for example, where this is indispensable to ensure that individual providers achieve minimum volumes of surgical procedures to ensure patient safety.
- 4.12. As discussed in section 2 above, commissioners will need to consider the full range of options for securing services for their populations. For example, they will need to consider strategies which harness competition alongside other options, including different models of tendering or introducing patient choice of any willing provider. They will need to be able to demonstrate that they have duly considered the available alternatives, based on objective criteria.
- 4.13. If commissioners decide to make arrangements which materially restrict competition, they will need to be able to demonstrate that these are in patients' interests. They will need to be able to demonstrate that the arrangement delivers tangible countervailing benefits for patients such as improvements in quality or efficiency. They will also need to be able to show that the benefits of the arrangement outweigh the disadvantages of restricting competition and that it is therefore in patients' overall interests.

An indispensability test

- 4.14. Commissioners will need to be able to demonstrate that the restrictions to competition are indispensable for delivering the intended benefits. They will need to be able to show that the restrictions were necessary and proportionate to deliver the benefits. They will also need to be able to show that they considered alternative options for securing services and be able to explain why it would not have been possible to secure the benefits for patients while preserving competition.
- 4.15. Figure 5 above provides an illustration of a robust process for identifying commissioning priorities, assessing options and developing commissioning approaches. Figure 8 below provides a summary of how commissioners should assess whether particular arrangements are permitted under the prohibition of anti-competitive conduct. Monitor will publish guidance on compliance with the regulations and its approach to enforcement (discussed further in section 6).

Figure 8: Assessing conduct under the requirement



Cooperation and integrated care

- 4.16. Stakeholders have raised concern that rules on conduct which restricts competition could prevent commissioners and providers from cooperating, in particular to develop more integrated services. It is therefore important to emphasise that the requirement would not prevent cooperation where this is in patients' overall interests.
- 4.17. As the NHS Future Forum argued, competition and integration are, potentially, complementary rather than opposing forces: "Integrated care is vital, and competition can and should be used by commissioners as a powerful tool to drive this for patients"¹⁸.
- 4.18. Commissioners can use competition in many ways as a lever to stimulate the development of more integrated services. For example, commissioners can tender for a provider to develop an integrated care pathway, rather than continuing to commission episodic services from different organisations. Commissioners can also tender for a lead provider to coordinate service delivery with several other providers so that they deliver an integrated service.
- 4.19. However, commissioners may also take action which restrict competition where these restrictions are indispensable to delivering better integrated care. This would be permissible under the regulations as we have proposed.

¹⁸ ["Choice and Competition: A report from the NHS Future Forum"](#), June 2011

Providing clarity regarding problematic conduct

- 4.20. We recognise that commissioners may want to have maximum certainty as to what is and is not permitted under the proposed requirements, but we have resisted taking a prescriptive approach because this would reduce flexibility for commissioners. An alternative option we have considered would be to include a list of specific, problematic behaviours on the face of the regulations. For example, we might specifically refer to the imposition of minimum waiting times in elective care or bundling services in ways which unfairly exclude particular providers from offering services.
- 4.21. However, there may be risks in this approach. Commissioners might assume that the types of conduct listed were automatically prohibited irrespective of their effects in different cases. They might be deterred from taking actions such as bundling services together, even though this is often beneficial for patients. Conversely, commissioners might assume that forms of conduct which were not listed expressly in the regulations were less likely to restrict competition against patients' interests.
- 4.22. An alternative would be for Monitor to clarify the types of conduct which could breach the regulations in its guidance. Monitor will be able to update its guidance as it gains experience of enforcing the regulations. We are keen to explore this further in consultation and have included a specific question below seeking views on this issue.

Figure 9: Examples of conduct which might breach the requirement

| | | | |
|---|--|---|---|
| <p>Example 1: Joint Purchasing Arrangements</p> <ul style="list-style-type: none"> A group of commissioners reach an agreement to establish joint purchasing for some services. They want to use their joint purchasing power to encourage providers to deliver better value for patients. | <p>Does this restrict competition?</p> <ul style="list-style-type: none"> Unlikely to restrict competition in most cases Joint buying often increases competition among providers But some joint buying such as tendering very large contracts can restrict competition <u>Likely to be permitted</u> | <p>Example 2: Tendering for integrated care</p> <ul style="list-style-type: none"> A commissioner tenders for an integrated COPD service. This will provide more joined up, seamless care. But in future patients will have fewer opportunities to choose provider. | <p>Does this restrict competition?</p> <ul style="list-style-type: none"> No. If there are multiple bidders, tendering should preserve competition. Commissioners can preserve competition even if they need to limit choice for some services. <u>Likely to be permitted</u> |
| <p>Example 3: A network to improve quality of care</p> <ul style="list-style-type: none"> A commissioner asks local providers to establish a network to improve care. The commissioner wants providers to focus on different specialisms so that they can improve clinical quality. | <p>Does this restrict competition?</p> <ul style="list-style-type: none"> It might restrict competition in some cases. For example, it might restrict competition to attract patients to specialist services. Some providers might be excluded or prevented from entering services | <p>Are there patient benefits?</p> <ul style="list-style-type: none"> There might be significant clinical benefits for patients. The arrangements might allow providers to increase patient volumes. This might allow them to develop expertise or invest in specialist equipment. | <p>Do patients benefit overall?</p> <ul style="list-style-type: none"> Commissioners must consider overall costs and benefits. <u>Would be permitted if the restrictions are essential and patients benefit overall.</u> Commissioners would need to consider any alternatives with less impact on competition. |
| <p>Example 4: Excluding a provider from offering choice</p> <ul style="list-style-type: none"> A commissioner refuses to allow a capable provider to offer a service where choice has been introduced locally. The commissioner wants to protect incumbent providers from competition. | <p>Does this restrict competition?</p> <ul style="list-style-type: none"> It would be likely to restrict competition in many cases The requirement might reduce the range of different providers It might prevent new providers introducing better services or more efficient delivery models. | <p>Are there patient benefits?</p> <ul style="list-style-type: none"> No. It reduces choice and protects some providers rather than improving care. Commissioners sometimes need to limit provider numbers But in these cases, they should use objective processes to select the best providers | <p>Do patients benefit overall?</p> <ul style="list-style-type: none"> It seems unlikely to deliver overall patient benefits. <u>Likely to be prohibited</u> |
| <p>Example 5: Minimum waiting times in elective care</p> <ul style="list-style-type: none"> A commissioner imposes a minimum waiting time for elective operations. The aim is to reduce patient volumes and constrain costs. | <p>Does this restrict competition?</p> <ul style="list-style-type: none"> Yes. The requirement prevents providers from competing on an aspect of quality of care Providers are unable to attract patients based on how quickly they can treat them. | <p>Are there patient benefits?</p> <ul style="list-style-type: none"> No. Patients are likely to suffer because they will have to wait longer for treatment. Commissioners need to manage resources. But this is unlikely to be an efficient mechanism for doing so. | <p>Do patients benefit overall?</p> <ul style="list-style-type: none"> No. It significantly restricts competition. It doesn't deliver substantive benefits for patients. There are better ways of managing resources <u>Likely to be prohibited</u> |

Proposed requirement prohibiting anti-competitive conduct

Commissioners shall not enter into any agreement or engage in any conduct which has the object or effect of preventing, restricting or distorting competition in the provision of healthcare services for the purposes of the NHS to the extent that it is against the interests of people who use healthcare services.

Restrictions to competition will not be in the interests of people who use healthcare services unless they are indispensable to the attainment of the intended benefits for people who use these services.

Consultation questions on the proposed requirement

We would welcome responses to the following questions on the proposed requirement as well as any additional comments that you would like to make:

- Do you agree that we should adopt an effects based approach to assessing restrictive conduct by commissioners, rather than assuming that conduct which restricts competition is automatically against patients' interests?
- What can the Department of Health, NHS Commissioning Board and Monitor do to ensure that commissioners understand the requirements so that they can effectively 'self-assess' whether or not their conduct falls within the rules?
- Are there particularly problematic behaviours which we should address specifically, for example in the requirements or in Monitor's guidance for commissioners?

5. Managing conflicts of interest

- 5.1. In the reformed system, commissioning groups led by local clinicians – the professionals closest to local people - will be responsible for purchasing the majority of healthcare services. They will be able to harness their clinical expertise and understanding of the local health system when deciding how best to improve services.
- 5.2. Commissioners will need to make objective comparisons between providers and select the most appropriate providers for local patients. However, individuals involved in commissioning may sometimes have private interests in particular providers. If these interests influence decisions, this could undermine best value, for example, if contracts were not awarded to the best providers based on objective, proportionate and non-discriminatory criteria.
- 5.3. As at present, therefore, we need to maintain safeguards to ensure that commissioners manage conflicts of interest and make objective decisions. In particular, we need to ensure that commissioners identify potential conflicts at an early stage and take appropriate measure to ensure that they do not influence any commissioning decisions.
- 5.4. The Government has already introduced primary legislation requiring commissioners to manage conflicts of interest effectively. This section invites comments on additional requirements which would allow Monitor to investigate potential misconduct.

Current rules on conflicts of interest

- 5.5. The previous administration recognised the need for commissioners to manage conflicts of interest so that they deliver best value. The current *Principles and Rules for Cooperation and Competition* require commissioners to declare conflicts. The *Procurement Guide for Commissioners of NHS Funded Services* also makes clear that commissioners are responsible for managing conflicts appropriately to ensure robust and transparent procurement processes.

Future arrangements to manage conflicts

- 5.6. It will be particularly important to ensure that commissioners identify and manage conflicts of interest in the reformed system. This is because the GPs who participate in clinical commissioning groups also provide healthcare services. We need to take steps to ensure that GPs in commissioning groups select the best providers in patients' interests without allowing interests in their practices or other providers to influence their decisions.
- 5.7. For this reason, the Government introduced robust requirements in primary legislation to ensure that clinical commissioning groups declare and manage conflicts of interest appropriately. Section 14O of the National Health Service Act 2006 (as inserted

Securing best value for NHS patients

by section 25(1) of the Act) requires clinical commissioning groups to maintain a register of interests. It also requires clinical commissioning groups to make arrangements for managing conflicts in such a way as to ensure that they do not, and do not appear to, affect the integrity of the group's decision-making processes.

- 5.8. The NHS Commissioning Board (the Board) will play an important role in ensuring that clinical commissioning groups comply with the legislation. The Board is required to publish formal guidance for clinical commissioning groups in managing conflicts. To support emerging clinical commissioning groups as they prepare for their future responsibilities, the NHS Commissioning Board Authority has published initial guidance and a code of conduct on how to manage conflicts of interest.

The proposed requirements on conflicts of interest

- 5.9. We do not wish to duplicate these requirements and governance arrangements in the regulations. However, we need to complement the primary legislation to ensure that interested parties can appeal to an independent authority if they believe that decisions have been influenced by an interest in a provider.
- 5.10. We are therefore proposing to establish a requirement specifically prohibiting commissioners from awarding a contract to a provider where that decision is the result of an interest in the provider. There are also proposed requirements for commissioners to maintain records of how they have managed conflicts of interest in individual cases.
- 5.11. This means that interested parties will be able to appeal to Monitor if they believe that commissioners have awarded contracts to particular providers because of interests in those providers. Commissioners would then be required to demonstrate how they had managed the potential conflict of interest and that the contract was awarded on the basis of objective, proportionate and non-discriminatory criteria. As discussed below, Monitor will have powers to investigate the commissioner's conduct and to take action in the event of a breach.

Commissioning from GP practices

- 5.12. In the new system, the Board will be responsible for contracting with GP practices to deliver primary medical services. However, clinical commissioning groups may also need to contract with local GP practices for some services, for example when developing more integrated services or moving care into community settings.
- 5.13. These proposed requirements coupled with the requirements in relation to procurement should therefore ensure appropriate further safeguards to ensure clinical commissioning groups manage conflicts of interest effectively when commissioning services from local practices. Interested parties will be able to appeal to Monitor where they believe that commissioners have failed to act transparently in the procurement of services or that private interests have affected their decisions.

Proposed requirements on conflicts of interest

In securing services, commissioners must not award a contract to a provider where that decision is the result of an interest in the provider.

When maintaining appropriate records of decisions (as required under the procurement section) commissioners must in particular record how they have managed any conflict of interests effectively and transparently in individual cases.

When publishing contract details, as required under the procurement section of the regulations, commissioners must record where a provider also appears in the register of interests they maintain under the Act.

Consultation questions on the proposed requirements

We would welcome responses to the following questions on the proposed requirements as well as any additional comments that you would like to make:

- Do you agree that the Act and proposed requirements impose sufficient safeguards to ensure that commissioners manage conflicts of interest appropriately?
- If not, what additional safeguards could we introduce?

6. Monitor's investigative and enforcement powers

- 6.1. In the reformed system, Monitor will become an independent regulator for the health sector with responsibility for enforcing the regulations for commissioners alongside comparable rules for providers in their licences. This section sets out Monitor's proposed powers to investigate and remedy breaches of the regulations.

Investigation and enforcement in the current system

- 6.2. In the current system, the Cooperation and Competition Panel is responsible for investigating potential breaches of the administrative rules on choice and competition. It is only able to investigate potential breaches of the rules when it receives a formal complaint. In most cases, it expects complainants to seek to resolve disputes with local commissioners before carrying out an investigation. As an advisory body, the Panel does not have powers to take enforcement action following a breach of the rules. Instead, it advises the Secretary of State on potential breaches of the rules by commissioners.

Monitor's investigative powers

- 6.3. Like other regulators, Monitor will need to gather evidence in order to assess whether organisations have breached the rules. Section 76 of the Act therefore provides for Monitor to be given powers to investigate potential breaches. These include the power to investigate a complaint, the power to require information, and the power to require an explanation of any information provided.
- 6.4. Monitor will only investigate potential breaches of the regulations on procurement, choice and conflicts of interest when it has received a formal complaint. However, Section 76 provides for Monitor to be able to investigate potential breaches of the regulation on anti-competitive conduct on its own initiative as well as following a complaint. This will allow Monitor to address serious restrictive conduct in circumstances where interested parties are unwilling to make a formal complaint, for example because they fear damaging their relationships with local commissioners.

Monitor's enforcement powers

- 6.5. In the current system, the Secretary of State can direct commissioners to take remedial action to address a breach of the procurement and competition rules. Under our proposals for the future, Monitor will need to have similar powers to direct commissioners to address breaches of the regulations.

Securing best value for NHS patients

- 6.6. Section 76 of the Act therefore provides for Monitor to be able to direct commissioners to remedy breaches of the regulations. These include the power to direct a commissioner to put in place measures to comply with the regulations, the power to direct a commissioner to remedy a breach of the regulations, the power to direct a commissioner to withdraw or vary a tender for the provision of services, and the power to accept an undertaking that a commissioner will take particular actions in lieu of an investigation.

Case-handling procedures

- 6.7. Monitor will be able to investigate complaints from any interested parties including providers, associations of providers, patient groups or individual patients. However, as required by the Act, Monitor will only be able to investigate where it considers that the person making the complaint has a sufficient interest in the subject of the complaint.
- 6.8. Like other regulators, we expect Monitor to publish clear criteria for prioritising and accepting complaints in its guidance on how it will enforce the regulations. It will be for Monitor to decide whether to launch an investigation based on these criteria, which will need to weigh the costs and benefits of investigating in patients' interests.

Appeals under the regulations and procurement law

- 6.9. Interested parties may be able to decide whether to appeal to Monitor regarding commissioners' conduct under the Section 75 regulations or whether to appeal to a court under the Public Contract Regulations 2006. However, we do not think it would be appropriate for Monitor to investigate a case which has already or is being investigated by a court. As provided for under Section 76(8) of the Act, we therefore propose to prevent a person who has brought an action under the Public Contract Regulations from bringing an action under the Section 75 regulations and prevent Monitor from investigating any complaint by that person relating to the same matter.

Evaluation

- 6.10. Under Section 68 of the Act, Monitor has a duty to keep the exercise of its functions under review and secure that, in exercising its functions, it does not impose unnecessary burdens. Monitor also has powers to carry out studies of the functioning of healthcare markets. It therefore has the necessary tools to evaluate the effectiveness of the regulatory regime and recommend changes where needed. We would expect that Monitor will evaluate the effectiveness of the regime before the end of the current Parliament.

7. Annex: How to respond to the consultation

Responding to the consultation

We would welcome responses to all of the questions above as well as any additional comments that you would like to make. An online response form can be found alongside this document on our website. Please use this to record your responses and comments. Alternatively, you can use the Word response form on our website or email your responses to: pccr.consultation@dh.gsi.gov.uk

If you do not have internet or email access, then please write to:

Sector Regulation Team
Room 229, Richmond House
79 Whitehall
London SW1A 2NS

Please submit your responses to the questions and any other comments that you have by 5pm on 26 October 2012.

If you wish to do so, you can request, via the online / Word response form on our website, that your name and/or organisation be kept confidential and excluded from the published summary of responses. Please mark email or postal responses in a similar way in order to ensure confidentiality.

Please note that we may use your details to contact you about your responses or to send you information about our future work. We do not intend to send responses to each individual respondent. However, we will analyse responses carefully and give clear feedback on how we have developed the regulations as a result.

Commenting on the consultation process

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds, LS2 7UE

e-mail: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

If you would like any part of the content of your response (as distinct from your identity) to be kept confidential, you may say so in a covering letter. We would ask you to indicate clearly which part(s) of your response are to be kept confidential. We will endeavour to give effect to your request but as a public body subject to the provisions of the Freedom of Information legislation, we cannot guarantee confidentiality.

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter.

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

Summary of consultation responses

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the consultations website at:

<http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm>