

Advice by David Lock QC of No.5 Chambers:

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

ADVICE

1. I have been asked to provide some further advice to the campaign group 38 degrees concerning the changes to the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013 as set out in the new National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (“the new Regulations”).
2. These new Regulations are SI 2013/500. They are intended to replace and revoke the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013 [SI 2013/257] (“the old Regulations”) which were laid on 11th February 2013 (and have not yet come into force). The new Regulations are very substantially the same as the old Regulations but there are some significant changes which are examined below. However I do not consider that the new Regulations properly meet any of the fundamental objections which were raised in respect of the old Regulations. Further there are some significant tensions in the new Regulations which present new and more difficult challenges for NHS commissioners.
3. The Regulations impose obligations on CCG commissioners to act in a transparent and proportionate way and to treat providers equally and in a non-discriminatory way (see Regulation 3). In doing this the Regulations substantially replicate the duties which are already imposed by EU law on NHS commissioners. The way in which EU law impacts on NHS commissioning was explored in *R (Ota Lloyd) v Gloucestershire PCT*. It is a complex subject but is outside the terms of this piece of advice.

1) Is there anything in the new Regulations which promotes or permits the transfer of NHS activities to the private sector?

4. The answer to this question is “Yes”, the new Regulations are likely to have the effect of both permitting and promoting the transfer of NHS services to private sector. At present when NHS commissioners are thinking about how to commission NHS services, they are entitled to “contract” with an NHS Trust without a competition if the commissioners believed that this would be in the best interests of patients. This option will be removed under the Regulations unless the NHS commissioners believe that the services are “*capable of being provided only by that provider*”. At present there are many proper reasons why an NHS body might contract with an NHS Trust or an NHS Foundation Trust for services without a competition where this condition is

not satisfied. However this option will not be possible for NHS bodies after 1 April 2013.

5. The statutory requirement in the new Regulations to run a competition applies to contracts for all services other than those where there could only be one provider. This will inevitably promote the transfer of NHS services to a more diverse set of providers, and this will inevitably include more providers from the private sector.

6. Commissioners would not be entitled to take a strategic decision to avoid a competition for a contract by taking the view that it would be in the interests of patients for a particular service to be integrated together with other health or social care services that were already being provided by an existing NHS provider. This is clearly the thinking which led to the change to Regulation 2 which specifically allows NHS commissioners to take account of the benefits of services being provided in an integrated way (including with other health care services, health-related services or social care services). However that objective cannot be achieved in practice because, in making the decision under Regulation 5 whether a commissioner can lawfully avoid having a competition, the only test a commissioner is permitted to apply is whether the contract relating to those services (as opposed to other services) is only capable of being delivered by a single provider. If the answer to that question is that the contract is capable of being delivered by more than one provider, the CCG must hold a competition even if it is not in the interests of patients to do so.

7. A second problem arises where there is more than one potential provider for a range of NHS services but where it is in the interests of integration of local services for a contract to be placed with a local hospital provider. This will happen for example in any urban conurbation where there is more than one major hospital within a reasonable ambulance ride from the CCG area. In such circumstances there is more than one potential provider of A & E services and therefore more than one provider of other acute services. A CCG may feel it has a strategic interest in maintaining services at its local hospital but, in such circumstances, the CCG will be forced to run an expensive competition between acute providers each year before it is able to re-let the annual acute services contract. It is difficult to see how such a process can benefit the NHS as a whole.

8. It follows that the statutory objective of recognising the benefits of integration under the new Regulation 2 (and repeated in Regulation 10) is effectively emasculated by the narrowness of the test for avoiding a competition under Regulation 5.

2) Will the regulations force services to fragment or be put out to tender?

9. The answer to this question is that the Regulations will almost certainly lead to more services to be put out to tender and will therefore lead to a degree of fragmentation.

10. Private providers will seek, for example, cherry pick services which are relatively cost effective to deliver may be able to put pressure on the commissioner to divide out those services

from others on the grounds that the private provider can provide those services more economically or that to bundle up these services with other services amounts to anti-competitive behaviour. This is likely to be an area of intense debate within the NHS as private providers seek to use the (in places unclear) wording of the Regulations to put pressure on CCGs to divide contracts. Some CCGs may be able to resist this pressure but others are likely to succumb to this pressure. It follows that whilst the wording of the regulations does not place any duties on CCGs explicitly to divide contracts, in practice this happens for the reasons outlined above.

3) Will the regulations take power away from commissioners and give power to the Secretary of State and regulators to decide when and how competition should be used to serve patients' interests?

11. The answer to this question is that the Regulations do not provide any additional power to the Secretary of State but do provide a new role for Monitor.

12. If a person feels that an NHS body has acted in breach of the 2013 Regulations including acting in a way that is “anti-competitive”, a complaint can be made to the Regulator Monitor under Regulation 13. Monitor may then conduct an investigation and may issue directions to require future compliance with the Regulations. However this power is exercised by Monitor, which is a regulator, and not by the Secretary of State. It remains to be determined how Monitor will exercise these powers. However these powers appear to me to be substantial powers which, depending on the extent to which they are exercised, may make fundamental changes to the shape of NHS commissioning.

4) Will these regulations restrict or limit commissioners' discretion to decide when and how competition is used to serve their patients' interest?

13. There are already very substantial constraints on the way NHS commissioners are required to operate in order to remain within EU law. These Regulations restrict the choices open to NHS commissioners because they remove the *Teckal* exemption in which contracts could have been placed with an NHS Trust without a competition. This has been an important provision which has allowed strategic commissioning by NHS commissioners from NHS Trusts without the need for a competition.

14. However, even without these Regulations (other than where a contract is placed with an NHS Trust), an NHS Commissioner cannot lawfully avoid a competition for the provision of NHS services because they believe that it would be in the best interests of patients to place the contract with a single provider without a competition. At present these obligations are not widely recognised within the NHS and challenges are rare. However, these Regulations will make it clear that competition must be the norm for placing NHS contracts (bringing the existing EU rules explicitly into domestic UK law).

15. The *Teckal* exemption applies to NHS Trusts but it is unclear whether it could be relied upon if a CCG contracts with an NHS Foundation Trust. It was the policy of both the last and the present government to phase out NHS Trusts and replace them with NHS Foundation Trusts. Accordingly this may have been a time limited exemption which would have disappeared in any event by 2016 when the last of the NHS Trusts is due to be converted to an NHS FT or to be taken over by one.

5) Do the regulations impose compulsory competitive tendering requirements on commissioners, or give Monitor powers to impose such requirements?

16. The answer to this question is “substantively yes”. The requirement on NHS commissioners to advertise opportunities for providers and to seek offers for contracts for services effectively imposes a duty on CCGs to hold tender competitions for all major contracts. It seems inevitable that this requirement will impose very substantial additional costs on CCGs because they will have to go through an expensive procurement process for all of their major contracts.

6) Under the regulations, will commissioners be under any legal obligation to create new markets?

17. The answer to this question is that the Regulations will inevitably create new markets because the option of contracting with an NHS Trust without a competition in which private sector providers will have the chance to tender will no longer exist.

18. There is a significant change to the new Regulations concerning the powers for Monitor to investigate anti-competitive behaviour. This part of the Regulations is largely unchanged except there is a significant new Regulation 15(2) which provides:
“Monitor may not direct a relevant health body under paragraph (1) to hold a competitive tender for a contract for the provision of health care services for the purposes of the NHS”

19. On the face of things, this appears to suggest that an NHS commissioner who acts unlawfully in failing to put a service out to tender (by for example wrongly concluding that the single provider test in Regulation 5 is satisfied) cannot be compelled to hold a competitive tender. However that would be a misreading of the effect of Regulation 5. All that Regulation 15(2) provides is that this is a sanction that Monitor may not impose. However if an NHS commissioner acts unlawfully (by for example concluding that the single provider test in Regulation 5 is satisfied when no reasonable commissioner could have come to that view because another provider who could provide the relevant services) there is a real possibility that the commissioner could be subject to a Judicial Review claim and the court would be entitled to quash the Regulation 5 decision of the commissioner. Thus, in effect, the High Court could order the commissioner to re-take the Regulation 5 decision and thus, in effect, order the services to be opened up to competition.

20. Paragraph 14 of the House of Lords Report concerning the previous set of Regulations raised the concern that competition would become the “default option” for the provision of NHS services. This would, as their Lordships noted in paragraph 10:

“... substantially increase the costs and time taken over commissioning ... and that commercial confidentiality would reduce public involvement in the commission process in violation of the NHS constitution and the public involvement and consultation by clinical commissioning groups provisions in the Health and Social Care Act”

21. There does not appear to me to be anything substantial in the new Regulations which responds to these very real concerns. The assurances given by Ministers in Parliament about the freedoms that commissioners would have to commission services in the way they consider best for their local populations (as recorded at paragraph 19 of the House of Lords committee report) do not appear to be honoured by these new Regulations just as they were not honoured by the old Regulations. The key problem is that the government is continuing to maintain the very narrow test in Regulation 5 which needs to be satisfied before a commissioner can lawfully take the decision to enter into a contract for NHS services without holding a competitive tender. The government has purported to introduce a wider test concerning the promotion of integration under Regulation 2 and to permit certain anti-competitive behaviour under Regulation 10. However the government has not carried that logic through to the test as to when a commissioner can let a contract without a competitive process under Regulation 5. In those circumstances the changes to Regulations 2 and 10 concerning the introduction of wording about integration and co-operation between providers does not amount to any substantial change to the effect of the Regulations.

22. It therefore seems clear however that these Regulations will mean that commercial healthcare operators will have arguments which they will be able to use to put pressure on CCGs to divide up services and thus allow them to “cherry-pick” profitable parts of existing NHS acute services, leaving NHS providers to provide emergency services and less profitable (and no doubt more complex) elective procedures. It will remain to be seen how brave CCGs will be in resisting such pressure but it seems inevitable that these Regulations will lead to a fragmentation of NHS services as CCGs seek to avoid complaints of anti-competitive behaviour.

23. I hope that this provides some advice in the areas in which I have been asked to provide an opinion. Please come back to me if anything is unclear.

DAVID LOCK QC

12th March 2013.

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

ADVICE No 2

1. I have been asked to provide some further advice to the campaign group 38 degrees concerning the changes to the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013 as set out in the new National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (“the new Regulations”).
2. These new Regulations are SI 2013/500. They are intended to replace and revoke the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013 [SI 2013/257] (“the old Regulations”) which were laid on 11th February 2013 (and have not yet come into force). The new Regulations are very substantially the same as the old Regulations but there are some significant changes which are examined below. However I do not consider that the new Regulations properly meet any of the fundamental objections which were raised in respect of the old Regulations. Further there are some significant tensions in the new Regulations which present new and more difficult challenges for NHS commissioners.
3. I refer my clients to my previous full advice which set out the EU law background to the issue of procurement in the NHS and explained the effect of the old Regulations.
4. There are a number of differences between SI 257 and SI 500. However there is no change to the scope of the Regulations. Thus the “NHS option” under which NHS commissioners had a general discretion to arrange to provide services by putting in place an NHS contract between an NHS commissioner and an NHS Trust without a competition continues to be removed as an option for NHS commissioners.
5. The changes to the Regulations are as follows. First, the new Regulations introduce the concepts of “health related services” and “social care services” by reference to section 62(11) of the Health and Social Care Act 2012. The term “health care services” is used in new Regulation 2 but is not defined. However defining this term (and indeed the terms “health related services” and “social care services” was probably unnecessary

because section 64(5) of the Health and Social Care Act 2012 already defines the term “health care services” to mean services provided under the National Health Service Act 2006. A definition in subsidiary legislation is deemed to have the same meaning as in the parent legislation: see section 11 of the Interpretation Act 1978.

6. Secondly, Regulation 2 is amended. The original text provided that commissioners must act with a view to the three aims of:

- a. securing the needs of the people who use the services;
- b. improving the quality of services; and
- c. improving efficiency in the provision of services.

7. The new Regulations add the following words to this definition:

“... including through the services being provided in an integrated way (including with other health care services, health-related services or social care services)”

8. Thus the new Regulations appear to provide that commissioners are entitled to take the view that they can secure the needs of people who use the services by providing them in a way that is integrated with the services provided by other health and social care providers. This approach would suggest that commissioners would be entitled to commission an integrated service from a provider if the commissioner took the view that having one integrated provider secured the general objectives listed in Regulation 2. However, for the reasons set out below, this approach is not permitted by Regulation 5.

9. There is a potential contradiction between the objectives in Regulation 2 and Regulation 3(3) (which remains the same from the old Regulations). Regulation 3(3) provides:

“The relevant body must procure the services from one or more providers that—

- (a) are most capable of delivering the objective referred to in regulation 2 in relation to the services, and
- (b) provide best value for money in doing so”

10. The use of the word “and” between sub-paragraphs (a) and (b) in Regulation 3(3) means that both tests must be satisfied in relation to each contract for services before a contract can be let. The natural reading of the words of Regulation 3(3)(b) is that the commissioner is only entitled to commission services from a provider who can provide the best “value for money” for the delivery of those particular services (aside from the wider objectives in Regulation 2 which may relate to the delivery of other services). Hence a commissioner may, for example, feel that an integrated service would best serve the needs of patients because of the benefits of a tie up between those services and other services.

In contrast a private provider, cherry picking that individual service, might be able to provide that individual service at a cheaper rate. Hence letting a contract for (say) physiotherapy to an NHS Trust would satisfy the integration objectives of Regulation 2 but letting the contract to a (cheaper) private provider would provide the best value for money. In such circumstances there would be a conflict between the two elements of Regulation 3(3). It is wholly unclear how a commissioner is supposed to deal with such a conflict because the Regulations say that both elements must be satisfied for each contract. I regret that these serious practical problems do not appear to have been thought through properly by those drafting the Regulations.

11. Regulation 5(1) is key to the Regulations because it defines the circumstances in which a commissioner is entitled to let a contract for healthcare services without competition. It provides (in both the old and new Regulations):

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

12. Regulation 5(2) of the old Regulations defined the circumstances in which an NHS commissioner was entitled to reach the view that “*the services to which the contract relates are capable of being provided only by that provider*”. The old Regulation 5(2) provided:

“(2) The services are to be determined as capable of being provided by a single provider only when—

- (a) for technical reasons, or for reasons connected with the protection of exclusive rights, the contract may be awarded only to that provider; or
- (b) (only if it is strictly necessary) for reasons of extreme urgency brought about by events unforeseeable by, and not attributable to, the relevant body, it is not possible to award the contract to another provider within the time available to the relevant body for securing the provision of the services”

13. This definition section has been removed from the new Regulations. Accordingly it appears to be up to commissioners to decide for themselves whether the services to which the contract relates are capable of being provided only by a single provider. However a commissioner could only reach that view if there was clear evidence that the services to which the contract relates were genuinely only capable of being provided by a single provider.

14. The House of Lords Secondary Legislation Scrutiny Committee drew attention in paragraph 20 of their Report dated 7th March 2013 concerning the old Regulations to the “narrowness of regulation 5” and its potential conflict with statements made by Ministers to Parliament (which are set out at paragraph 19 of the Report and are referred to in my previous advice). I consider that the new Regulations have done little if anything to respond properly to this concern because the statutory “single provider” test for the circumstances in which a CCG can avoid a competition remains unchanged.

15. One key question is whether commissioners would be entitled to take a strategic decision to avoid a competition for a contract if they took view that it would be in the interests of patients for a particular service to be integrated together with other health or social care services that were already being provided by an existing NHS provider. This is clearly the thinking which led to the change to Regulation 2 which specifically allows NHS commissioners to take account of the benefits of services being provided in an integrated way (including with other health care services, health-related services or social care services). However that objective cannot be achieved in practice if, in making the decision under Regulation 5 whether a commissioner can lawfully avoid having a competition, the only test a commissioner is permitted to apply is whether the contract relating to those services (as opposed to other services) is only capable of being delivered by a single provider. If the answer to that question is that the contract is capable of being delivered by more than one provider, the CCG must hold a competition even if it is not in the interests of patients to do so.

16. A second problem arises where there is more than one potential provider for a range of NHS services but where it is in the interests of integration of local services for a contract to be placed with a local hospital provider. This will happen for example in any urban conurbation where there is more than one major hospital within a reasonable ambulance ride from the CCG area. In such circumstances there is more than one potential provider of A & E services and therefore more than one provider of other acute services. A CCG may feel it has a strategic interest in maintaining services at its local hospital but, in such circumstances, the CCG will be forced to run an expensive competition between acute providers each year before it is able to re-let the annual acute services contract. It is difficult to see how such a process can benefit the NHS as a whole.

17. It follows that the statutory objective of recognising the benefits of integration under Regulation 2 is effectively emasculated by the narrowness of the test for avoiding a competition under Regulation 5 (bearing in mind that a competition is likely to lead to a diversity of providers and thus prevent integration of services within a single provider).

18. The other major change in the new Regulations is in Regulation 10 which seeks to prevent commissioners acting in a way that amounts to anti-competitive behaviour. Anti-competitive behaviour is defined in section 64(2) of the 2012 Act as follows:
““Anti-competitive behaviour” means behaviour which would (or would be likely to) prevent, restrict or distort competition and a reference to preventing anti-competitive behaviour includes a reference to eliminating or reducing the effects (or potential effects) of the behaviour”

19. Section 62(3) of the 2012 Act provides:
“Monitor must exercise its functions with a view to preventing anti-competitive behaviour in the provision of health care services for the purposes of the NHS which is against the interests of people who use such services”

20. Thus Monitor is under a statutory duty to prevent NHS commissioners undertaking anti-competitive behaviour. The original Regulations 10(1) and 10(2) provided:

- “(1) When commissioning health care services for the purposes of the NHS, a relevant body must not engage in anti-competitive behaviour which is against the interests of people who use health care services for the purposes of the NHS.
- (2) An arrangement for the provision of health care services for the purposes of the NHS must not include any restrictions on competition that are not necessary for the attainment of intended outcomes which are beneficial for people who use such services”

21. This Regulation has now been changed to read as follows:

- “(1) When commissioning health care services for the purposes of the NHS, a relevant body must not engage in anti-competitive behaviour unless to do so is in the interests of people who use health services for the purposes of the NHS which may include:
 - a) By health services being provided in an integrated way (including with other health care services, health-related services or social care services); or
 - b) By co-operation between the persons who provide services in order to improve the quality of services.
- (2) An arrangement for the provision of health care services for the purposes of the NHS must not include any restrictions on competition that are not necessary for the attainment of intended outcomes which are beneficial for people who use such services”

22. This wording is, to say the least, rather strange because it appears specifically to licence NHS commissioners acting in an anti-competitive way. There is a potentially

important difference between:

- a. Defining actions which would constitute or specifically do not constitute anti-competitive behaviour by an NHS commissioner; and
- b. Purporting to permit NHS commissioners to act in a way which acknowledged to be anti-competitive provided if the anti-competitive behaviour achieves certain defined objectives.

23. The wording of these Regulations appears to permit NHS commissioners to engage in some types of anti-competitive behaviour, but they are only permitted to do so if the commissioners can show objectively that the anti-competitive behaviour is in the interests of people who use health services for the purposes of the NHS. The Regulations then give 2 examples where this type of anti-competitive behaviour which may be considered to be justified. It is not clear whether it is *intra vires* the enabling legislation for Regulations to permit NHS commissioners to act in a way that is acknowledged to be anti-competitive. It seems foreseeable that this part of the Regulations will be challenged by a commercial provider on that ground.

24. However there is a practical problem with Regulation 10(1), as presently drafted, because the test as to whether anti-competitive behaviour is justified is expressed to be an objective test rather than a subjective test. Thus an NHS commissioner might feel strongly that it is in the interests of patients for services to be integrated but, in the final analysis, it will be for Monitor will be entitled to judge whether any anti-competitive behaviour is justified or not. Thus, at the time that NHS commissioners take relevant decisions, they will not know whether their actions are lawful or not. It seems inevitable therefore that NHS commissioners will err on the side of caution and thus put more contracts out to competition.

25. The final significant change to the Regulations concerns the powers for Monitor to investigate anti-competitive behaviour. This part of the Regulations is largely unchanged except there is a significant new Regulation 15(2) which provides:
“Monitor may not direct a relevant health body under paragraph (1) to hold a competitive tender for a contract for the provision of health care services for the purposes of the NHS”

26. On the face of things, this appears to suggest that an NHS commissioner who acts unlawfully in failing to put a service out to tender (by for example wrongly concluding that the single provider test in Regulation 5 is satisfied) cannot be compelled to hold a competitive tender. However that would be a misreading of the effect of Regulation 5. All that Regulation 15(2) provides is that this is a sanction that Monitor may not impose. However if an NHS commissioner acts unlawfully (by for example concluding that the single provider

test in Regulation 5 is satisfied when no reasonable commissioner could have come to that view because another provider who could provide the relevant services) there is a real possibility that the commissioner could be subject to a Judicial Review claim and the court would be entitled to quash the Regulation 5 decision of the commissioner. Thus, in effect, the High Court could order the commissioner to re-take the Regulation 5 decision and thus, in effect, order the services to be opened up to competition.

27. Paragraph 14 of the House of Lords Report raised the concern that competition would become the “default option” for the provision of NHS services. This would, as their Lordships noted in paragraph 10:

“... substantially increase the costs and time taken over commissioning ... and that commercial confidentiality would reduce public involvement in the commission process in violation of the NHS constitution and the public involvement and consultation by clinical commissioning groups provisions in the Health and Social Care Act”

28. There does not appear to me to be anything substantial in the new Regulations which responds to these very real concerns. The assurances given by Ministers in Parliament about the freedoms that commissioners would have to commission services in the way they consider best for their local populations (as recorded at paragraph 19 of the House of Lords committee report) do not appear to be honoured by these new Regulations just as they were not honoured by the old Regulations.

29. The key problem is that the government is continuing to maintain the very narrow test in Regulation 5 which needs to be satisfied before a commissioner can lawfully take the decision to enter into a contract for NHS services without holding a competitive tender. The government has purported to introduce a wider test concerning the promotion of integration under Regulation 2 and to permit certain anti-competitive behaviour under Regulation 10. However the government has not carried that logic through to the test as to when a commissioner can let a contract without a competitive process under Regulation 5. In those circumstances the changes to Regulations 2 and 10 concerning the introduction of wording about integration and co-operation between providers does not amount to any substantial change to the effect of the Regulations.

DAVID LOCK QC

11th March 2013.

Advice by Ligia Osepciu, of Monckton Chambers:

RE: NATIONAL HEALTH SERVICE (PROCUREMENT, PATIENT CHOICE AND COMPETITION) (NO. 2) REGULATIONS 2013

NOTE OF ADVICE

1. I am asked to advise 38 Degrees on three discrete issues arising out of the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (“the New Regulations”) made on 6 March 2013 and coming into force on 1 April 2013. The New Regulations repeal and replace the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013 (“the Old Regulations”) made on 11 February 2013.
2. I address each question in turn below.
 - I. Do the New Regulations go as far as permissible under European law in meeting the assurances given in Parliament last year?
3. The “assurances” referred to are as follows:
 - a. A statement by the Secretary of State for Health that *“there is absolutely nothing in the Bill that promotes or permits the transfer of NHS activities to the private sector”*;
 - b. A statement by the Secretary of State for Health that CCGs would not be forced to fragment health care services or put such services out to tender;
 - c. A statement by the Health Minister that regulations would not *“impose compulsory competitive tendering requirements”* in CCGs, nor provide for Monitor to have powers to impose such requirements;

- d. A statement by the Health Minister that CCGs will have a full range of options and will be under no legal obligations to create new markets.

4. Statements (a) and (d) in particular focus on the changes (or lack thereof) that the New Regulations would make to the existing provision of public procurement of health care services. It is, therefore, worth beginning with an overview of the status quo.

Existing obligations on NHS Trusts when procuring health care services

5. NHS Trusts are “contracting authorities” for the purpose of the Public Contracts Regulation 2006 (“PCR”): see regulation 3(1)(y) and Schedule 1, paragraph 1, PCR.
6. Under the PCR, contracting authorities (including NHS Trusts) are obliged to advertise and follow a competitive tendering process when procuring contracts for goods, works and certain types of services (“Part A Services”) having a value over specified thresholds: regulation 5(1) and 8, PCR. Certain categories of contract, none of which seem immediately relevant for present purposes, are excluded from the scope of this tendering obligation: see regulation 6(2), PCR. In addition, the obligation to advertise and conduct a competitive tender is excluded in certain limited circumstances – for example, in cases of extreme urgency or where for technical or artistic reasons, or for reasons connected with the protection of exclusive rights, the contract may only be awarded to a particular economic operator: see regulation 14, PCR.
7. Contracts for the provision of health and social services are classified as Part B services contracts: see Schedule 3, Part B, Category 25, PCR.
8. Part B services contracts are subject to the PCR only in limited respects. Thus, the PCR imposes no *explicit* obligation on a contracting authority to advertise or tender a Part B services contract above a certain value, only an obligation to treat economic operators (a) equally and in a non-discriminatory way and (b) act in a transparent manner when awarding Part B services contracts: regulations 4(3) and 5(2), PCR.
9. However, European Court of Justice (“ECJ”) precedent indicates that the application of the aforementioned general European law principles of transparency and non-discrimination effectively requires a contracting authority to advertise and tender a Part B services contract where there is a “*realistic prospect of cross-border interest*” in that contract: Case C-324/98 *Telaustria* [2000] ECR I-10745. The advertising and tendering requirements that apply in Part B services cases involving a cross-border interest are probably more flexible than the relatively rigid framework for tendering and contracts award

applicable to goods, works and Part A services under the PCR.

10. For the avoidance of doubt, there is nothing in the PCR requiring a contracting authority to buy in Part B services rather than providing these in house. For these purposes, there is EU and UK case law confirming that “in house” provision covers both:
- a. provision by the contracting authority itself; or
 - b. contracting out the services to an entity:
 - i. over which the contracting authority exercises decisive influence either jointly or in conjunction with other contracting authorities; and
 - ii. that carries out an essential part of its activities with contracting authority or authorities that have decisive influence over it (“the *Teckal* exemption”).

See Case C-107/98 *Teckal v Commune di Viano* [1999] ECR I-8121; *Brent LBC v Risk Management Partners Ltd* [2011] UKSC 7.

11. In addition, I am instructed that a number of NHS Trusts currently take the view that purchasing health care services from other NHS entities constitutes a form of “in-house” provision even where the *Teckal* test is not met - because the NHS should be regarded as a single contracting authority. I am not aware of any UK or European case law that tests the legal position in this respect, but I am instructed that, in practice, a number of NHS Trusts currently rely on this analysis in order to purchase health care services from other NHS entities without going through a competitive tendering procedure.
12. There is nothing in the PCR that specifically dictates the package of Part B services that a contracting authority can seek to procure at any given time: it is for the contracting authority to define its own requirement for services.
13. Thus, the contracting authority is, in principle, free to bundle together requirements for different services in to a single procurement subject to the risk of:
- a. a judicial review challenge on the grounds that such bundling is *Wednesbury* unreasonable; or
 - b. a challenge under regulation 4(3)(a), PCR on the grounds that such bundling is discriminatory – effectively because the services requirement has been

artificially concocted to ensure that there is only one possible provider of the service to which a direct award of the contract can be made.

I am not aware of any UK or EU case law in which such a challenge to the scope of the service requirement itself has succeeded.

Do the New Regulations promote or permit transfer of NHS activities to the private sector?

14. Against that background, it seems to me that, as compared with the status quo, the New Regulations might potentially permit or promote a transfer of NHS activities to the private sector in the following four ways:
 - a. By removing the option of direct in house provision of services by the commissioning bodies (now CCGs);
 - b. By removing the availability of the aforementioned *Teckal* exemption;
 - c. By removing the possibility of reliance on the broader understanding of “in house” provision detailed in paragraph 11 above (i.e. all purchases of health care services from other NHS entities are considered “in house” provision);
 - d. By requiring advertisement and tender of Part B services contracts in instances where there is no realistic prospect of cross-border interest (where a direct award would otherwise probably be acceptable under the PCR);
 - e. By requiring commissioning bodies (now CCGs) to fragment their services requirements (i.e. procure each required service separately), thereby undermining any available arguments about awards going to the “only capable provider” of an integrated package of services.
15. I now consider whether each of the above concerns is justified in respect of the New Regulations.
16. As regards point 14(a), the New Regulations apply to CCGs “*when procuring health care services*”: see regulation 2(1) and 3(1). Thus, the New Regulations themselves do not address the prior question of whether a CCG is required to procure all services from a third party provider or whether it may provide some services itself. In my view, there is nothing in the Regulations that prevents a CCG from providing required services itself. However, I appreciate that there may be a relevant restriction on the role of CCGs in the primary legislation – i.e. the Health and Social Care Act 2012 – which I have not had time to review in detail.

17. As regards point 14(b), there is, in my view, a genuine risk that the New Regulations will be interpreted as abolishing the *Teckal* exemption as it applies to CCGs commissioning health care services. As noted above, the New Regulations apply to CCGs “*when procuring health care services*”. One reading of “*procuring*” in this context is as “*purchasing services from any third party even one that satisfies the Teckal exemption*”. Another reading of “*procuring*” in this context involves considering purchases from an entity that meets the *Teckal* requirements as a form of in house provision (i.e. not procurement at all).
18. One way of achieving clarity on the retention or abolition of *Teckal* in the New Regulations would be to include a definition of “*procuring*” in regulation 1 specifying that it is not intended to cover
- “purchases by a relevant body from an entity (i) over which the relevant body exercises decisive influence either jointly or in conjunction with other relevant bodies or contracting authorities within the meaning of the PCR and (ii) that carries out an essential part of its activities with contracting authority or authorities that have decisive influence over it”*
19. Given the narrowness of the *Teckal* exemption, it is not obvious that its express preservation in the New Regulations will make much difference in practice. In particular, it is not clear whether, following the current NHS reforms, CCGs will be entitled to have/will have the structural (controlling) links with other NHS entities that are necessary to engage *Teckal* in respect of those entities.
20. As regards point 14(c), there is, in my view, a genuine risk that the New Regulations eliminate the possibility for reliance on the broader understanding of “in house” provision outlined in paragraph 11 above. This goes back to the undefined term “*procuring*” in regulations 2 and 3 and the fact that one obvious way of interpreting that term is as covering any purchase of services by a CCG or by the Board from any other entity (including another NHS entity). If “*procuring*” in the New Regulations is construed in that way, the Board and CCGs will not be able to purchase health care services directly from another NHS entity (without running a competitive tender) unless they can show that the other NHS entity is the only possible provider of the relevant services (see below).
21. In my view, there remains some scope to argue that the term “*procuring*” in the New Regulations can be construed to exclude the purchase of health care services from other NHS entities. However, it is not at all obvious that such a construction would prevail if

tested in court.

22. Therefore, there is a practical risk that the Board and the CCGs will err on the side of caution when interpreting the New Regulations and will cease to rely on the broad understanding of “in house” provision outlined above in support of direct award to other NHS entities – resulting in more competitive tendering of health care services than there is under the current regime and effectively promoting the transfer of NHS activities to the private sector.
23. One way of achieving clarity in respect of the continued availability of this broad understanding of “in house” provision is to include an appropriate definition of “procuring” in regulation one stating that it is not intended to cover “*purchases by a relevant body from another NHS entity*”. The Term “*NHS entity*” would itself require appropriate definition.
24. As regards point (d), the New Regulations do not expressly state an obligation to advertise and conduct a competitive tender in respect of all health care service contracts that are not being procured (see (a) and (b) above on the definition of “in house”). Instead, regulation 5(1) provides that a relevant body “*may award a new contract for the provision of health care services for the purpose of the NHS to a single provider without advertising an intention to seek offers*” where the provider is the only capable provider of those services. The fact that regulation 5(1) provides for this exception from the advertising requirement strongly implies a duty on relevant bodies to advertise all contracts for the provision of health care services that do not fall within that exception. In my view, the New Regulations are likely to be interpreted in this way and that seems to be their plain intent.
25. On that basis, under the New Regulations it appears that, once a CCG has taken a decision to procure health care services, it is obliged to advertise an intention to seek offers from providers in relation to the relevant contract unless the “only capable provider” exception in regulation 5(1) applies. Thus, there is no scope to argue, as there currently is for NHS Trusts under the PCR, that a particular contract for the provision of health care services is a Part B services contract carrying no realistic prospect of cross-border interest in respect of which advertising is not required (i.e. in respect of which a direct award to a particular provider is warranted).
26. Removal by the New Regulations of this exception to the advertising and tendering requirement for health care services contracts could, in practice, promote the transfer of NHS activities to the private sector – i.e. because CCGs will not be able to rely on their assessment of the cross-border interest in support of a decision to award a contract to an NHS body rather than advertising and tendering that contract and opening it up to the

market.

27. However, in the past contracting authorities under the PCR have tended to be overly optimistic in their assessment of the lack of cross-border interest in a particular contract. In the health care sector, where there are an increasing number of providers that are active across Europe, it is by no means clear that CCGs would be able properly to rely on an argument that there is no prospect of cross-border interest in any great number of cases. Indeed, the New Regulations might be read as reflecting an assumption on behalf of government that there will be a realistic prospect of cross-border interest in respect of the preponderance of health care services contracts.
28. Nevertheless, one way of the maintaining the status quo would be to build the lack of cross-border interest exemption back into the New Regulations.
29. As regards point (e), as noted above, under the PCR there is very little scope of challenging the way in which a contracting authority frames its requirement for services – i.e. what services and packages or “bundles” into a single contract. In my view, the New Regulations do not change this for health care services contracts procured by CCGs.
30. The concern has been raised that regulation 5(1) effectively requires CCGs to fragment their requirements for services – that is, to procure only one type of service under each contract, for example, one contract for ambulance services and another for emergency services. Regulation 5(1) provides in relevant part:
- “A relevant body may award a new contract for the provision of health care services...without advertising...where the relevant body is satisfied that the services to which the contract relates are capable of being provided only by that provider”.*
31. The argument that fragmentation is required by the New Regulations seems to be based on a reading of the reference to “*the services to which the contract relates*” in regulation 5(1) as meaning “*one single category of health care services – e.g. ambulance services*” (“the narrow view”) as opposed to “*one or multiple categories of health care and other services – e.g. ambulance and emergency services*” (“the broad view”), the word “services” confusingly being plural in both cases.
32. In my view, both the broad and the narrow views of regulation 5(1) are open on the wording of that regulation alone. However, when regulation 2 is taken into account, the

broad view – that “*services to which the contract relates*” refers to one or multiple categories of services procured under a single contract – becomes far preferable. Regulation 2 provides that, when procuring, a body must act with a view to securing the needs of the people who use the services etc “*including through the services being provided in an integrated way (including with other health care services, health-related services, or social care services)*”. In my view, regulation 2 makes it fairly clear that CCGs are entitled to formulate requirements for bundles or packages of services.

33. Read in light of regulation 2, regulation 5 places no restriction or limit on the “services to which a contract can relate”; it simply supposes a requirement of services formulated in accordance with regulation 2. On this interpretation, regulation 5 would allow a CCG to award a contract for bundled health care services without advertising or tendering when the entity awarded the contract is the only provider capable of providing the CCG with the whole bundle of required services.

34. In my view, there is a strong argument that regulation 5 should be read in light of regulation 2 and not the other way around. However, I do recognise that working through the interaction between regulations 2 and 5 in their current state is likely to require some litigation and interpretation by the courts. Pending the development of judicial precedent, it is conceivable that, in practice, the Board and/or some CCGs may seek to “err on the side of caution” by procuring each category of services separately, resulting, in practice, in fragmentation of services and allowing scope for “cherry-picking”.

35. To the extent that there remains some measure of ambiguity as to the whether the broad or the narrow reading of regulation 5(1) is appropriate, great clarity might be provided by adding the following or similar drafting to regulation 2:

“For the avoidance of doubt, nothing in these regulations is intended to restrict or prescribe the way in which a relevant body formulates its requirement for a particular contract involving the provision of health care services, and, in particular the extent to which a relevant body integrates different types of health care, health-related and social services into a single contract requirement”.

36. I note that inappropriate bundling of services into a single requirement will remain subject to the possibility of challenge by way of judicial review or on grounds of discrimination under regulation 3(2)(a) of the New Regulations (on the basis that the requirement has been framed with a pre-conceived intent of awarding to a pre-selected provider). However,

both of these sorts of challenges are very difficult to bring and I am not aware of one succeeding in the past (either on judicial review or under the PCR).

Do the New Regulations require fragmentation of services?

37. This point is addressed at paragraphs 29-36 above.

Do the New Regulations impose compulsory tendering?

38. In my view, the New Regulations make advertising and tendering of health care services contracts compulsory where:

- a. There has been a decision not to provide the relevant services “in house” at the CCG; and
- b. There is more than one capable provider of the services (noting that there is a strong argument that the services requirement under a particular contract can be framed so as to package together multiple types of services – e.g. ambulance and emergency services).

39. However, having said that, the only changes that the New Regulations make from the current position with respect to the compulsory tendering of health care services contracts under the PCR are as follows:

- a. The potential abolition of the *Teckal* exemption as regards health care services;
- b. The potential elimination of the option to rely on the broad view of “in house” provision in the NHS context (involving an understanding of the NHS as a single contracting authority, thereby enabling direct awards of services contracts to be made between NHS bodies)[1];
- c. The removal of the exception to tendering requirements in the event of a lack of realistic prospect of cross-border interest.

In addition, there is an argument that fragmentation of services is required under the New Regulations, which is addressed at paragraph 29-36 above.

Do the New Regulations require CCGs to create new markets?

40. I understand this to be another way of giving assurances on the fragmentation of services issue. My views on that are set out at paragraphs 29-36 above.

II. How do the New Regulations improve upon the Old Regulations?

41. In my view, the key improvement on the Old Regulations is the addition of express reference to “*services being provided in an integrated way*” in regulation 2 of the New Regulations.
42. As noted above, I consider that this wording very much favours the broad view of regulation 5(1) – i.e. that “*services to which the contract relates*” can encompass “*one or multiple categories of health care and other services*” - and so makes it clearer that fragmentation is not being required. In paragraph 35 above, I give a suggestion for how this can be made clearer still.

III. Does regulation 5 permit the integration of a number of different health care services into a single bundled requirement and award of the whole requirement to the “only capable provider” of that requirement?

43. This point is addressed in paragraphs 29-36 above, esp. paragraph 32-34.
44. The short answer is that I think that there is currently a (limited) measure of ambiguity on this point in the drafting regulation 5, which I think is likely to be resolved through the courts in accordance with the position stated by Lord Clement-Jones. However, some extra wording suggested above (or similar) could be used to firm up the statutory position.

IV. Follow-up question: can a direct award be made under regulation 5(1) where there are multiple possible providers of the contract services, but only one that offers a CCG’s desired level of integration with other services?

45. By way of follow-up question, 38 Degrees has asked me specifically to consider possibility of a direct award regulation 5(1) where a CCG has taken a decision to procure for a narrow service requirement – for example, a single service requirement for ambulance services – for which there are multiple possible providers, but only which will be able to integrate the individual service requirement with the provision of other services (those other services falling outside the scope of the contract being procured).
46. Under regulation 5(1), a direct award is permissible where there is only one capable provider of “*the services to which the contract relates*”.
47. Thus, having decided the scope of the services that it would like to take under a contract,

regulation 5(1) seems plainly to limit the CCG to a consideration of whether those particular services, and not other related services that sit outside the contract, are only available from one provider.

48. I can see some scope for a policy argument that regulation 5(1) should be read to permit a direct award to facilitate a later integration of services and thereby avoid an undesirable inconsistency in the treatment of "up front" bundling and later bundling of service requirements. However, the statutory language in regulation 5(1) is relatively clear and I am not confident that such a policy argument would succeed.
49. I note that, whilst a direct award is unlikely to be permissible in these circumstances, there is nothing in the New Regulations that prevents a CCG from taking into account the desirability of services being provided in a more integrated way when assessing the value for money of tenders submitted for a particular health care services contract. Indeed, that seems to be contemplated in regulations 2 and 3(3)(a).
50. In practice, using the "desirability of service integration" or similar as a criterion for the award of health care services contracts may well draw complaints of discrimination contrary to the PCR from challengers who are unable to provide such integrated services. However, where the criterion requiring service integration is formulated pursuant to a genuine commissioning need/a considered commissioning policy, it may well be difficult for such a challenge to succeed. The outcome of each individual such challenge will, of course, very much depend on the exact underlying facts.
51. I am very happy to discuss or clarify any aspect of this advice.

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19 MARCH 2013

[1] Note that, to the extent that this view goes beyond *Teckal*, it has not, to my knowledge yet been tested in either the UK or the EU courts.