Healthcare Sector

NHS reform and the case of A v B (2016) [1]

This case involved an application by a Clinical Commissioning Group (CCG) to lift an automatic suspension that had been applied after an unsuccessful bidder (and the incumbent provider) challenged the award of a contract for adult community services in Kent. A striking aspect of this case was that the CCG had awarded the contract to Virgin Care and the challenger was an NHS Trust. Colloquially, "the NHS" tends to be viewed as a single organisation rather than as multiple organisations that may be competing with each other or have different views about what is best for the public. This case is interesting because it provides an insight into commercial and cultural changes happening in the NHS both in terms of the parties involved and how it was argued.

As is usual in applications to lift an automatic suspension, the Court applied the American Cyanamid principles. The Court concluded without much complexity that there was a serious issue to be tried and that damages would be an adequate remedy for the NHS Trust but that there was a significant risk that damages would not be an adequate remedy for the CCG. The interesting argument came around the balance of convenience and what was in the public interest. The NHS Trust argued that it was in the public interest for health services to be provided by an NHS organisation. The CCG had a very different view in that it thought that the public interest would be best met by the provider it had selected after a competitive tender. The Court had to rule in a case where two limbs of the NHS had diametrically opposing views of what was in the public interest. It concluded that "It could not be said that the trust would provide better care, and therefore the public interest could not be taken into account as a significant weight on one side of the balance when assessing the balance of convenience".

NHS reforms **[2]** made a massive change to the NHS landscape possible. The 211 CCGs across the country were given control of approximately two-thirds of the NHS budget (currently exceeding £100 billion per annum). The NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 govern how CCGs and other commissioning bodies should operate in relation to procurement, patient choice and competition. On the one hand, part of these regulations give the impression of an agenda to promote competition; commissioning organisations have the objectives

of securing the needs of service users, improving quality, improving efficiency and enabling service integration. In doing so, services must be procured on the basis of the provider(s) that are most capable of delivering these objectives and providing best value for money. On the other hand, part of these regulations and Monitor's guidance on applying them seem to permit commissioning bodies to side-step competitive tendering **[3]**. It seems that the outcome of these regulations is to leave it to the commissioning bodies to decide what is best for the public. Perhaps, the result of all this reform is to create a broad church - you can do or believe in what you want; competition in services or NHS-only delivery or a bit of both. The problem, of course, with a broad church is the risk of conflict.

Up until 18 April 2016, the Public Contracts Regulations 2015 did not apply to health service procurements. Now, NHS procurements are covered by both the NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 and the Public Contracts Regulations 2015. The overlap seems unlikely to make compliance any easier. Within the Public Contracts Regulations 2015, health services are covered by the "light touch regime". This requires advertisement in the Official Journal of the European Union (amongst other obligations) if the contract has a value greater than £589,148. As CCGs have over £60 billion of NHS funds to spend, one could reasonably expect a number of contracts to be above threshold. However, the number of published notices relating to CCGs for 2016 is relatively low (12 on the date of writing). This compares with 25 notices for 2015 and, perhaps, suggests that little has really changed and competitive tendering is still experimental rather than fundamental.

Another point to which this case draws attention, is the extent to which NHS bodies are well-prepared to compete with commercial organisations in competitive tenders. In the past, NHS bodies' experience of tendering has been as the buyer not the seller. There may be a need for some NHS bodies to adapt and expand their skills to be effective in submitting tenders. There is also cause for concern in relation to the UK Competition Act; its implications may be lost on an organisation that can not determine whether it is one indivisible whole or something quite different.

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[1] A v B (2016) QBD (TCC) 27/05/2016
[2] Health and Social Care Act 2012, NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013
[3] See regulation 10 NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013

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