



Community Network response to the provider selection regime consultation

The Community Network is the national voice of NHS community providers. We support trusts and not-for-profit organisations providing NHS community health services to deliver high-quality care by influencing national policy development, sharing good practice, and promoting a vision of integrated care in the community. The Network is hosted by the NHS Confederation and NHS Providers.

In this consultation response for the Community Network, we deliberately align our key messages with the NHS Providers submission, but have focused on the implications for community providers more specifically and in greater detail.

Key points

- **We welcome the intention behind the new provider selection regime, to move away from competitive retendering and burdensome procurement processes**, in support of a more collaborative approach to planning and delivering services within local systems. We agree that the current procurement rules can be costly and time-consuming, disincentivise collaboration, and contribute to workforce instability.
- **The issues outlined above have a significant effect on the providers of community health services, which tend to face the regular retendering of services.** This creates undue disruption and costs for community services, as well as creating uncertainty for both staff and patients. On a related point we welcome the suggestion in the proposals that public health services commissioned by local authorities will be subject to be the same procurement processes as NHS services. We see this an important step in reducing unnecessary fragmentation.
- **We also welcome the emphasis on applying the new regime equitably across all provider types.** However, it is also important to acknowledge that, within the community sector, different types of providers will be affected differently by these proposals. It will be important to understand the impact of the regime on different models of community provision including trusts and Community Interest Companies (CICs).
- **However, we still have questions and concerns about how the new regime will operate in practice, especially around the level of transparency and accountability provided for in the initial proposals.** This includes a lack of robust safeguards and processes for meaningful challenge, a lack of detail on managing conflicts of interest and uncertainty about how decision-making bodies will demonstrate compliance with the regime.
- **The proposals would benefit from strengthened safeguards for quality and patient safety.** We welcome the inclusion of quality and patient safety as key criteria. However, there are risks attached to the level of flexibility prescribed in the consultation, particularly given the financially constrained environment. In our view, the wording, which allows decision-making bodies to compare providers against the key criteria 'according to any hierarchy of importance they decide is necessary', may risk scenarios where quality is compromised, leading to unwarranted variation.



- **The new regime needs to be considered in the context of other proposals in the health and care white paper.** Successfully delivering the new provider selection regime is connected to the development of ICS Boards, the roll out of the new financial architecture and the development of provider collaboratives. Without a clear understanding of ICS governance and accountability arrangements, it is difficult to judge whether the new regime will be sufficiently, and we would welcome ongoing engagement with NHSE/I as the regime develops.
- **These proposals represent a significant legal, cultural and operational shift in approach.** Commissioners at all levels of the system from the ICS Board to provider collaboratives, lead providers, individual NHS trusts and foundation trusts, and non-NHS providers of community services will need a comprehensive programme of support to underpin delivering this change of approach successfully. We would welcome the opportunity to continue engaging with NHSE/I as the regime develops, and feeding in the views of the community sector.

Introduction

We welcome the opportunity to give the views of trusts and CICs on NHSE/I's consultation on the new provider selection regime. As outlined above, the community sector is disproportionately affected by the current procurement arrangements, and we support the decision to move away from competitive procurement rules. However, the proposals outlined in the consultation document create some new risks and concerns which will need to be addressed before we can fully support these proposals. In addition, given the range of organisational types that make up the community provider landscape, it will be important for NHSE/I to further explore any unintended consequences for different types of community providers.

Specific questions:

1. **Should it be possible for decision-making bodies (eg the clinical commissioning group (CCG), or, subject to legislation, statutory ICS) to decide to continue with an existing provider (eg an NHS community trust) without having to go through a competitive procurement process?**

Agree. We support this proposal under the suggested conditions. Community providers are clear that the current regime can be costly, absorb significant amounts of leadership time, impede longer term planning and that repeated tendering creates unjustifiable uncertainty for staff, patients and services. Ultimately, this can create an unnecessary distraction from the improvement of clinical delivery and integrating care. As such, we welcome the intention to move towards a system that addresses some of these challenges and reduces the burden on providers. In addition, the current procurement regime disincentivises collaboration, and, as the NHS rightly moves towards further integration, removing default competitive retendering will further support this direction of travel.



However, the new provider selection regime will only work if it is underpinned by robust processes and appropriate safeguards to ensure contracts are not inappropriately awarded. We have some concerns around how transparently the regime will operate in practice, which will need to be addressed before we can fully support the proposals outlined (Q7).

In many cases, the proposal to allow the decision-making body to confirm the continuation of existing arrangements will be beneficial, for instance where there is only one provider, and when the provider is performing well. However, even in these circumstances, the decision to continue with a provider should be subject to robust evidence-based criteria, transparent to all parties, with suitable mechanisms to make representations where interested parties have significant concerns. In addition, we would expect the timing of particular decisions by the new ICS Board as a commissioner, to be transparent to all relevant parties. Indeed, providers, and other stakeholders, must be given adequate opportunity to make representations to the decision-making body, should they wish to do so. These checks and balances will help to create trust in the process, and to ensure that quality is continually being improved.

We expect NHSE/I to set out exceptions to the application of the regime in due course. We would welcome more detail on this, and the 'appropriate steps' that decision-making bodies should take when awarding and managing contracts, and how this will interact with CQC's revised approach to regulation and the new NHSE/I oversight framework.

Finally, we welcome the fact that the consultation document specifically highlights that the new regime will be applied to all types of provider. We would invite NHSE/I to share further details of the supporting provisions that will ensure that this encouraging intention is taken forward. This could include provisions to guarantee that a provider cannot be scored down or ruled out of a process due to organisation type. This transparency issue is particularly key for CICs, who have raised concerns about how the new provider selection regime may unintentionally create an uneven playing field, with procurement preference inherently tilted towards NHS bodies through the ICS structure. Some CICs have noted concerns about the fact that, while they may have a voice on ICS boards, they are unlikely to have a vote or decision-making power in the expected structure, unlike many NHS providers.

2. Should it be possible for the decision-making bodies to be able to make arrangements where there is a single most suitable without having to go through a competitive procurement process?

Agree. As per our answer to Q1, we support the intention to move away from default competitive procurement processes, which create several challenges for providers, and sit outside of the agreed



direction of travel towards greater integration and collaboration. Where there is a single suitable provider, it is reasonable to bypass costly and time-consuming competitive procurement processes. However, we would reiterate that this new regime needs to be underpinned by sufficient safeguarding, transparency and governance to avoid inappropriate decisions.

As well as assessing the provider against key criteria to confirm that the provider is performing well, the decision-making body should publicly set out the steps taken to confirm that there is no alternative provision to make the regime as robust as possible.

This will be particularly important in the circumstances outlined in Q2, as there must be sufficient safeguards to ensure that idiosyncratic or inappropriate decisions cannot be made “where the decision-making body wants to use a different provider”, and must be based on clear evidenced criteria, with rationale that is open and transparent to all parties, especially incumbent providers. Providers must then also have sufficient recourse to challenge any decision that is viewed as inappropriate, based on the clear set of criteria and robust and transparent steps to assess any alternative decision-making.

Community providers have raised concerns about the reduction in the market-place for community contracts, and how this will impact the non-NHS sector. In light of this, robust mechanisms must be available to challenge decisions where they may be inappropriate. We would encourage NHSE/I to engage with CICs, who feel most compromised by these proposed changes, to understand how these challenges can be addressed in the proposals.

3. Do you think there are situations where the regime should not apply/should apply differently, and for which we may need to create specific exemptions?

We would agree that circumstances where the regime as described should not apply are:

- where patient safety is immediately at risk; and/or
- where a provider suddenly becomes unable to operate e.g. through insolvency, lack of critical workforce

However, we also believe that the document would benefit from highlighting the complexities created by commissioning across multi-ICS footprints, or how decisions made by the ICS Board or decisions delegated to ‘place’ may operate. This is particularly relevant for community providers which operate at scale (sometimes across ICS boundaries) within a number of individual places.

The community sector will particularly welcome mention in the consultation document that section 75 agreements with local authorities, and local authority commissioned health care services will fall under the same regime. This is especially important for the providers of community health services who deliver many local authority public health contracts, and who tend to be affected by the challenges around fragmentation that separate procurement arrangements can bring. While the



proposals embody a move towards a more co-ordinated and coherent approach that we support, we would also welcome, when possible, greater detail on how joint commissioning arrangements will operate in the new ICS context, and whether further modifications to local government procurement rules are required to enable this approach.

However it is unclear how commissioning arrangements at the ICS level will interact with functions delegated to 'place'. We assume that this will be for local discretion within individual systems. However there will be a tension between the pull of more localised provision at the level of place, and the benefits many trusts and other larger scale providers can offer, in terms of a consistent model of service within a number of places sometimes, in the case of mental health and community providers, offering services which are delivered locally, at home and in the community, but organised at scale across ICS boundaries. This reflects the variation in viewpoints across different types of community providers, who are likely to be impacted in different ways dependent on size, type and local geography.

More specifically, we have some concerns about criterion 5 outlined in the consultation document, which states the need for, "decision-making bodies give due consideration to how their decisions may affect the current stability and wider sustainability of services over time and/or in the wider locality". We would question the level of discretion this may give the decision-making body, and would ask for further detail of how 'current stability and wider sustainability' will be measured as part of this criteria. While we understand the need for flexibility, there must also be appropriate safeguards to ensure that there are clear parameters for the use of such criteria.

4. Do you agree with our proposals for a notice period?

We disagree. We question whether the proposed 4-6 week notice period for challenging decisions is sufficient to allow for credible representations from providers', to communicate effectively with relevant staff, or crucially, to safely transfer complex services to another provider/provider alliance. We also have concerns that, under current proposals, the decision-making body could set a shorter notice period as long as it is deemed 'suitable.' We would not recommend an arbitrary minimum notice period, as we appreciate that contracts vary in complexity and there will be some circumstances where urgent and immediate action is required (for instance, where patient safety is at risk). However, we would recommend that there should be a longer standard notice period of 12-weeks as the default position, and any decision-making body deviating from this should provide a robust explanation of this proposed action.

We would also welcome clarification about who has the right to challenge a decision-making body. For instance, does the term 'other providers' include providers outside of the relevant geographical footprint and non-NHS providers? It is currently unclear whether other stakeholders who may be



impacted by new services arrangements (such as Primary Care Networks, patients, carers or families) have the right to challenge decisions. This is particularly important for CICs, who have raised significant concerns about the new provider selection regime, and how this may unintentionally disadvantage non-NHS bodies during procurement processes.

We would welcome further discussions to clarify these issues, and would suggest that commencing the new regime with a defined, robust and refined challenge function would benefit all parties.

- 5. It will be important that trade deals made in future by the UK with other countries support and reinforce this regime, so we propose to work with government to ensure that the arranging of healthcare services by public bodies in England is not in scope of any future trade agreements. Do you agree?**

We strongly agree. The arrangement of healthcare services by public bodies in England should be made by the UK government, in collaboration with local partners, to ensure accountability and the delivery of high quality care. In light of this, the arrangement of healthcare services should not be included in the scope of future trade agreements.

- 6. Should the criteria for selecting providers cover: quality (safety effectiveness and experience of care) and innovation; integration and collaboration; value; inequalities, access and choice; service sustainability and social value? Do you have any additional suggestions on what the criteria should cover/how they could be improved?**

We agree. We agree with the criteria outlined in the document, and support some level of flexibility in their application. In many cases, local situations are likely to benefit from a tailored approach. However, under the current proposals, the decision making-body can use any hierarchy of importance that they deem necessary, which creates a risk that financial considerations could be prioritised at the cost of quality of care. This could then lead to safety issues and unwarranted variation across the country, which we understand is not the intention of the proposals outlined in the consultation document. While all criteria should be considered in some way, the current wording outlined in the document seems to be overly-permissive in the level of flexibility designated to decision-making bodies.

In light of this, we would encourage NHSE/I to explore the potential to implement clear safeguards to mitigate the risks around quality and safety, outlined above. This could include the introduction of a weighting system for criteria, or the creation of a set of core qualifying criteria. Clear and robust criteria will help to prevent inappropriate decisions, and reduce the reliance of appeals and judicial review, which is in the best interests of all stakeholders.

While we broadly support the core criteria outlined, we also have some outstanding questions around the structure and content of some of the criteria:



- We question why quality and innovation are grouped together. Although innovation can enable improvements to service quality, the two are not inextricably linked. Likewise, collaboration does not always lead to integration.
- As part of criterion 2 on value, we would also suggest that there should be safeguards against commissioning or costing services on a basis where a deficit will be incurred by the provider. We know this has a significant impact on the sustainability of services, the quality of care, and ultimately, patient outcomes and experience.
- We would welcome a greater emphasis placed on clinical outcomes or reducing health inequalities and improving population health, the latter being the overarching purpose of all ICS business.

7. Should all arrangements under this regime be made transparent on the basis that we propose?

As currently worded, we disagree. We agree that all arrangements, decision-making and criteria must be transparent.

Opportunities for appropriate and meaningful challenge

We have some concerns about the proposals as currently drafted, including around the lack of opportunities for appropriate challenge. NHSE/I states that it wishes 'to avoid the possibility of providers being able to use the current challenge process as a way of delaying contract awards or disrupting justifiable and sound arrangements made by decision-making bodies.' While we acknowledge that this is a reasonable consideration, it must be balanced against the risk of idiosyncratic contract awards in a proportionate way. In the current proposals, we believe that the balance is out of kilter, as there is no meaningful local challenge process set out for the contract award decision-making process. This is compounded by the fact that the challenge function currently played by Monitor (now NHS England and Improvement) is also set to be reduced.

The proposals also suggest that decision-making bodies will monitor their own compliance with the regime via their own annual audit process. While decision-making bodies should, to a large degree, be trusted to make the best decisions on behalf of patients, taxpayers and the population, appropriate safeguards (for example, a rigorous appeals process) should be built in to ensure that NHSE/I can intervene where there are potential issues with compliance. In our view, it is concerning that the only route for challenge is through the judicial review process; this is a high bar and is only a mechanism to appeal the lawfulness of decisions. We would therefore recommend that NHSE/I explores the potential for an additional appeals process whereby a decision can be impartially reviewed by a third-party if certain criteria are met.

Demonstrating compliance



In addition, we would welcome further detail on some key parts of the regime outlined in the consultation document. Firstly, the document says ‘decision-making bodies must keep a record of their considerations and decisions made under the regime, including evidence that they have considered all relevant issues and criteria, and that the reasons for any decision are clearly justified.’ We would question what constitutes sufficient evidence, and what requirements will be in place to ensure that this is provided.

Managing conflicts of interest

We would also welcome further detail on how conflicts of interests will be managed, and which rules will be set out in legislation, and which rules will be set out in guidance. This is particularly important as health and care becomes more integrated, and it is likely that some decisions could affect the majority of ICS Board members. For instance, we would question whether it is only potential bidders who would need to recuse themselves from the contract award decision-making process, or whether this would apply more broadly.

Broader ICS governance and accountability arrangements

Finally, without a clear understanding of ICS governance and accountability arrangements, it is difficult to make an informed judgement on how the mechanisms outlined in the proposals we be translated into the final proposals. For instance, there are still questions about how provider collaboratives are set to interface with ICSs, and the extent to which meaningful delegation is possible. We understand that more of this will become clear once the forthcoming health and care bill has passed through parliament.

8. Beyond what you have outlined above, are there any aspects of this engagement document that might (a) have an adverse impact on groups with protected characteristics as defined by the Equality Act 2020 (b) widen health inequalities?

As noted above, we would recommend a stronger emphasis on the importance of addressing health inequalities through these proposals.

Nevertheless, we see no reason from the information available that the implementation of the proposed regime will have an adverse impact on groups with protected characteristics. However, we note that, under the new regime, the role of the voluntary and independent sectors will be continued through simplified Any Qualified Provider (AQP) arrangements. There is a risk that AQP arrangements may benefit better informed patients (especially in the context of widened health inequalities over COVID-19 and a backlog in planned care), and we would ask NHSE/I to consider the potential impact that this could have on further widening health inequalities.



More specifically, the consultation document proposes that ‘decision-making bodies should not use a procurement process to pre-select which providers are placed on the lists from which patients are able to choose’, as long as they meet the five service conditions outlined.

9. Do you have any other comments or feedback on the regime?

The Community Network supports the intention to move away from default competitive retendering. We also support the proposition to apply this change to both NHS and local authority commissioners of healthcare services, which we would help to reduce some of the unnecessary fragmentation between public health services commissioned by the NHS, and those commissioned by local authorities.

In addition, despite our support for the direction of travel, as outlined above, we have some significant concerns about the level of transparency and accountability provided for in these proposals. We would welcome more details from NHSE/I on how these risks will be mitigated, especially around the application of the marking criteria (especially around the weight given to quality and patient safety), and the mechanisms to review and appeal decisions made. We are of course happy to work with colleagues within the national bodies and with our membership to support clearer guidance in this regard.

We do have concerns about how the proposals will affect CICs, which form a significant part of the community sector, and their ability to compete fairly within the new provider selection regime. In this context, considerations around transparency, accountability and governance are even more important.

We would also welcome further details around the legal status of the new proposed regime, and the third-party enforcement powers that are available, particularly for NHSE/I. Indeed, any new legislation must provide a meaningful basis for judicial review and intervention.

Finally, it is worth emphasising that changes to the new provider selection regime must also be viewed through the lens of the health and care white paper. As the proposed governance of ICS Boards is still developing, it is difficult to make a full and informed judgement about the effectiveness of then mechanisms outlined in the proposals. We look forward to further engagement with NHSE/I to ensure the new regime benefits patients and supports collaboration in systems as intended.