NHS Providers

NHS provider selection regime: consultation response from NHS Providers

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

Key points

- **We support 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.** We agree that the current rules for procuring healthcare services can unnecessarily disrupt the provision of high-quality local services and impede effective planning over the longer term. This is particularly the case for community, mental health and NHS111 providers, and patient transport services. These are frequently subject to disruptive and costly retendering, consuming leadership time and creating undue uncertainty for patients, service users and staff alike.
- **However, we have questions and concerns about how the new regime will operate transparently and robustly in practice, and believe that the inclusion of an appropriately defined challenge function would be beneficial.** The proposals currently lack a meaningful challenge function for those who have legitimate reason to feel that the decision-making process, or a particular decision, should be reviewed, scrutinised or justified. We feel that a clearer challenge function would only strengthen the proposals on the table. We are also unclear about how decision-making bodies will demonstrate compliance with the regime. Finally, there is a need for NHSE/I to expand on their expectations and the practical implications of managing conflicts of interest in a system working context. Addressing these issues now will help avoid a new regime with potential for local disputes and wasteful legal costs.

- **The new regime would benefit from clearer safeguards around quality and patient safety.** We welcome the inclusion of quality and patient safety in the key criteria, and the commitment to local flexibilities. However, allowing decision-making bodies to compare providers against the key criteria 'according to any hierarchy of importance they decide is necessary' seems too permissive and, in a financially constrained environment, may risk scenarios in which quality is compromised, leading to unwarranted variation. Clearer safeguards would also support decision-making bodies to develop their commissioning capabilities in line with the new regime.
- **The legal status of the new regime remains unclear.** It is unclear what elements of the new regime will replace the current rules governing NHS procurement of healthcare services when these are removed from the statute book. We understand there is a difficult balance to achieve: an enabling framework which is underpinned by clear, robust legislation providing a meaningful basis for challenge, intervention by NHSE/I when necessary, and ultimately judicial review.
- **The new regime needs to be considered in the context of the health and care white paper.** The smooth operation of the provider selection regime is inextricably linked 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 robust. If ICS governance or local relationships in a particular system are weak, there is a real risk that the contract award decision-making process may not be optimal and could lead to unnecessary financial, operational or clinical risk, or (given the lack of an appropriate challenge and resolution function) costly and time-consuming legal challenges.
- **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, and individual NHS trusts and foundation trusts 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.

Application

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?

We agree. We support the intention to move away from competitive retendering and burdensome procurement processes, when this is in the best interests of patients, taxpayers and the population.

We know that the current rules for procuring healthcare services can unnecessarily disrupt the provision of high-quality local services and impede effective planning over the longer term. This is especially true for community, mental health and NHS111 providers, and patient transport services, as commissioners frequently feel required to tender for many of their services, often at considerable cost to the public purse. These processes can absorb significant amounts of leadership time better invested in improving and integrating care, and create unnecessary uncertainty for patients, service users and staff. However, we have significant concerns regarding the transparency of the new regime in practice, which need to be addressed before we can fully support the proposals (see Q7).

Specifically with regard to continuation of existing arrangements, this will be beneficial in many cases where the provider is performing well. However, even in these instances, we would expect the right checks and balances to be in place to sustain and continually improve quality. We would also expect the timing of decisions – either to extend, change or market test particular contracts – to be transparent, with all relevant providers (and other key stakeholders) given the opportunity to make representations to the decision-making body should they wish to. Finally, we note that NHSE/I is considering setting out some situations where the regime would not apply, including when patient safety is at risk – we would welcome more detail on this and the 'appropriate steps' that decision-making bodies should take when managing contracts, as well as how this will interact with CQC's revised approach to regulation and the new NHSE/I system oversight framework.

2. Should it be possible for the decision-making bodies (eg the CCG or, subject to legislation, the statutory ICS) to be able to make arrangements where there is a single most suitable provider (eg an NHS trust) without having to go through a competitive procurement process?

We agree. We support the principle of moving to a regime that better supports integration and collaboration, as long as it is underpinned by robust processes and appropriate safeguards to ensure that contracts are appropriately awarded.

It is sensible to avoid a competitive procurement process when there is a single most suitable provider. In fact, as the consultation document points out in paragraph 5.2, this will give greater clarity of expectation and reduce legal risk where there is no 'market' to provide services such as 'commissioner requested services' and a range of operations for which there is no competitor (for example, much specialist care, A&E, and most ambulance services). When justifying the contract award, it would be helpful for decision-making bodies to distinguish between services where there is no alternative provision and services where they have deemed there to be a single most suitable provider that is preferable to all the available alternatives. The two scenarios are very different.

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?

The final documentation could benefit from acknowledging the complexities created by commissioning across multi-ICS footprints, as well as explaining how the relationship between decisions made by the ICS Board and decisions delegated to 'place' may operate. Notably:

- The health and care white paper is clear that, while some specialised services may in future be commissioned at ICS or multi-ICS level, national commissioning policies and service specifications will continue to apply (and therefore we assume that specialised services will still have to be delivered at NHSE/I designated centres). If an ICS Board(s) is procuring a specialised service, it must be explicitly required to abide by the relevant commissioning policies and service specifications. This is vital to protecting patient outcomes and experience. We would welcome the opportunity to continue working with NHSE/I to understand and shape the broader implications of system working for specialised services.
- We note that ambulance services will need to continue being commissioned over a multi-ICS footprint. It would be helpful for NHSE/I to make explicit reference to services such as these in the final documentation and guidance it issues.
- We 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 seems to give local system partners considerable flexibility in support of a more co-ordinated and coherent approach, which will benefit local collaboration, taxpayers, patients and service users. At the appropriate time, we would welcome 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.
- Finally, but significantly, it is unclear how commissioning arrangements at 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 place level, and the benefits that 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 that are delivered locally at home and in the community, but organised at scale across ICS boundaries).

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

We disagree. We do not believe that a 4-6 week notice period is enough time for providers to make 'credible representations', communicate effectively with relevant staff or, crucially, make plans to safely transfer complex services to another provider/provider alliance. The consultation document

also suggests that the decision-making body could set an even shorter notice period at their discretion. We would not recommend an arbitrary minimum threshold because we recognise that contracts vary in complexity and that there will be circumstances when urgent action is required, for example when patient safety is at risk. Instead, we propose a standard notice period of at least 12 weeks. In our view, a decision-making body deviating from this should explain why in its intention to award the contract.

In addition, NHSE/I should clarify exactly who has the right to challenge a decision-making body and in what circumstances. Do 'other providers' include providers outside the relevant geographical footprint and non-NHS providers? It is unclear if this also includes stakeholders who may be impacted by new service arrangements, such as primary care networks, individual GP practices, patients, service users, carers and families or members of the public. We would welcome further discussion to clarify these issues, and would favour a defined, robust and transparent challenge function which provides clarity for all parties from the commencement of the new regime.

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 NHS should remain accountable to the public, communities and patients that it serves. In order to ensure that patients receive the highest quality care and decisions are made in the best interests of patients, we believe that arrangement of healthcare services by public bodies should be made by the UK government in collaboration with local partners, and should not be included in the scope of future trade agreements.

It will also be important to provide clarity on what is included within 'healthcare services by public bodies for the purposes of the health service in England'. For example, the provision of NHS111 and patient transport services should be included as part of this definition so that services can be designed with the patient at the centre.

Key criteria

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 and believe that the range of criteria outlined in the consultation document are important. Our primary concern relates to the way in which the key criteria may be applied, specifically the proposal that the decision-making body can compare providers against the criteria – and 'any other relevant factors' – 'according to any hierarchy of importance they decide is necessary'.

It is right that there is flexibility in the regime because different local situations are likely to benefit from a tailored approach. Sometimes the focus will rightly need to be on quality, at other times an emphasis on access will be more appropriate to drive improved outcomes. However, the proposals in their current form appear to be too permissively worded, leaving the door open to financial considerations being prioritised over quality of care. This could result in quality being compromised purely to cut costs, particularly in the context of a constrained financial environment, leading to safety issues and unwarranted variation across the country. We understand that this is not the intention behind the proposals. However, it is not enough to say that decision-making bodies 'must ensure that all criteria are considered in some way'. We encourage NHSE/I to explore the introduction of much clearer safeguards around quality.

The areas covered by the key criteria seem broadly right but could be further refined. For example, it is unclear why quality and innovation are grouped together as innovation does not necessarily improve quality and should be thought of as an enabler, rather than an end-goal. The same could be said for integration and collaboration – integration experienced from the patient's perspective is a good thing, but collaboration is the means by which a system may achieve an improvement, and by itself does not guarantee a more integrated service.

We had also expected to see more emphasis placed on clinical outcomes, reducing health inequalities and improving population health, providing greater alignment with the overarching purpose of all ICS business.

Transparency and scrutiny

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

As currently worded, we strongly disagree. We are of course in favour of transparency, but we believe the proposals in their current form warrant further consideration. We have a number of significant concerns, including the lack of opportunity for appropriate challenge, uncertainty over how decision-making bodies should demonstrate compliance with the regime, and the need for greater detail on identifying and managing conflicts of interest. We are also mindful that, without a clear understanding of broader ICS governance and accountability arrangements, it is difficult to judge whether the new regime will be robust enough.

We hope that highlighting these issues contributes to making the new regime as effective and robust as possible, helping to avoid protracted disputes and potentially wasteful legal costs, and ensures that the new regime can support integration and collaboration as intended.

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.' This is a fair consideration, but the risk of a decision-making body inappropriately awarding a contract – especially innovative or novel contracts – also needs to be recognised. The current proposals do not quite get this balance right in our view because there does not appear to be an appropriate challenge process. This is compounded by the fact that the challenge function currently played by Monitor (officially) is also set to be reduced.

For instance, if credible representations are received from providers during the notice period, it is decision-making bodies who must deal with them by discussing the issue with the providers in question and publishing a response to the objections before the contract award. Similarly, it is decision-making bodies who are required to monitor compliance with the regime via their annual audit processes, and address any non-compliance issues. The fact that the only additional route for challenge is judicial review is, in our view, problematic. This is a high bar, which is expensive and can only be used to question the lawfulness of a decision, so its application may be much more limited than is currently the case, depending on how the existing section 75 regulations are replaced in the forthcoming health and care bill. It is not impossible, for example, that an ICS Board could make a lawful decision based on the information available to them, which is not in the best interests of the local population – say if the ICS Board continued an existing service with a decently performing

incumbent, but failed to take into account (or was unaware of) the fact that a new provider alliance was forming locally that could, over time, improve pathways by delivering particular services differently.

We urge NHSE/I to explore the introduction of an additional appeals process whereby a decision can be impartially reviewed by a third-party if certain criteria are met, for example if there is reasonable evidence to suggest that the service change could negatively impact on patient outcomes or health inequalities, or there is evidence that the decision-making body has not considered the merits of all local providers of a service. We see this as a helpful means of quickly resolving disagreements locally before they reach judicial review, rather than increasing administrative bureaucracy. The proposals suggest that NHSE/I, local authority oversight and scrutiny committees, and health and wellbeing boards can all intervene in the contract award decision-making process, but their precise roles are not clear. We suggest that the roles of existing bodies such as these are clearly laid out in the final document.

Demonstrating compliance

The issue above is compounded by the fact that the proposals do not clearly define what evidence decision-making bodies should provide to demonstrate their compliance with the new regime. 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.' However, it is unclear what constitutes sufficient 'evidence', what requirements will exist to ensure decision-making bodies publish this information and how compliance will be assured.

There is also a question around the input of providers throughout the contract award decision-making process: will there be opportunities for decision-making bodies to consult potential providers, provider collaboratives or alliances of providers at an early stage to ensure that they are considering the most relevant and up-to-date evidence (recognising that such evidence will not always be readily accessible, such as patient survey results)? This is not intended to make the regime more burdensome, rather it is to help avoid confusion and minimise the risk of challenge once a decision is published. It may also support innovation and integration in allowing new partnerships of providers to form an alliance to improve how particular services are delivered, and put forward their joint case collaboratively.

Managing conflicts of interest

There is very little detail on managing conflicts of interest in the proposals despite the fact that, as health and care becomes more integrated, it is likely that most decisions could affect the majority of ICS Board members.

The fact that an ICS Board will always have some providers represented and not others (including both NHS and non-NHS providers) needs careful management. If a contract award favours a provider represented on the ICS Board, how can the ICS Board clearly demonstrate that the decision-making process was objective and fair? Perceived, as well as actual, conflicts of interest must be considered. For example, it may be decided that there is no actual conflict of interest if the individual on the ICS Board does not stand to gain personally or financially. However, their organisational ties may mean that external parties – rightly or wrongly – still perceive a conflict of interest. In the absence of a very clear and practical process for managing conflicts of interest, this may undermine the credibility of ICS decision-making and governance, and could lead to unnecessary disputes.

In finalising the regime, we suggest that NHSE/I considers what rules will be set out in legislation compared to guidance and whether it is only providers with an interest in delivering the service who would need to recuse themselves from the contract award decision-making process. It would seem sensible for this to apply to all three 'decision circumstances', rather than only competitive procurement, as well as decisions over which route to take in the first place. However, this is not stated explicitly.

We are not suggesting that ICS Boards are incapable of making sensible decisions in the best interests of patients, taxpayers and the population. However, it must be recognised that greater system working creates new complexities for managing conflicts of interest, which the regime needs to address in order to be a success, and to maintain the confidence of the wider health and care sector.

Broader ICS governance and accountability arrangements

We are conscious that the new NHS provider selection regime is just one of many proposals in the health and care white paper. Without a clear understanding of ICS governance and accountability arrangements, it is difficult to judge whether the new regime will be robust enough. For example, NHSE/I's September 2019 legislative proposals highlighted the importance of appropriate scrutiny and oversight mechanisms. These mechanisms included roles for:

- NHS England through its formal accountability relationships with clinical commissioning groups (CCGs)

- internal audit in ensuring that CCGs have acted in the interests of patients, taxpayers and the local population in accordance with the new regime's criteria
- health and wellbeing boards, which should be engaged in deliberations about key service developments.

As we do not yet have detail on the formal arrangements underpinning system working, nor the statutory basis of the new regime (see Q9), it is unclear how mechanisms similar to the above – reflecting the fact that ICS policy has moved on substantially since September 2019 – will be translated into the final proposals. There is a risk that, if the rules and procedures governing ICSs are not well-defined and sufficiently robust, the use of the provider selection regime could become a de facto stress test of ICS leadership, decision-making and processes. This would be highly undesirable, given the current spectrum of ICS maturity and the impact on patients, communities and systems of inappropriate decisions. We urge NHSE/I to continue engaging with external stakeholders as it develops statutory guidance, which needs to recognise differing levels of ICS maturity.

General questions

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 we set out in our answer to Q6, we had expected to see more emphasis overall on reducing health inequalities and improving population health, providing greater alignment with the overarching purpose of all ICS business.

Under the new regime, there will be a continued role for the voluntary and independent sectors in complementing NHS provision, in part delivered through simplified Any Qualified Provider (AQP) arrangements. There are two types of provider lists: (1) those that allow patient choice for first consultant-led outpatient appointment, which commissioners must provide by law and (2) those for other (non-consultant led) services, which commissioners may choose to establish.

We observe that AQP could mean that some patients are seen ahead of strict clinical need. This is not a general comment on the value of AQP or patient rights. It is, however, noteworthy in the context of COVID-19, which has widened health inequalities, and the associated backlog in planned care. NHSE/I should consider the potential impact that AQP could have on further widening health inequalities and publish an impact assessment to accompany its proposals for a new NHS provider selection regime.

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

Importance of provider equity

We welcome the commitment that 'This regime must be applied even-handedly irrespective of the type of provider'. This applies not just to NHS providers, independent sector providers and voluntary providers, but also the different types of NHS providers: acute, mental health, community, ambulance and specialised. Historically, mental health, community and NHS111 providers, and patient transport services, have been disproportionately affected by competitive retendering. Our late 2018 survey of mental health trust leaders identified reducing tendering activity as one of the most effective ways of alleviating pressure on services, as well as helping to facilitate the expansion and roll out of mental health new care models.[1] Community providers have highlighted that the current rules for procuring healthcare services can be costly and time consuming, prevent long term planning and, ultimately, provide a distraction from clinical delivery. The new regime must address these sector-specific issues and we urge NHSE/I to back up its commitment with clear mechanisms to ensure that all provider types are treated equally.

Arranging of services by providers

There will be occasions where health services are arranged by a provider, for example where lead providers in provider collaboratives have responsibility for the budget and pathway for their given population, and sub-contract with other providers. This is touched on in paragraphs 7.15-7.19, but it is not immediately obvious who is accountable to whom. Is the ICS liable for any decision made with its programme budget, including delegated decisions made by a provider? If so, will decisions taken by providers need to be assured by the ICS, and is true delegation of both decision-making powers and accountability for those decisions therefore possible? The same questions also apply to place-level delegation. Who has the final say in the event of any disagreement between the lead provider and the ICS? The broader issue is that it is unclear how provider collaboratives are set to interface with ICSs, and the extent to which meaningful delegation is possible.

Roles of legislation and guidance

We support the principle of local areas being able to apply the regime flexibly to best meet the needs of their population. It is important that primary and secondary legislation allows for this by establishing an enabling, permissive framework.

At the same time, the legislation must also provide a meaningful basis for judicial review (for example, by setting out the steps that decision-making bodies must follow in any circumstance) and

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[1] https://nhsproviders.org/mental-health-services-addressing-the-care-deficit

intervention by NHSE/I when necessary. The proposals state that any legislation implementing the regime will still contain requirements around conflicts of interest and that the legal right to patient choice for first outpatient appointment will also remain in place. Beyond this, it is unclear which elements of the new regime will replace the current rules governing NHS procurement of healthcare services when these are removed from the statute book. The legal status of the new regime and third-party enforcement powers (such as those of NHSE/I, local authority oversight and scrutiny committees, and health and wellbeing boards) both require further explanation.

We would welcome the opportunity to contribute further to the development of statutory guidance, which we suggest should have a strong emphasis on transparency (on top of legislative requirements). Furthermore, ICSs and providers involved in sub-contracting may benefit from support to further develop their commissioning capabilities in line with the new regime, which may require a more sophisticated approach than is typically used today – for example, how to appropriately balance the key criteria and additional advice on manging conflicts of interest, such as worked examples.

Patient choice

We support the commitment to strengthening patient choice, in line with the *NHS long term plan*, and the desire to make AQP arrangements work better in the interest of patients, so that they always have the ability to choose the elective care available to them at the point of referral by their GP. It is absolutely right to place patients at the centre of the new regime. However, operating patient choice in practice can be complex and we feel that more support for providers would be beneficial to ensure that patient choice works smoothly in the new collaborative environment – for example, additional detail on how providers themselves should enable choice of location/service/team. Furthermore, building on our answer to Q8, more consideration needs to be given to patient choice in the context of the ongoing COVID-19 pandemic and we urge NHSE/I to publish an impact assessment to accompany its proposals for a new NHS provider selection regime.

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