IHPN submission to Commons Health and Social Care Committee
NHS Long-term Plan: legislative proposals inquiry
March 2019

Summary

1. The Independent Healthcare Providers Network (IHPN) is the representative body for independent sector healthcare providers. Our members deliver a diverse range of services to NHS and private patients including acute care, primary care, community care, clinical home healthcare, diagnostics and dentistry.

2. IHPN members deliver services to millions of NHS patients each year. This means that the independent sector has a significant interest in the legislative framework for care delivery to make sure that it works as well for patients as possible. The key test for any health legislation must be how it will maintain and improve patient care for the population. We therefore welcome the opportunity to provide comment on this important issue.

3. There has been signalling that these legislative proposals are an attempt to 'end privatisation' of the NHS that supposedly started with the 2012 Health and Social Care Act[1]. We view this as a fundamentally unhelpful foundation for a discussion about the right legislative framework for the NHS.

4. As the Health Select Committee itself made clear in its report on integrated care[2] last year, concerns expressed about the 'Americanisation' and 'privatisation' of the NHS are "misleading".

   "Private companies have played a role in the NHS throughout its 70-year history…most GP practices are profit-making independent contractors to the NHS and community pharmacies are private businesses for example" (p.47).

   Care remains funded through general taxation and no NHS assets have been sold off.

5. The NHS therefore remains, and in our view should continue to remain, publicly funded and free at the point of use. Moreover, while the notion that the move towards more integrated models of care is a smokescreen for greater involvement by private providers was robustly dismissed by the Health Committee, these two misconceptions persist in some quarters which we do not believe is a solid foundation for improving patient care.

6. We also have important technical concerns about NHS England's proposals currently out for consultation. Further detail is provided in the remainder of this submission, but two key points stand out:

[1] https://www.theguardian.com/society/2019/jan/07/nhs-chiefs-tell-theresa-may-time-to-curb-privatisation-automatic-tendering-care-contract
[2] https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/650/650.pdf

i. removing the NHS from the scope of the Public Contracts Regulations could considerably reduce accountability for securing value for taxpayer spend with decisions taken in the interests of providers and not patients.

ii. This problem is exacerbated by the fact that NHS England has either not formulated or not communicated an alternative 'best value test' proposal alongside their legislative asks. This lack of clarity raises a material concern over whether these changes would have the effect of reducing transparency. This problem would be further exacerbated should proposals for joint commissioner/provider Boards ever be implemented.

The current legislative framework for the NHS

7. Despite our stated concerns over these draft legislative proposals our view is that the current legislative framework is imperfect. The sector is open to change that benefits patients and removes some of the challenges posed by the current regime, especially as in important ways it no longer fits with new NHS structures. There is a good case for creating a statutory basis for larger, more effective commissioning organisations. There is also a good case for giving statutory authority to the regional teams that have been re-created through recent changes within NHS England and NHS Improvement. Real barriers to more collaborative working should be removed. However, we believe that considerably more work is required to provide reassurance that NHS England's proposed changes to legislation will achieve these ends and protect important principles about securing the best available provision.

Proposals to change procurement rules

8. The specific rules that govern NHS procurement are less important than the principles that sit behind them. We are open to changes to NHS procurement which ensure that commissioners are genuinely able to commission innovative, integrated services and where providers are not wasting time and money on bidding for contracts where the incumbent provider is demonstrably delivering an excellent service. And there should always be a focus on reducing bureaucracy where this does not serve to improve efficiency and ensure accountability. We note that the Health Committee made clear in its report on integrated care[3] that it did not feel integration was incompatible with a plural provider base and we support that view.

9. We are concerned however that the changes to procurement put forward in these proposals would not in fact achieve these positive goals. This is largely because they seem to be founded on a set of mistaken assumptions about the current procurement regime.

Procurement myths

10. A set of myths have grown up around the current set of NHS procurement rules, connected with the false impression that the NHS is being 'privatised' and that 'compulsory tendering' has been introduced into the NHS. These myths are important because they have influenced the debate around NHS procurement and risk introducing new rules which address non-existent problems.

[3] https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/650/650.pdf p16

11. **Myth one – most NHS services are awarded through competitive procurement**.

    Interim results from research into CCG contracting carried out on behalf of IHPN show that relatively few contracts are awarded through competitive procurement in the NHS and that these contracts represent a relatively low proportion of overall spend on clinical services.

Table 1: Competitive procurement by CCGs[4]

Year	CCG contracts awarded through competitive procurement as a percentage of the total number of contracts awarded that year	CCG contracts awarded through competitive procurement as a percentage of the total value of CCG clinical services spend
15/16	12%	3%
16/17	6%	2%
17/18	9%	2%

12. **Myth two – competitive procurement leads to greater private sector involvement in NHS services.**

    In fact, as you would expect under a regime which is purposefully blind to provider ownership status, tenders are won by a variety of public, independent, social enterprise, and voluntary sector NHS providers. According to the Department of Health and Social Care the proportion of NHS spending on independent sector providers was 7.3% in 2017/18, compared to 6.07% in 2013/14, although this rises to over 20% of total NHS spend once General Practice, community pharmacy and NHS-funded dentistry is added. It is important to note that competitive procurement provides an important way of choosing between different NHS-funded organisations when deciding who should deliver a service with a primary emphasis on quality and not ownership status. This is true whether or not a procurement exercise involves a private sector provider.

13. **Myth three – competitive procurement is incompatible with integrated care**.

    The key question here is what services are being procured by commissioners. Commissioners are under no obligation to continue to procure the same mix of services as they do currently and it is entirely correct that commissioners should have discretion as to how they remodel services providing it is done openly and transparently. In fact, commissioners are obliged under current rules to consider how services can be improved, including whether they can be provided in a more integrated way. If services are currently fragmented, commissioners have the opportunity to consider whether they can procure more integrated services either by encouraging and incentivising

[4] Source: FOI data from 46 CCGs received Feb/Mar 2019

different service providers to work together more closely, or by bundling different services together. Both these options are entirely possible under the current set of procurement regulations. If procurement has led to fragmentation then it is as important to tackle the underlying commissioning capability that has generated that fragmentation as it is to examine the procurement rules.

14. **Myth four – direct award of contracts to NHS providers would lead to integration.**

    The current set of proposals argues that procurement rules are not appropriate "where there is a strong rationale for services to be provided by NHS organisations, for instance to secure integration with existing NHS services." This assumes that direct award of contracts to public sector providers is an effective route to more integrated care *and* that 'integration' is an end in itself. However, there is ample evidence, not least from the Transforming Community Services programme which saw many community services transferred to local hospital trusts, or indeed from the operation of the NHS in Scotland, Wales and Northern Ireland, that simply bringing together services in a single organisation does not automatically lead to a more integrated outcome for patients. What is needed is sophisticated supply chains focused on securing good outcomes for patients, with providers in that supply chain incentivised to collaborate but also strongly regulated to deliver high quality services, with failing providers removed from the supply chain where performance persistently falls below an agreed level.

Principles of NHS procurement

15. The persistence of the myths described above does not mean that the current set of procurement rules should continue unchanged. However, it does mean that any change should be based on a proper analysis of the defects of the current regime and opportunities for improvement.

16. In our view an NHS procurement regime should:
    a. Be based on a commonly accepted set of principles that would help to ensure that commissioning decisions deliver good outcomes for patients and taxpayers in terms of both quality and value.
    b. Recognise the special circumstances of the NHS with an NHS specific set of regulations to sit alongside the Public Contract Regulations 2015, enforced by a health regulator.
    c. Rigorously enforce patients' right to choose the best care provider for their needs.

17. As stated above, the important thing to establish is the principles that inform NHS procurement. In our view these should command broad support from patients and taxpayers alike and be based on quality, transparency and value. Transparency ensures that patients and taxpayers can be assured that decisions are made in the best interest of delivering quality and value. Fairness ensures that there is equal treatment of actual or potential providers, and that the issue to determine is which provider would deliver the best possible service to patients within the available level of resources. Neither the public or independent sectors have a monopoly on quality and the commissioning system must be guided by this principle. A failure to apply these

principles risks leaving NHS patients "trapped" in underperforming local health care systems with little or no opportunity to access high quality healthcare they have a right to expect.

18. If these proposals were to be enacted, we have concerns that the potential for conflicts of interest to adversely affect NHS contract awards would be substantially increased, particularly if provisions included joint commissioner/provider Boards as is currently proposed. And patients would have no protection from the continuation of poor services when they are delivered by NHS organisations as commissioners may no longer be under an obligation to seek the best possible providers of care, although we argue very strongly that the proposed 'best value test' must have a legally enforceable mechanism for replicating this requirement.

19. We would welcome changes to the Procurement, Patient Choice and Competition Regulations, specifically to:
    a. Strengthen commissioner obligations to protect and extend patients 'right to choose' in line with the broader policy agenda in this area, supported by the Health and Social Care Committee in "Integrated Care: Organisations, Partnerships and Systems"[5]
    b. Strengthen commissioner obligations to procure services that work closely alongside others to deliver an integrated experience for patients with provisions included to penalise any provider of NHS-funded care that does not work in an integrated way within its local healthcare system
    c. Clarify the process obligations of commissioners so that decisions about compliance can be made quickly, and in advance of contract award rather than retrospectively
    d. Establish a specific body with enforcement power over the regulations
    e. Ensure neutrality about the type of provider this is commissioned with service quality and value benchmarked.

20. These new regulations could also be extended to apply to integrated care systems as and when they emerge. This will help ensure that patients and taxpayers have assurance that integrated care systems are open to the full range of high-quality providers delivering good value care on a transparent 'make-or-buy' basis and do not become 'airless rooms'.

21. It is clear that the strength of an NHS specific regime lies in large part with whether it is perceived as a genuine alternative to court action by interested parties under the regulations. We would argue that one of the failures of the current regime is in the record of Monitor (NHS Improvement) in overseeing and enforcing the Procurement, Patient Choice and Competition Regulations. This has led to many more challenges under the Public Contract Regulations 2015 being taken through the courts as public sector, independent sector, social enterprises, patient groups and other organisations have no confidence that complaints made under the Procurement, Patient Choice and Competition Regulations will be properly investigated.

[5] P16 - https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/650/650.pdf

22. It is important for the purposes of this Committee investigation to note that since the establishment of the Procurement, Patient Choice and Competition Regulations in 2013 which apply to the commissioning of all NHS services there have been only five formal investigations undertaken by Monitor (NHS Improvement) and none at all since August 2016 – nearly three years ago.

Other issues

23. There are also a number of other issues raised by these proposals that require further scrutiny.

Patient choice

24. We welcome the proposal to strengthen in law patient rights to choose. These rights are an important part of efforts to create a person-centred health service. Patients should be free to choose a range of different providers and to be confident that there is recourse when these rights are circumscribed inappropriately. In the absence of further information on the proposed 'best value test' it is unclear how these rights will be enforced however, meaning that in future these rules may have to be enforced through the courts.

25. As with the NHS experience of procurement, when there is no NHS regulatory authority the likelihood of costly court action increases. Court actions also tend to be slower than resolution by an NHS regulatory body – potentially increasing distress and worry for affected patients. If there is to be a firmer statutory basis for patient rights to choose then they must be accompanied by a suitable enforcement mechanism.

National tariff

26. Since the introduction of the national tariff and Payment by Results there has been broad agreement that national prices help to protect patients from poor quality care. Not only do efficient national prices help to drive up standards throughout the sector, they also ensure that there is no incentive for providers to lower their quality of care in an effort to compete primarily on price. Regulated prices are a common feature of national health systems across the world for this reason – a 'race to the bottom' is in nobody's interest, especially patients.

27. We are concerned that the proposals on "increasing the flexibility of NHS national payment systems" risk incorporating price competition within NHS services to a much greater degree than ever before. The use of local adjustments to tariffs, prices set as a formula rather than a value, and the removal of regulatory powers to modify the tariff in favour of discretion at ICS level, all present risks to patients and the system and as things stand are very unclear. Close scrutiny will be required to ensure that any positive results from these changes are not outweighed by the unintended consequences of moving further away from regulated national prices.

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