Independent Healthcare Providers Network

Provider Selection Regime
Consultation Response

April 2021

Overview

IHPN is the representative body for independent healthcare providers. IHPN members deliver a diverse range of NHS services including primary, community, diagnostic, hospital and specialist care. Independent and other non-statutory NHS providers make up a significant proportion of NHS provision, especially in primary and community services, but also in other areas including diagnostics, electives, clinical home healthcare and population health management.

IHPN supports the objective of ensuring that the rules around procuring NHS services helps to achieve greater integration and collaboration while reducing administrative bureaucracy. Independent providers successfully collaborate with system partners across the NHS and are committed to the goals of integrated care.

We note that in some cases the current procurement rules have not worked as well as they were intended to. There are examples where commissioners have been confused over the processes they must follow in observing two parallel sets of procurement rules – the Procurement, Patient Choice and Competition Regulations, and the Public Contract Regulations. This has meant that in some cases commissioners have sought to avoid using competitive procurement entirely. We therefore welcome the move to establish a new procurement regime which has the full support of the NHS system to achieve the goal of securing high quality, good value services for NHS patients.

It is important to note the context for reforms to NHS procurement. Data obtained from CCGs in 2019 showed that just 2% of CCG spending is through contracts awarded through competitive tender. This amounts to an estimated 7% of all CCG contracts. In other words, thirteen out of every fourteen contracts held by CCGs are awarded without a competitive tender[1]. This means that we need to get the balance right between reforming the current system to reduce bureaucracy but also to ensure that the new regime enables the NHS to secure the very best services from a range of different providers and does not inadvertently lead to a return to monopoly provision with no choices available to either commissioners or patients. As the Health Foundation concluded in an evidence review, "Competition between organisations providing healthcare may improve clinical outcomes, reduce costs and help the system function more efficiently".[2] It is important that these benefits are not lost in the pursuit of more integrated decision-making.

Overall, we are supportive of the direction of travel outlined in the consultation. We have several suggestions where the proposals could be strengthened or where further work is required to ensure that the regime operates effectively on behalf of patients and taxpayers. These are outlined below.

Fairness and non-discrimination

We support the purpose of the NHS procurement regime to ensure that decisions about how care is arranged are made in the best interests of patients, taxpayers and the population. To achieve this, we welcome the clear statement in 5.10 of the consultation that "This regime must be applied even-handedly irrespective of the type of provider". In our view the regime must be neutral over the types of

[1] https://www.hsj.co.uk/comment/nhs-england-bid-to-change-ccg-tendering-rules-could-make-things-worse/7025090.article
[2] https://www.health.org.uk/sites/default/files/CompetitionInHealthcare.pdf

organisation that deliver or have potential to deliver services, whether they are NHS, independent, social enterprises or voluntary sector.

The provider selection regime should apply equally and fairly to all providers at all times, with no presumption in favour of different types of organisational form. The requirement that the regime be applied even-handedly should not simply apply to competitive procurement but all aspects of the regime This will help to ensure that the NHS is able to access the best possible services, regardless of who provides them. It would therefore be helpful to expand on the statement referenced above to be clear that all the circumstances in which NHS decision making bodies award contracts should apply equally to different types of providers, including continuing arrangements that are working well for patients.

Where contracts are extended because they are working well it will be vital that there is a high degree of transparency and public visibility over these decisions, especially in the current context where many NHS contracts are extended without a clear and open justification by commissioners.

Circumstances in which competitive tenders are not required – AQP and patient choice

We welcome the clarification that there are some services where competitive procurement is explicitly ruled out as a way of allocating contracts. This includes services where no competitive market applies (such as A&E) services and it is useful to have this clarification as part of the regime. In the definition at 5.5 of services where there is no alternative provision, the list includes “commissioner requested services”. It is important to note that the list of commissioner requested services (CRS) has not been updated for some years and that in some cases all services provided by particular organisations were designated as CRS at the point when the policy was introduced. The list of CRS should be fully revised and updated in the course of moving towards any new regime to ensure that they genuinely are those services only where no genuine alternative does or could exist.

We further welcome the confirmation that services under AQP type arrangements should not be procured but instead work on the basis of an accreditation model based on NHS standards and prices. This is an important step in enabling a range of different providers to deliver NHS planned care – something that will be of vital importance given the challenge of growing NHS waiting times caused by Covid-19. This will help in attracting new expertise and capacity to the NHS and encourage organisations to develop new services for which they can seek commissioner accreditation. It would be useful to develop supplementary guidance for commissioners about best practice in using AQP in existing services and also developing that model further, including services where patient choice may not currently apply at present.

Further to this, there is an apparent tension between the White Paper/Provider Selection Regime policy direction to extend and strengthen AQP arrangements and the widespread use of procurement Frameworks (particularly the Increasing Capacity Framework) as the main contracting tool for the NHS to secure independent sector elective provision. Contracts procured through Frameworks typically do not operate in the same way as AQP arrangements – they are time limited, and often contain other provisions including the use of ‘mini-competitions’ at certain points with the potential for service change and disruption. Frameworks also mean that providers must indicate in advance the services for which they are accredited, which can make it more difficult to respond to changing demand for care in a given area. We would welcome the opportunity to work further with NHSE to resolve the tensions between the current use of Frameworks and the long-term direction of travel towards AQP as the basis for contracting.

Governance and conflicts of interest

One area of opportunity to further strengthen these proposals is in clarifying the governance arrangements around decision making by NHS bodies in the context of further moves to create statutory

ICS bodies. We are supportive of the move towards a statutory ICS including the creation of a single strategic commissioner across NHS systems. The government's recent NHS White Paper makes clear that within the ICS the split between purchaser and providers will remain.

We know that NHS statutory provider organisations will become part of a statutory ICS Board and that this Board will have responsibility for commissioning services and allocating contracts within its area. This means that it will be particularly important from the perspective of patients and taxpayers alike that there is strong governance in the exercise of these commissioning functions given the clear potential for conflicts of interest to emerge with the presence of provider organisations on the commissioning board.

We propose two solutions to this. The first is to be clear about the role of independent and other non-statutory providers as part of the ICS Partnership Board, and the role that Board will have in the commissioning process including application of the Provider Selection Regime. Offering a clear role to the full range of providers will go some way to ensuring that decisions are not inadvertently made in a way that favours statutory over non-statutory providers by virtue of their position on the main ICS Board.

The second solution is to draw up clear statutory guidance about the management of conflicts of interest within the Provider Selection Regime. This should be clear about the need to identify and manage conflicts of interest at every stage of the commissioning process, not simply the point at which a contract is awarded. In our view it will not be sufficient for individual providers or their representatives to recuse themselves from aspects of the commissioning process and there must be additional safeguards to ensure that the regime is applied fairly without preference to particular providers.

We also wish to highlight the potential for the involvement of statutory NHS providers in commissioning decisions to entrench the current disparity between acute, primary, community and mental health care. In primary, community and mental health services the nature of the diverse provider market means that in many areas a significant amount of provision is delivered by non-statutory NHS providers. Some estimates are that up to 40% of NHS community provision may be delivered outside of NHS Trusts. This means there is the potential for under-representation of primary, community and mental health providers on ICS statutory boards given that only statutory providers will be eligible to be members. In our view this is likely to make it more challenging to achieve the NHS Long-Term Plan goals for greater investment in primary and community services and parity of esteem between physical and mental healthcare.

Sources of information for key criteria

We welcome the key criteria that need to be considered when decision makers are identifying the most suitable provider or running a competitive tender.

As far as possible, the sources of information used when considering these criteria should be based on objective metrics. We therefore welcome the content of Annex A which sets out in further detail some of the information sources decision makers should draw on.

We would welcome the opportunity to work with NHSE on the further development of the key criteria to ensure that a full range of providers are able to demonstrate their suitability to deliver services through the sources of information decision makers will be using. This should again continue the principle that providers of all types are treated fairly throughout the regime. This should include consideration of how potential providers may demonstrate their capability against the same criteria applied to the incumbent to avoid an unintentional 'incumbency bias' emerging. Furthermore, the criteria should be clear that they cannot be fulfilled simply by virtue of organisational form. For example, it should be equally possible for an independent provider to score highly for 'social value' rather than this being viewed as something that an NHS organisation achieves by default because of its organisational form.

The regime sets out how decision makers may identify the most suitable provider for new or substantially changed arrangements from 5.8 of the consultation. Further work is needed on how potential providers of those services would become aware of the process the decision maker is commencing and have the opportunity of demonstrating their capability against the key criteria being used. This should be separate from the announcement of their intention to award a contract to a particular provider, with the notice period of 4-6 weeks outlined at 5.8.iv.

Enforcement and remedies

Patients and taxpayers will rightly expect that there should be the opportunity to scrutinise and, if necessary, challenge decisions about the arrangement of services and the allocation of contracts.

We note therefore the potential options in the regime where a provider organisation may appeal to the decision making body (8.6) with escalation to NHS England or potential Judicial Review as a last resort. As it stands, we believe further work is needed to go beyond this and establish a sector-specific oversight and enforcement regime to deal with complaints or challenges under the rules. This regime should be proportionate (tailored to the size of the contract in question), timely (not simply retrospective), fair to both commissioners and providers (offering commissioner protection against frivolous complaints and offering providers the chance for genuine resolution) and a real alternative to court challenge. In our view, judicial review (which focuses on the lawfulness of actions by a public body) is not the right route to evaluate the merits of a provider selection process and a different approach is required.

Consistency across the public sector

While we accept the need for a healthcare specific set of procurement rules, as far as possible there should be consistency with the broader set of public procurement regulations. This would help to provide a more straightforward environment for NHS commissioners and provide assurance to patients and taxpayers that consistently high standards are adhered to across all areas of public spending.