NHS Provider Selection Regime

Consultation on proposals

February 2021

Contents

1. Introduction

1.1. We have previously announced our proposals to replace the current rules for procuring NHS healthcare services with a set of more flexible arrangements that better support the NHS ambition for greater integration and collaboration between NHS organisations and their partners, while reducing administrative bureaucracy.

1.2. In September 2019, NHS England and NHS Improvement set out their recommendations to government for an NHS Bill, the aim of which is to remove barriers and promote collaboration between NHS organisations and their partners to help speed the implementation of the NHS Long Term Plan. This included proposals to revoke the procurement and competition requirements under section 75 of the Health and Social Care Act 2012 (the PPCCR) and remove arrangements between NHS commissioners and providers from the scope of the Public Contracts Regulations 2015 (the PCR), to be replaced by a new regime.

1.3. The engagement exercise undertaken in early 2019 collected views from across the health sector. Our proposals around procurement of healthcare services attracted the strongest weight of support, with 79% of respondents agreeing or agreeing strongly with our proposals.

1.4. Since then, the NHS ambition for greater collaborative working has expanded and further legislative proposals have been developed. These seek to place integrated care systems (ICS) on a statutory footing by creating ICS Boards and giving them decision-making responsibility for arranging healthcare services. Representatives of NHS statutory providers (trusts and foundation trusts) would be core members of an ICS Board, alongside local authorities and other system partners. ICS members will participate in the governance of the ICS Board, and have a central role in making decisions about how local services should be arranged and provided.

1.5. The creation of statutory ICSs brings with it the opportunity to create a way of making decisions about healthcare services that fits more neatly with the integrated, collaborative approach we are working towards. We want a decision-making process that makes space for real collaboration to happen; that does not frustrate integration by creating adversarial relationships; and that ensures all decisions about how care is arranged are made in the best interests of patients, taxpayers and the population.

1.6. In future, we want competitive tendering to be a tool that the NHS can choose to use where it is appropriate, rather than being an imposed, protracted process that hangs over all decisions about arranging services, drives competitive behaviour where collaboration is key and creates barriers where integrating care is the aim.

1.7. Our proposed regime therefore provides significantly more flexibility than before to make decisions about arranging care in a streamlined way, including without competitive tendering, where this can be shown to be in the best interests of patients, taxpayers and the population.

1.8. **This document sets out the proposed regime that should apply when healthcare services are arranged in future, following removal of the current procurement requirements**. **It should be read alongside other published information on the establishment of statutory ICS Boards, including Legislating for Integrated Care Systems: five recommendations to Government and Parliament**.

1.9. We are inviting patients, NHS staff, partner organisations and interested members of the public to give us their views on the proposals for the new regime. You can take part and ensure your voice is heard by completing the short survey which is available online here.

You can also email your responses to: england.legislation@nhs.net.

1.10. We want to hear from as many people as possible. We will use the views expressed in response to this consultation to help shape the new regime, and the legislation and guidance that would underpin it. We invite you to send your views by 07/04/2021.

2. Why do we need a new provider selection regime?

2.1. The creation of statutory ICSs recognises that collective decision-making between different bodies is the best way to arrange services. We need to make changes to the law so that the rules around how service arrangements are decided fit with this more collaborative model.

2.2. A common view expressed by respondents to the 2019 engagement exercise (and since reiterated in our more recent ICS engagement) is that the current competition and procurement rules, particularly the PCR, are not well suited to the way healthcare is arranged, and create barriers to

integrating care, disrupt the development of stable collaborations, and cause protracted processes with wasteful legal and administration costs.

2.3. The main reason that the current procurement rules are so unhelpful in the NHS is that, combined with other policies and provisions of the Health and Social Care Act 2012, they can sometimes create an expectation that nearly all contracts for NHS services should be advertised and awarded following a competitive tendering exercise. This can create continual uncertainty, upheaval and disruption among providers.

2.4. As we move away from this model, we want to make it straightforward for the system to continue with existing service provision where the arrangements are working well and there is no value in seeking an alternative provider. And, where the system wants or needs to consider making changes to service provision, we want there to be a flexible, sensible, transparent and proportionate process for decision-making that allows shared responsibility to flow through it, rather than forcing the NHS into pointless tendering and competition.

What are we recommending for legislation?

2.5. We have recommended that government legislates to remove the current rules governing NHS procurement of healthcare services stemming from both the Health and Social Care Act 2012 and the PCR; and that these are replaced by a new regime specifically created for the NHS, underpinned by **a new duty** that services are arranged in the best interests of patients, taxpayers and the population.

2.6. We are recommending that the new regime would be established via a combination of primary and secondary legislation and set out in detail in statutory guidance.

2.7. This new regime would apply to bodies responsible for arranging healthcare services for the purposes of the health service (NHS and public health) – including local authorities where they are commissioning healthcare services. Local authority commissioning of healthcare services, including public health, would be subject to the same rules as the rest of the NHS, to encourage and simplify joint working between local authorities and NHS bodies.

2.8. It will be important that trade deals made in future by the UK with other countries support and reinforce this regime. So we also propose to work with government to ensure that the arranging (procuring and sub-contracting) of healthcare services by public bodies for the purposes of the health service in England is not to be included within the scope of any future trade agreements.

2.9. The Cabinet Office has recently launched a consultation on its Green Paper – Transforming Public Procurement. The procurement of healthcare services is **not being considered** as part of their Green Paper because of the work we are doing to develop the new NHS regime. However, if you are interested in the Green Paper consultation (which runs until 10 March 2021), you can access it here.

2.10. As part of our wider NHS Long Term Plan proposals we are committed to strengthening patient choice. We propose preserving the rules for providing patient choice currently contained in the regulations under section 75 of the Health and Social Care Act 2012, by including them in the 'Standing Rules' regulations made under section 6E of the NHS Act 2006, and also strengthening them to make clear how decision-making bodies should operate the Any Qualified Provider Regime. See paragraph 7.4 for more detail on **patient choice**.

3. Regime overview

3.1. The central requirement of the proposed new regime is that arrangements for the delivery of NHS services must be made in a transparent way, in the best interests of patients, taxpayers and the population.

3.2. The regime would need to be applied by NHS bodies (NHS England, ICS Boards, NHS trusts and foundation trusts) and local authorities when arranging certain healthcare services for the purposes of the health service, as specified in **Section 4: Scope** below.

3.3. There are broadly three kinds of **circumstance** that decision-making bodies could be in when arranging services. First, they could be seeking continuation of existing arrangements using the existing provider. Second, they could be selecting the most suitable provider when a service is new or changing substantially, but a competitive procurement is not appropriate. Third, they could be selecting a provider by running a competitive

procurement. These circumstances dictate the subsequent approach to be followed. **Section 5: Applying the regime** provides more detail on this.

3.4. The regime sets out a number of **key criteria** to be considered when making decisions, in particular in circumstances where services are changing or competitive tendering is being used (see **Section 6**).

3.5. There are also a number of steps that must be taken when applying the regime to provide transparency and scrutiny, and to allow for challenge. These are set out in **Section 8: Transparency and scrutiny**.

4. Scope

4.1. This regime would apply to the following bodies, in the circumstances described:

- ICS Boards when commissioning healthcare services for the purposes of the health service (whether NHS or public health)
- NHS England when commissioning healthcare for the purposes of the health service (whether NHS or public health)
- local authorities when arranging healthcare services as part of their public health functions
- local authorities when arranging NHS healthcare services as part of section 75 partnership arrangements with the NHS
- NHS trusts and foundation trusts when arranging the provision of healthcare services by other providers.

4.2. **This document refers to the above bodies collectively as decision-making bodies/decision-makers.**

4.3. References to '**healthcare services**' in this document mean services involving the provision of all forms of healthcare provided for individuals, whether relating to physical or mental health.

4.4. This regime **would not apply to:**

- social care services

- any public health services not arranged by NHS bodies or local authorities (for example those arranged by the Secretary of State directly such as Test and Trace)
- other non-clinical services such as consultancy or catering
- procurement of goods or medicines
- community pharmaceutical services, as separate regulations already set out how community pharmaceutical services are to be arranged, negating the need for additional rules.

5. Applying the regime

5.1. The way in which decision-makers reach decisions about who provides services would depend on the type of service under consideration, and the kind of decision being made. Broadly there are three decision circumstances in scope of this regime for decision-making bodies, which are:

1) **Continuation of existing arrangements.** There will be many situations where the incumbent provider is the only viable provider due to the nature of the service in question, and a change of provider is not feasible or necessary – many NHS services are already arranged in this way. There will be other situations where the incumbent provider/group of providers is doing a good job and the service is not changing, and there is no value in seeking another provider. In these situations, it needs to be straightforward to continue with the existing arrangements.

2) **Identifying the most suitable provider for new/substantially changed arrangements.** There will be situations where existing arrangements need to change – for example, when a service is changing considerably; when a new service is being established; when the incumbent is no longer able/no longer wants to provide the service; or when the decision-making body wants to use a different provider. In these situations, the decision-making body should consider a set of **key criteria**. If after having done so they have reasonable grounds for believing that one provider/group of providers is the most suitable provider (which may or may not be the incumbent), they may award the contract to that provider without conducting a tendering process. This must be done in a way that is fully transparent as outlined in **Section 8: Transparency and scrutiny.**

3) **Competitive procurement** – for situations where the decision-making body cannot identify a single provider/group of providers that is most suitable without running a competitive process, **or** the decision-making body wants to use a competitive process to test the market.

5.2. In practice, the bulk of current NHS services are arranged without competitive processes or tendering (though this approach is sometimes not without legal risk). There is a justifiable reason for this. As set out in paragraph 5.5 below, in many circumstances the choice of service provider will be constrained by the nature of the service and its interdependencies with other services. Our proposed regime explicitly recognises this reality and makes it clear that such core NHS services can be arranged without NHS decision-making bodies being pushed through valueless bureaucratic exercises.

5.3. Where services are new, or changing substantially, we want to give more flexibility to decision-makers than at present, but with some common requirements that make sure they are made in the best interests of patients, taxpayers and the population.

5.4. The broad steps we propose decision-making bodies must follow in each circumstance are set out below.

Continuation of existing arrangements

5.5. If a decision-maker wants to continue with existing arrangements, they may do so where:

A) The type of service means there is no alternative provision. This may include the following kinds of service:

- Type 1 and 2 urgent and emergency services
- 999 emergency ambulance services
- commissioner requested services/essential services – ie those services commissioners have designated via the provider licence (foundation trusts) or NHS contract (trusts) as being ones with no/very limited alternative provision
- elective services which rely on cross-specialty working and can only be delivered by particular providers.

B) The alternative provision is already available to patients through other means such as the exercise of patient choice, for example:

- elective services subject to any qualified provider (AQP) arrangements (see paragraph 7.5)
- core primary care services commissioned on the basis of continuous contracts, where patients have the right to exercise choice at the point of registration with a GP surgery.

C) The incumbent provider/group of providers is judged to be doing a sufficiently good job (ie delivering against the key criteria in this regime) and the service is not changing, so there is no overall value in seeking another provider.

5.6. The decision-making body will need to be satisfied that they can justify continuing the existing arrangements, having regard to the best interests of patients, taxpayers and the population. They will need to:

i. take appropriate steps when awarding and managing contracts to ensure that the service will continue to deliver well

ii. be transparent about their intention to continue with the current arrangements by publishing their intent in advance, including their justification

iii. (in the case of C) publish their intention to award the contract, with a suitable notice period (eg 4–6 weeks unless a shorter period is required due to the urgency of the case); and if during the notice period credible representations are received from other providers, the decision-making body must deal with them as set out in **Section 7: Further considerations**.

5.7. **Annex A** contains more detail on the types of service mentioned in paragraph 5.5 A and B.

Identifying the most suitable provider for new/substantially changed arrangements

5.8. This approach can be taken where the decision-making body is changing a service/existing contract considerably; a brand new service is being arranged; the incumbent no longer wants to or is no longer able to provide the services; or the decision-making body wants to use a different provider.

In such situations, if after considering the key criteria set out in this regime (but without conducting a full tendering process), the decision-making body has reasonable grounds to believe that one provider/group of providers is the most suitable provider (which may or may not be the incumbent), they may award the contract directly. To do so, they must:

i. set out clearly that they are using this approach to select a provider

ii. be satisfied that they can justify that the provider they are proposing to select is the most suitable provider **by reference to the criteria set out in the regime** and any other relevant factors, and according to any hierarchy of importance the decision-making body decides is necessary

iii. **have carefully considered other potential options/providers** within the relevant geographical footprint (ie a local service is a local footprint, a regional specialised service is a regional footprint, etc) in reaching this decision and be able to evidence this

iv. publish their intention to award the contract, with a suitable notice period (eg 4–6 weeks unless a shorter period is required due to the urgency of the case)

v. if during the notice period credible representations are received from other providers, the decision-making body must deal with them as set out in **Section 7: Further considerations**.

Competitive procurement

5.9. It would be for the decision-making body to decide when a competitive procurement is the most appropriate means to select a provider. Moreover, where:

- the decision-making body is changing a contract/service substantially
- a new service is being arranged
- the incumbent no longer wants to or can no longer provide the services, or
- the decision-making body wants to use a different provider

and after considering the key criteria, the decision-making body does not identify a single candidate that is the most suitable provider, and/or concludes that the most suitable provider can only be identified by carrying out a competitive procurement, then it would run such a process. This process would require decision-making bodies to:

i. have regard to relevant best practice and guidance; for example, HM Treasury's managing public money guidance

ii. ensure the process is **transparent, open and fair**

iii. ensure that any provider that has an interest in providing the service is not part of any decision-making process (ie when ICS Boards are using this process)

iv. formally advertise an opportunity for interested providers to express interest in providing the service

v. compare providers against the criteria set out in the regime and any other relevant factors, and according to any hierarchy of importance they decide is necessary – which must be published in advance

vi. publish their intention to award the contract with a suitable notice period (eg 4–6 weeks unless a shorter period is required due to the urgency of the case)

vii. if credible representations are received from other providers about the process, deal with them as set out in **Section 7: Further considerations**.

5.10. This regime must be applied even-handedly irrespective of the type of provider. Voluntary and independent sector providers currently deliver a range of NHS services that benefit patients, paid at NHS prices. The NHS will still be able to arrange services with voluntary and independent sector providers in future, as now, where this is in the best interests of patients, taxpayers and the population. Decision-making bodies also have an important role to play in shaping local healthcare provision, ensuring the services are sustainable and able to innovate. Where changes to services are being considered, the regime's key criteria (see **Section 6**) ensure that decision-makers must take into account the potential effect of any changes on the sustainability of other services and providers, and do not stifle innovation in the short or long term.

5.11. In all the above circumstances, the steps involved are intended to provide a framework for a robust yet proportionate decision-making process, aimed at delivering the best outcome for patients, taxpayers and the population. The three circumstances are not to be considered as a hierarchy – we have been careful to ensure that the regime as a whole is a sound process so that, whatever the circumstances, we can be confident that decision-making

bodies have given thorough consideration to relevant issues and reached a sensible and proportionate decision, which will need to be in line with general public law decision-making principles.

5.12. As we refine our proposals, we may seek to set out some exemptions for situations where the regime would not need to apply, for example where urgent needs arise unexpectedly or patient safety is at risk.

6. Key criteria

6.1. We are proposing a number of key criteria to be considered when decision-makers are **identifying the most suitable provider, or running a competitive tender**, to ensure that services are arranged in the best interests of patients, taxpayers and the population.

6.2. **We propose that decision-making bodies must be able to justify their decisions for arranging services in those circumstances with particular providers in relation to these key criteria.**

6.3. Our proposed criteria are summarised below. The more detailed criteria are set out fully in **Annex A**.

Quality (safety, effectiveness and experience) and innovation – ensuring that decision-making bodies consider the fundamental utility and performance of the service and the quality of the provider generally, and seek to maximise these. Ensuring decision-making bodies seek to innovate and improve services delivered by either existing or new providers, proactively developing services that are fit for the future.

Value – ensuring that decision-making bodies seek to maximise the value offered by a service. This is not about choosing the 'cheapest' option, but instead selecting the option with the best combination of benefits to individuals in terms of outcomes and to the community in terms of improved health and wellbeing; and value to taxpayers by reducing the burden of ill-health over the lifetime of the arrangement and the cost.

Integration and collaboration – ensuring that decision-making bodies seek to maximise the integration of services for patients to improve outcomes, and that their decisions are consistent with local and national NHS plans around integrating care and joining up services for patients (recognising that

integrating services does not mean services have to be delivered by the same provider).

Access, inequalities and choice – ensuring that patient choice is promoted and protected, and that the services patients need are available and accessible to all groups, with a particular focus on tackling inequalities.

Service sustainability and social value – ensuring that 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; and seek to maximise the social value created by the arrangements, recognising the vital role the NHS plays in local communities and its leadership role in achieving net zero emissions.

6.4. The breadth and variety of healthcare services the regime may apply to makes it impractical for us to prescribe any central hierarchy of importance to the criteria. Instead, **we propose decision-making bodies must:**

i. Decide if and how they **prioritise and balance the above criteria** for each decision they make under this regime, to best reflect their intentions. For example, if an integrated service is what decision-making bodies desire, they may choose to balance the criteria to justify their award of a contract to the provider(s) best able to integrate.

ii. **Apply the regime proportionately** to reflect the scale, cost and significance of the services being arranged. We do not recommend a minimum financial threshold for application of the regime. However, the regime criteria are clear that decision-making bodies should ensure the cost involved in establishing the service is proportionate to the value of the service.

iii. Where decision-making bodies do decide to prioritise the criteria and balance them against each other, they must ensure that all criteria are considered in some way and be mindful that other relevant statutory duties may apply, including normal public law decision-making principles. For example, a decision-making body may feel that choice and access are not the central consideration for a given service; however, their statutory duties around patient choice would still need to be met.

7. Further considerations

Interaction with other existing duties

7.1. The new NHS regime would sit alongside the requirements and duties placed on decision-making bodies by other pieces of legislation and guidance. These will vary subject to the nature of the service and whether the decision-making body is an ICS Board, NHS England, an NHS trust or foundation trust or a local authority. For example, they may include duties around public involvement and engagement, managing conflicts of interests, enabling choice, promoting innovation, promoting continuous improvement, and promoting equality and reducing health inequalities.

7.2. Decision-making bodies will need to ensure that they adhere to any relevant existing duties as they discharge their functions and commissioning responsibilities. Decision-making bodies should not assume that these other duties will be met just by adhering to this regime.

7.3. The PPCCR currently includes some requirements around the proper management of conflicts of interest when making commissioning decisions. Though our proposal is to repeal the PPCCR, we propose that any legislation implementing the regime still contains requirements around conflicts of interest, to ensure that decision-makers are managing such conflicts appropriately. An example of such a requirement would be where an ICS is using a competitive process to arrange services and provider members of the ICS that are potential bidders would need to recuse themselves from the contract award decision-making process.

Alignment with patient choice and 'any qualified provider' arrangements

7.4. An ongoing role for the voluntary and independent sectors in complementing NHS provision would continue; through national and regional procurement exercises as are currently underway to boost NHS capacity to provide elective services; and through simplified AQP arrangements.

7.5. The legal right to patient choice for first outpatient appointment will also remain in place. There are some circumstances where patients are able to decide which provider they wish to be treated by, choosing from lists of accredited providers – known as any qualified provider (AQP) arrangements. But we are aware that AQP arrangements are not operated in a consistent

way, with unnecessary hurdles for some providers to get on the list in the first instance and providers sometimes being removed from a list without justifiable reason.

7.6. We want to make AQP arrangements work better in the interest of patients. There are two types of provider lists – those that allow patients a choice for a first consultant-led outpatient appointment (the '**legal right to choice of first outpatient appointment**' – which commissioners must currently provide by law); and those for **other** (non-consultant-led) services, which commissioners may **choose** to establish if they wish.

7.7. We propose 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. Instead, they need to demonstrate the providers meet the stated service conditions, which are:

- are registered with the Care Quality Commission (CQC) and licensed by Monitor where required, or meet equivalent assurance requirements
- agree to meet the Terms and Conditions of the NHS Standard Contract, which includes a requirement to have regard to the NHS Constitution, relevant guidance and law
- accept NHS prices
- can provide assurances that they are capable of delivering the agreed service requirements and complying with referral protocols
- reach agreement with local commissioners on supporting schedules to the standard contract, including any local referral thresholds or patient protocols.

7.8. Once a list of qualified providers is established, patients can choose any provider on the list. Note that, subject to legislation on ICSs, the requirements of commissioners will likely be exercised by ICSs in the future. Where ICS Boards establish and operate provider lists, we propose to strengthen the rules to make clear that:

i. Where a provider meets the stated service conditions above, they **must** be offered the NHS Standard Contract by the decision-making body, meaning the provider can then register its services on the Electronic Referral System (ERS) lists from which patients make their choice.

ii. To reduce administrative bureaucracy, decision-making bodies **must not run any additional local procurement**/comparative/competitive process when managing these lists.

iii. Decision-making bodies cannot **set their own criteria** for services where patients have a right to choice.

iv. Decision-making bodies have **no discretion to remove a provider** from the ERS lists, or end/withdraw its NHS Standard contract unless the provider ceases to meet the required service conditions or is demonstrably failing to deliver the safety/quality/service standards.

v. For 'legal right to choice' provider lists, the decision-making body cannot restrict the number of providers on the list, so long as they meet the stated qualification criteria.

vi. Finally, we also intend to require that when contracting with providers, in particular in a lead provider model, ICS Boards should require via the contract that providers themselves enable choice (eg of location/service/team).

7.9. These requirements should ensure that patients always have the ability to choose the elective care available to them at the point of referral by their GP, irrespective of whether services in their area have been arranged on a lead provider/provider collaborative/ICP contract basis by the decision-making body.

7.10. This AQP regime does not prevent decision-making bodies from seeking to contract directly with voluntary and independent sector providers for other reasons – for example, to secure additional capacity for the NHS (as has happened recently to help support the response to the COVID-19 pandemic). By mutual agreement, these arrangements could be instead of the AQP arrangement for that provider, while still protecting patient choice.

Alignment with wider commissioning intentions and contract-management

7.11. The purpose of the regime is to ensure that decisions about which providers should deliver services are made in the best interests of patients, taxpayers and the population. To do this effectively, decision-making bodies will first need to understand and decide what services are needed by the population. It may be that some of these intentions are developed at place or system level with other local partners, reflecting agreed priorities and strategies.

When developing these intentions, decision-making bodies will need to ensure they adhere to existing statutory duties, including those relating to public and patient involvement, and the duties and principles of public law decision-making.

7.12. It is important that decision-making bodies are clear about the outcomes they are seeking from a service, and that the decisions they make under this regime are reached with these outcomes clearly in mind. The criteria included in this regime have been designed to help decision-making bodies arrange services in a way that meets their commissioning intentions.

7.13. Once decisions have been made about who should provide services under this regime, the contracts and associated contract management arrangements need to reflect the desired outcomes. They should include appropriate mechanisms to periodically assess whether the anticipated benefits to patients, taxpayers and the population are being realised, and to amend or end contracts where they no longer do so.

7.14. **To facilitate this, we propose that decision-making bodies must ensure that:**

i. contracts have a length appropriate to the service in question

ii. wherever appropriate, include clear review provisions and break points

iii. set expectations about the possibility of extension when the initial contract period ends.

Arranging of services by providers

7.15. There will be occasions where health services are arranged by a provider of services, eg a sub-contract with an NHS trust, foundation trust or independent sector provider.

7.16. If an NHS provider is arranging for the provision of a service by another provider, then this regime must be followed when deciding the arrangement.

7.17. If a non-NHS provider has been awarded a contract under this regime, and then sets out to sub-contract any elements of that service, the NHS body that awarded the initial contract must hold the non-NHS provider accountable via that contract for any sub-contracting it undertakes (as is the case at present).

7.18. Where any provider sub-contracts, ongoing contract management of both the lead provider by the decision-making body and of the sub-contractors by the lead provider is important to ensure that the service in place is achieving the desired outcome.

7.19. Good information sharing between the original decision-making body and lead provider about the arrangements with other providers will be an important means of assurance for both the decision-making body and the lead provider.

Joint-commissioning and lead commissioning

7.20. In circumstances where decision-making bodies are arranging services jointly with other decision-making bodies (eg multi-ICS arrangements), or where one decision-making body is acting as a 'lead body' on behalf of other decision-making bodies, all those involved share the responsibility for ensuring that the decisions about who should provide services are made in the best interests of patients, taxpayers and the population in accordance with this regime where appropriate.

7.21. The use of such joint arrangements may mean the work of assessing arrangements against this regime is distributed between the decision-making bodies, but this does not fundamentally alter **each** decision-making body's responsibility to ensure the arrangements being made are in accordance with this regime and in the best interests of patients, taxpayers and the population.

7.22. Under joint arrangements such as these, a decision-making body may rely on the work done by another decision-making body as a valid means of demonstrating that its own responsibilities under this regime have been met, so long as this is transparently agreed and documented in line with this regime.

8. Transparency and scrutiny

8.1. It is important that the outcomes of decision-making bodies' decisions reached under this regime are made public, and that sufficient scrutiny is applied to ensure the regime is being followed. **We propose that the regime requires decision-making bodies to take a number of steps to evidence**

that they have properly exercised the responsibilities conferred on them by this regime.

8.2. The list below applies to all decisions to which this regime applies irrespective of circumstances:

i. Where contracts are being continued or rolled over, or a change in providers is being considered, decision-making bodies must **publish their intended approach in advance**.

ii. Decision-making bodies must **publish a list of contracts awarded** along with other relevant information about the contract and its contents. The final guidance for the regime will specify what should be published and where, with the aim of maximising transparency and disclosure.

iii. 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.

iv. Decision-making bodies must monitor compliance with this regime via their own **annual audit** processes, publish the results of annual audit of the regime and address any non-compliance with the regime found via audit.

v. Decision-making bodies must include in their **annual report** a summary of their contracting activity, including an indication of which contracts were rolled over, where providers changed, where formal tender exercises were advertised, and information about any complaints received in relation to adherence to this regime.

8.3. Our proposed legislative reforms remove the right for competitors to legal challenge currently enshrined in the PCR and the right to challenge via Monitor (or a claim for damages) in the PPCCR. Instead, representations can be made to the decision-making body once it has published its decision. Judicial review would be available for providers that want to challenge the lawfulness of the decision.

8.4. Alongside addressing the issues of unnecessary bureaucracy for decision-making bodies and providers alike, and ensuring decision-making bodies behave transparently and reasonably, we also wish 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. We also want to avoid NHS England becoming routinely involved in complaints and challenges against individual decision-making bodies, as this would be contrary to the principle of increasing the discretion of those bodies.

8.5. Therefore, the steps set out in **Section 5: Applying the regime** include some additional requirements about how challenges to decisions should be made.

8.6. In circumstance one C (rolling over a contract on the basis that the service isn't changing and the incumbent is doing a good job – see paragraph 5.5 C), circumstance two (paragraph 5.8) and circumstance three (paragraph 5.9), we propose that decision-making bodies **must publish their intention to award the contract to the intended provider, with a suitable notice period (eg 4–6 weeks, subject to any exceptions such as for urgent or patient/public safety cases)**. If representations objecting to the process or outcome are received from other providers in that time, the decision-making body must:

i. **discuss** the issue with the providers or their representatives

ii. **publish** a response to the objections before the award, setting out its decision to either: (a) not to proceed with the contract award as intended and reconsider its process and/or decision; or (b) award the contract as intended and publish reasons for so proceeding as part of the contract award procedure.

8.7. NHS England would be able to use current powers of intervention in relation to local NHS commissioners (ie those set out in 14Z17-21 of the NHS Act 2006, which we intend to apply to ICSs) in serious cases where we consider such a commissioner to be acting in breach of its statutory duties and intervention is appropriate.

8.8. The above requirements would also apply to NHS England in relation to its role as a commissioner of healthcare services (and therefore a decision-making body).

8.9. Local authority oversight and scrutiny committees already have powers to scrutinise the activities of certain NHS bodies, as do health and wellbeing boards. These powers will remain and will provide an additional means of

scrutiny and another means of oversight of decision-making body decision-making.

9. Next steps

9.1. We hope to achieve broad support for these proposals and we want to hear from as many people as possible. The consultation questions are below.

9.2. A response to this document can be completed by following this link.

9.3. If you prefer, we would be happy to receive views via email at england.legislation@nhs.net

9.4. If you prefer to send a response by mail, you can send it to:

Policy Development and Implementation Team
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9.5. Alongside this consultation, we will continue to reach out to the NHS through our ongoing discussions and will seek views at targeted events with partner organisations and interested bodies.

9.6. The consultation on these proposals will run until 07/04/2021.

9.7. The responses will inform the development of the regime, and the associated legislation and statutory guidance. NHS England will publish a response as soon as possible after the consultation closes.

Consultation questions

Our engagement exercise in 2019 demonstrated strong support for scrapping section 75 and the PPCCR. On the basis that government proceeds with legislation to do this, we are now asking questions specifically about how the new regime would work.

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?

   Strongly disagree | Disagree | Neutral | Agree | Strongly agree | Don't know

   Please explain your answer below.

   [free text]

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?

   Strongly disagree | Disagree | Neutral | Agree | Strongly agree | Don't know

   Please explain your answer below.

   [free text]

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?

   [free text]

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

   Strongly disagree | Disagree | Neutral | Agree | Strongly agree | Don't know

   Please explain your answer below.

[free text]

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?

   Strongly disagree | Disagree | Neutral | Agree | Strongly agree | Don't know

   Please explain your answer below.

   [free text]

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?

   Strongly disagree | Disagree | Neutral | Agree | Strongly agree | Don't know

   Do you have any additional suggestions on what the criteria should cover/how they could be improved?

   [free text]

Transparency and scrutiny

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

   Strongly disagree | Disagree | Neutral | Agree | Strongly agree

   Please explain your answer below.

   [free text]

General questions

8. Beyond what you have outlined above, are there any aspects of this engagement document that might:

   - have an adverse impact on groups with protected characteristics as defined by the Equality Act 2010?
   - widen health inequalities?

   [free text]

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

   [free text]

In what capacity are you responding? [please tick]

Academic institute [ ]

Charity, patient representative organisation or voluntary organisation [ ]

Clinical commissioning group [ ]

Clinician [ ]

Commercial organisation [ ]

Family member, friend or carer of patient [ ]

General practitioner [ ]

Healthcare professional [ ]

ICS/STP representative [ ]

Independent provider organisation [ ]

Industry body [ ]

Local authority [ ]

Member of the public [ ]

NHS foundation trust

NHS national body [ ]

NHS non-clinical staff [ ]

NHS trust [ ]

Patient [ ]

Professional representative body [ ]

Regulator [ ]

Think tank [ ]

Trade union [ ]

Other [please specify]……

If responding on behalf of an organisation:

Organisation name…….

Annex A: Detail on service type and key criteria

Service type

In some situations the options about who to arrange services with will be influenced by the nature of the service being arranged. Examples would include instances where there is no alternative to the existing provision, and where patient choice rights already provide market access for multiple providers. In such situations, decision-making bodies can justify making arrangements with these providers as being in the best interests of patients, taxpayers and the population.

Examples of such services include:

- **Type 1 urgent and emergency services**. These are 24-hour consultant-led services with full resuscitation facilities. They are integral to NHS provision and cannot be provided by non-NHS organisations.
- **Type 2 urgent and emergency services.** These are specialist, consultant-led emergency care services that cannot be provided by non-NHS organisations, eg emergency children's services.
- **999 emergency ambulance services.** These are about ambulance dispatch and management arrangements.
- Elective services that rely on cross-specialty working and can only be achieved within individual providers.
- **Core primary care services** commissioned on the basis of continuous contracts, where patients have the right to exercise choice at the point of registration with a GP surgery.
- **Commissioner requested services/essential services** – ie those services commissioners have designated via the provider licence (foundation trusts) or NHS contract (trusts) as being ones with no/very limited alternative provision.
- **Elective services subject to AQP.**

Decision-making bodies must take care when assessing whether there is no alternative to existing provision. There may be other services which are closely-

related to the above in nature (eg Type 3 and 4 urgent and emergency care services, call handling and clinical assessment related to 999/111, patient transport service), but for which there is more than one capable provider and some broader consideration needs to be given.

Key criteria

Criterion 1: Quality (safety, effectiveness and experience) and innovation

Quality, safety and effectiveness

Decision-making bodies must give due consideration to the quality, safety, outcomes and effectiveness of providers when deciding who to arrange services with.

Decision-making bodies should establish the desired outcomes in terms of quality, safety and health outcomes, and seek to ensure that the arrangements they make with providers are capable of maximising these.

Decision-making bodies should give consideration to all relevant available local and national information on the quality, outcomes and safety of the service received by the patients. Sources of information could include (but should not be limited to):

- CQC inspection data and rating of service and provider
- performance against relevant national targets
- patient safety incidents and learning from incidents
- comparisons of performance with other similar organisations
- patient experience and feedback
- patient survey results
- data relating to performance against any existing contracts.

When considering the available data, decision-making bodies should consider: any upward or downward trends in quality, safety and outcome indicators; the criteria that may affect these trends; and how they may be expected to change over time, to establish how performance may change over the life of the proposed arrangement.

Decision-making bodies should also consider whether quality will be maintained or improved as a result of the arrangements being considered.

For example, if a provider is not providing care of sufficient quality or safety, but is showing clear signs of an upward trajectory, is there good evidence to suggest this trajectory will continue and lead to sustained improvement? If a provider's performance has been declining, are there risks in continuing to contract with it? If quality and safety issues in a particular provider are a reflection of underlying organisational, structural or other local issues, are these likely to be alleviated or exacerbated by further contracting with the provider?

Where a new service is being considered and data on quality is unavailable, decision-making bodies should weigh the potential value of the innovation against the risk that the service does not deliver the anticipated quality, and have an understanding of how performance will be tracked and risks managed.

Innovation

Decision-making bodies must ensure that they seek to improve the quality of services when making decisions under this regime, including through the promotion and adoption of innovations in care delivery, and by proactively developing services that are future-proofed and capable of meeting likely future health needs.

The arrangements decision-making bodies make for given services should not stifle the potential for development and adoption of innovation within the services, or result in a local provider market that may be unable to support the development of new or innovative services for patients in future.

Decision-making bodies should continue to ensure that they have a good understanding of the range of potential providers locally, and the varying actual/potential approaches to delivering services.

Decision-making bodies should give due consideration to any particular innovative approaches offered by providers that could help to deliver better outcomes, and avoid assuming that what is currently provided will match current or future need.

Decision-making bodies should give consideration to ways in which innovation can be unlocked though the way services are arranged, eg by considering the use of longer contracts, with expectations about innovation and service transformation set out in the contract, or by piloting new and/or risky services, with a view to awarding the contract if the pilot is successful.

Our expectation is that ICS Boards and NHS England will be subject to a duty to seek to continually improve the quality of services (similar to those currently set out under sections 13 K and 14X of the NHS Act 2006), and would therefore need to ensure that they apply the new regime in a way that is consistent with these duties.

Criterion 2: Value

Decision-making bodies must give due consideration to the value offered by a service. In this context, value should not be interpreted as 'cheapest'. Rather, an arrangement with a provider constitutes value if it offers the best trade-off between costs of the service and the benefits to individuals in terms of outcomes and to the community in terms of improved health and wellbeing, and value to taxpayers by reducing the burden of ill-health over its whole life, within the resources available.

Furthermore, 'value' needs to be judged in relation to the extent to which the service/arrangement can satisfy the other criteria listed in this regime, as well as against the cost and affordability of the service.

Considerations around value will need to be determined by decision-making bodies and can include many elements, including but not limited to:

- efficiency of the service and associated cost benefits
- length of contract
- historic market valuation of certain services
- benchmarking against other similar services
- broader local/national financial goals
- long-term benefits to the service/related services.

When a decision-making body is considering the value of an arrangement with a provider, due consideration should be given to the financial value of the contract over its entire contractual term.

As some contracts can run for many years, consideration should be given to fluctuations in external trends and the potential variation of the value of the service over the length of the contract. What may be considered good value for money in year one may no longer offer the same benefits by year six.

Decision-making bodies should also consider any transactional costs of changing existing arrangements or establishing new ones for both the decision-making body

and the provider, alongside anticipated cost of the contract itself when assessing value.

For example, arranging a service with a new provider may offer a financial saving to the decision-making body over a relatively long contract duration, but if the anticipated cost of switching to a new provider, including any start-up funding required, outweighs the savings the new provider offers, then consideration needs to be given as to whether such an arrangement is still in the best interests of taxpayers.

Under this regime, decision-making bodies always have the option to test provision via tendering exercises. In some circumstances, such an approach may be a helpful way to establish the value offered by available providers.

Criterion 3: Integration and collaboration

Decision-making bodies should ensure that their decisions about who should provide service are consistent with local and national NHS plans around integrating care and joining up services for patients. Here joined-up or integrated services means that the services are delivered in a seamless way from the patient's perspective, regardless of whether they are provided by different professionals within an organisation or different organisations altogether.

Decision-making bodies should consider the extent to which the service under consideration will be able to integrate with other related services likely to be used by patients, in accordance with relevant local plans and strategies.

Decision-making bodies should seek to avoid unnecessary fragmentation of services and consider the extent to which changing a particular arrangement may impact on the quality and completeness of wider patient journeys.

Decision-making bodies should consider the extent to which a service is willing and able to be part of local integration plans when deciding whether contracting with it is in the best interests of patients, taxpayers and the population.

For example, if a provider is able to clearly demonstrate that the services it provides will sufficiently integrate into the existing infrastructure and patient pathway, but the cost of the service is slightly higher than others, there could be an argument made for still pursuing this service due to the overarching benefits it offers.

Decision-making bodies should also consider whether individual services will be improved if delivered in a more joined-up way with other services.

When considering this criterion, decision-making bodies should give thought to several issues, including:

- the extent to which the service provided will be improved by greater collaboration and co-ordination
- the relationships between the current provider(s) and connected organisations within the area
- relevant geographical criteria such as the distance between related services
- flow of patient data
- whether the respective working practices, culture, infrastructure and systems of the providers involved across a service are likely to help or hinder integration.

Consideration must also be given to the newly planned Triple Aim Duty, which will require NHS bodies to have regard to the 'triple aim' of better health and wellbeing for everyone; better care for all patients; and sustainable use of NHS resources, when exercising any of their functions.

Our expectation is that ICS Boards and NHS England will in future be subject to a duty to seek to promote the integration of services (similar to those currently set out under sections 13N and 14Z1 of the NHS Act 2006), and would therefore need to ensure that they apply the new regime in a way that is consistent with these duties.

Criterion 4: Access, inequalities and choice

The purpose of this criterion is to ensure that patient choice is protected, and that the services patients need are available and accessible to all groups.

Decision-making bodies must ensure that the decisions they make about who should provide services are consistent with any general duties to secure appropriate care for the population, and any duties to ensure choice is available to patients/the population.

Decision-making bodies should consider the pledges/rights set out in the NHS Constitution when thinking about arrangements, in particular those set out at section 3a in relation to patient and public rights, including the right to:

- access NHS services and not being refused access on unreasonable grounds
- expect the NHS to assess the health requirements of the local community and to arrange and put in place the services to meet those needs as considered necessary, and in the case of public health services arranged by local authorities to take steps to improve the health of the local community
- not be unlawfully discriminated against in the provision of NHS services, including on grounds of sex, race, disability, age, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity or marriage or civil partnership.

If the decision-making body's plans could limit patient choice in some ways, the decision-making body should consider whether this is sufficiently offset by the wider benefits of the proposal, and whether other forms of choice could be included in the arrangement, e.g. choice of treatment. It may be beneficial for decision-making bodies to engage with incumbent and prospective providers to:

- understand what services they can provide and how choice could fit in
- share information about what is important to patients
- build choice into their contracting approach.

Decision-making bodies should consider whether services could be improved by giving patients a choice of provider to go to and/or by enabling providers to compete to deliver services. Decision-making bodies should give thought to:

- Whether it is possible to have choice (ie are there a minimum number of patients which need to move through the services in order to ensure patient safety?).
- How would choice be included and offered to patients?
- Could choice improve quality?
- Would a variety of delivery models improve the reach of services?

- Are there a number of providers that would be interested in providing the services?

Decision-making bodies should consider the extent to which the arrangements may help to drive personalisation of care, support population health needs and ensure access for minority, excluded and vulnerable groups.

Decisions about who provides services are important in terms of contributing to a reduction in health inequalities. Decision-making bodies should consider the ways in which the arrangements under consideration will impact health inequalities, and seek to reduce health inequalities by considering the specific needs of local populations, including geographical and social constraints when considering who can best provide services.

Our expectation is that ICS Boards and NHS England will in future be subject to a duty to seek to enable patients to make choices about the services provided to them (similar to those set out now under sections 13I and 14V of the NHS Act 2006), and would therefore need to ensure that they apply the new regime in a way that is consistent with these duties.

Criterion 5: Service sustainability and social value

The purpose of this criterion is to ensure that 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, and to the social value created by the arrangements, recognising the influential role they have in their local communities.

Decision-making bodies should consider whether and how the decisions they make about who should provide services might impact on the stability and sustainability of the NHS locally, including but not limited to:

- the financial stability of local services
- how continuity of other related services will be affected
- the potential impact on quality, safety and effectiveness of other related and/or dependent services (including those arranged by other bodies)
- the stability and sustainability of other providers in the short, medium and long term

- the impact on the ability of the wider market to provide required services in future.

Decision-making bodies should consider whether and how the decisions they make about who should provide services might impact on the local healthcare workforce, including but not limited to:

- the retention of a skilled local workforce.
- the ongoing availability of relevant training opportunities for the local workforce (eg apprenticeship, training structure, clinical placements)
- the impact on well-established teams
- whether the models of employment used by providers are consistent with current NHS workforce policy priorities.

If the proposals are likely to negatively impact the stability, viability or quality of other services immediately or over time, decision-making bodies should consider if this can be justified by the wider benefits of the proposal.

Social value

Decision-making bodies must seek to ensure that the decisions they make about who should provide services are aimed at maximising 'social value' by contributing to improvements in social, economic and environmental conditions in the local area.

In doing so decision-making bodies should think about how the arrangements under consideration impact on:

- environmental issues and sustainable development, including the commitments made around waste, water consumption, carbon footprint and air pollution in the NHS Long Term Plan
- local employment
- local economic growth
- community cohesion
- social determinants of health
- the wider health and wellbeing of the population.

Decision-making bodies should consider the extent to which providers have acted to increase social value within their own activities, and how social value improvements can lead to other improvements in health outcomes.

Social value is not something to be considered at the outset and then forgotten, or considered in isolation from the other criteria in this regime. For example:

- a better integrated service which leads to fewer patient journeys may also enable environmental gains to be made
- a service which leads to improved air quality may contribute to improved health outcomes over time and hence projected savings.

The arrangements decision-making bodies make for given services should also not stifle the potential for development and adoption of sustainability within the services, or result in a local provider market which may be unable to support the development of new or sustainable services for patients in the future.

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Publication approval reference: PAR135