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NHS provider selection regime: response to consultation

July 2021

Contents

Summary

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 for healthcare services between NHS commissioners and providers from the scope of the Public Contracts Regulations 2015 (the PCR), to be replaced by a new regime.

The engagement exercise in early 2019 collected views from across the health sector and our proposals around procurement gained widespread support, with 79% of respondents agreeing or agreeing strongly with them.

Earlier this year we consulted on further detail of the proposed regime that should apply when healthcare services are arranged in future, following removal of the current requirements. The consultation ran from 11 February 2021 to 7 April 2021.

This document summarises the responses we received to that consultation. It should be read alongside the original consultation document, NHS Provider Selection Regime consultation on proposals, and published information on the establishment of statutory integrated care systems, including Legislating for integrated care systems: five recommendations to government and parliament.

As with our previous consultation exercises, we received clear and strong consensus for our more detailed proposals from a wide range of stakeholders, with 70% of respondents either strongly agreeing or agreeing with the detail we set out. Respondents welcomed the move away from competition and the greater focus on integration and collaboration, as well as acknowledging the benefit of the proposed regime in reducing unnecessary costs and bureaucracy.

A number of key themes emerged from the consultation responses including:

Continuing with existing providers or selecting the most suitable provider without competition: overall respondents agreed with the three broad approaches proposed for arranging services – rolling over contracts with incumbent providers,

selecting a single most suitable provider, and running a competitive process. In particular, over 70% of respondents agreed that decision-making bodies should be able to continue arranging services with an existing provider or choose a most suitable provider without having to go through a competitive process. Many respondents expressed the benefits of removing the (perceived) requirement for competition, suggesting that competition was not always the best way to manage provider selection. Certain respondents highlighted the need for additional detail on selecting the most suitable provider, and the transparency requirements when not running a competitive process.

Weighting and considering key criteria: Around 80% of respondents agreed or strongly agreed that the key criteria we proposed were appropriate considerations when selecting providers. In particular, many respondents welcomed the inclusion of social value (which includes equalities and health inequalities) and sustainability and the fact that value would not focus solely on financial considerations. There were some comments around how criteria could be objectively applied as well as whether minimum weightings should be considered.

Length of notice periods: Over 60% of respondents agreed with our proposals for a notice period – viewing this as necessary to show transparency in decision-making and allow for decisions to be reviewed by those affected by them. Respondents offered several reasons why notice periods were important and highlighted the importance of balancing transparency with the need for decision-making processes to be efficient and not too time-consuming. However, of those who expressed a view on the length of the notice period the majority thought that four to six weeks is potentially too short. Respondents also raised some practical and helpful suggestions around how the notice period would operate.

Scrutiny and challenge mechanisms: Over 80% of respondents agreed or strongly agreed with the transparency and scrutiny proposals. However, a number of respondents also expressed reservations around the lack of independent scrutiny in the decision-making process and where challenges have arisen.

Publishing requirements: There were mixed views about what constitutes an appropriate level of transparency and how transparency requirements should be balanced against not overburdening the system.

Each of these themes is explored in more detail below.

Given the extensive support for the proposals in the consultation document we recommend to government that they are taken forward as set out, which is a decision for Government.

We thank respondents for their engagement with the proposed provider selection regime.

Next steps

We will continue to work on the detail of the regime as the Bill progresses through parliament and as we develop secondary legislation and guidance.

Many of the views we received are particularly helpful in relation to the development of guidance and we will take on board comments from respondents as we progress to the next stage of work.

It is important to note that at the time of publishing this document and until new provisions are commenced, current rules and regulations in relation to procurement continue to apply. Commissioners should not pre-empt the outcome of the legislative process nor begin to apply the new regime, until it is agreed by Government and brought into force.

How we involved and engaged stakeholders

NHS England and NHS Improvement carried out an extensive engagement process on our proposals. Launched on 11 February 2021, the engagement document was accompanied by a survey that sought views on the more detailed proposals and could be completed online or returned in hard copy by post. In addition respondents could respond separately on any of the proposals or additional issues they wanted to raise via a central NHS England and NHS Improvement email address.

The formal engagement process closed on 7 April 2021. We received 420 responses made up of:

- 368 responses to our online survey, clearly setting out a position of agreement or disagreement on our proposals
- 52 further written responses from organisations providing detailed feedback.

The biggest proportion of these responses came from individuals identifying themselves as a member of the general public, patient, NHS staff or a healthcare professional. We also received a range of responses from NHS national and representative bodies such as NHS Confed, clinical commissioning groups (CCGs), NHS trusts and foundation trusts, GPs, royal colleges, patient advocate groups, local authorities, charity and voluntary organisations, and independent provider organisations.

In addition to written feedback we met NHS colleagues and external stakeholders to gain feedback on specific topics, including sessions with CCGs arranged by NHS Clinical Commissioners, sessions with providers arranged by NHS Providers, and meetings with Care England, procurement professionals from Local Government Association, specialised commissioning experts and colleagues from several government departments.

We would like to thank respondents for the time they have spent responding in detail to many aspects of the proposed regime. Much of the feedback has been very useful in considering how we will frame the more detailed work that will follow, including key

issues to address in guidance. We will continue to take this into account as we continue to develop the regime beyond the primary legislation.

Responses by question

Application of the regime

Summary of proposals

In the engagement document, we set out the three decision circumstances for decision-making bodies when selecting providers. These are:

1. **Continuation of existing arrangements** – where the incumbent provider is the only viable provider due to the nature of the service; or where the incumbent is doing a good job and the service is not changing.

2. **Identifying the most suitable provider for new/substantially changed arrangements** – for situations where existing arrangements need to change; when the incumbent is no longer able/wants to provide the service; or when the decision-making body wants to use a different provider.

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 to test the market.

We asked the following questions:

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

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?**

Many respondents provided broad responses covering both questions 1 and 2.

There was clear agreement that the provider selection regime would be beneficial in terms of enabling continuity and stability for providers, long-term planning and improvement of services; and for the workforce, supporting recruitment, retention and morale.

> "Care can benefit from continuity of service provision and reduced pressure on time and local relationships which comes from mandatory competitive public tendering. Procurement creates avoidable financial costs, [taking up] resources which can be re-invested in patient care. The proposals outlined should successfully enable a process akin to procurement but without associated costs of a tender exercise. This approach will enable long-term strategic partnerships, with a clear mutually agreed vision for service delivery and a steady journey to improve patient care." (NHS Confederation/NHS Clinical Commissioners)"

> "It should be possible for decision-making bodies to decide to continue with an existing provider without having to go through a competitive procurement process. This is a way of ensuring continuity and enables providers to concentrate more clearly on the quality of care they are providing rather than spending their time bidding for contracts. As NHS providers make up the vast bulk of incumbent providers, it is also a way of providing some reassurance for public sector bodies and the staff that work for them." (Unison)

A large number of responders appreciated the benefit of the proposed regime in reducing unnecessary costs and bureaucracy.

> "We support the intention to move away from competitive retendering and burdensome procurement processes, when this is in the best interests of patients, taxpayers and the population. We know that the current rules for procuring healthcare services can unnecessarily disrupt the provision of high-quality local services and impede effective planning over the longer term. This is especially true for community, mental health and NHS111 providers, and patient transport services, as commissioners frequently feel required to tender for many of their services, often at considerable cost to the public purse. These processes can absorb significant amounts of leadership time better invested in improving and integrating care, and create unnecessary uncertainty for patients, service users and staff." (NHS Providers)

Many respondents also expressed the benefits by suggesting that competition was not always the best way to manage provider selection.

> "The competitive framework can be disruptive and creates disincentives to service efficiency and innovation. Stable funding of an NHS department can enable it to give greater focus on service improvement, innovation and efficiency which can help manage overall costs and increase the patient choice of available services." (Royal Berkshire NHS Foundation Trust, Audiology Department)

There was also the suggestion that winning bids can sometimes depend more on the skills of the bid writer rather than on which provider is best.

Often this support for the move away from competition was tempered by the sentiment that a complete absence of competitive procurement would be a bad outcome. Some recognised that there can be benefits to competitive processes, particularly around innovation, and it would be a shame if these processes were completely unavailable in future.

> "A competitive process encourages all bidders to develop innovative, cost-effective and high quality services and can also encourage partnership working.…Opportunities to work with the private sector may also be lost [as well as] innovative contractual arrangements such as managed services or the provision of capital, equipment, joint research, teaching, etc as part of the service solution." (Guy's and St Thomas' NHS Foundation Trust)

Many respondents expressed agreement that the flexibility provided by the regime (to continue with current provider, to select most suitable provider or to conduct competitive tendering) is important.

In response to question 1, over 70% of respondents agreed that decision-making bodies should be able to continue with an existing provider without going through a competitive process.

Respondents noted the importance of ensuring that the incumbent provider was delivering a high quality, safe service that meets contractual requirements, and delivering value for money.

> "If the existing provider is doing a good or excellent job in providing the service then there is little to be gained from conducting a full procurement exercise. In addition, knowing that a full procurement exercise will be conducted at the end of a contract term acts as a disincentive for providers to work with commissioners on further investment or service improvement." (Leeds CCG)

> "This would definitely reduce unnecessary man hours devoted to the lengthy process of procurement, but again there should be a demonstration by the provider of its ability to provide a safe and good standard service." (Patient)

However, concerns were expressed that the option to continue contracts without the requirement to tender would lead to complacency, and rolling over contracts without full consideration.

> "There is also a concern that this approach may be considered a line of least resistance, particularly when having to prioritise commissioning resources. It could lead to poorly performing (but not disastrously) services being renewed, leading to continuation of mediocrity and lack of service innovation, with little growth of overall improvement or social value." (NHS South, Central and West Commissioning Support Unit)

In response to question 2, over 70% of respondents agreed or strongly agreed that decision-making bodies should be able to select the most suitable provider in certain circumstances without running a competitive exercise.

> "Decision-making bodies often know their local providers well and are best placed to identify where this is only one suitable provider and what service configuration will deliver best quality and value of service. This will often vary depending on scale – neighbourhood, place or system. For some services that are based upon access to facilities, there may be a clear advantage to maintaining consistent provision with a certain provider. Retaining the option to tender services where decision-making bodies feel it appropriate can still encourage improvement in quality and value in the right circumstances." (NHS Confederation/NHS Clinical Commissioners)

Alongside this agreement, there were some questions about how a 'suitable' provider should be defined and how judgements of the most suitable provider should be made. This included whether decision-makers would need to know the suitable

providers in advance, and questions about how innovative new providers would enter the market in future.

> "There is an onus in the documentation currently on decision-making bodies knowing all providers in the market, information needed to ensure that a provider is the single most suitable [one]. Provision needs to be made for providers to be able to engage with the decision-making body prior to contract notice in order to identify the single most suitable provider." (NHS non-clinical staff)

However, other respondents noted that our proposals will assist with piloting new and innovative services.

> "This process may be more beneficial when 'piloting' new services/pathways, providing more flexibility to create a partnership with providers to develop innovations which can then be extended for a longer term should they be proven to be successful." (Herts and West Essex ICS)

Some respondents noted the distinction between circumstances where the type of service means there is only a single provider with no alternative provision (eg Type 1 and 2 urgent and emergency services) and where there are many suitable providers to select from.

> "A single provider situation is not the same as a most suitable provider situation and therefore the type of justification required would be different." (North East London Clinical Commissioning Group/East London Health and Care Partnership)

There were also calls for clarity on whether the most suitable provider circumstance can be used to select independent sector providers.

Further clarity was requested on whether there was a limitation to the geographical footprint when identifying providers (eg national, regional).

Transparency considerations were also highlighted by respondents when selecting the most suitable provider. These included the suggestion that the rationale for selecting the most suitable provider should be documented and, in some cases, published. Respondents also agreed with our proposal that alternative providers should be able to make representations about decisions.

> "There would need to be clear rationale and recording for the definition of 'single most suitable' provider. A clear process within the decision-making body is needed with a challenge process built in for any differences of opinion. Again robustness and recording of decision-making and transparency are key." (West Kent and East Kent ICP finance group)

Issues around conflicts of interest in relation to transparency were also raised, particularly for NHS Integrated Care Boards' decision-making where, potentially, the provider being selected as most suitable is a member of the NHS Integrated Care Board (i.e. NHS trusts and foundation trusts).

> "Competitive tendering is a time-consuming and wasteful process, but it is an open process with standards. If this process is not used we must be sure that the procurement is above board, and that the commissioners are not just giving contracts to their mates." (GP)

When responding to questions on the continuation and most suitable provider circumstances within the regime (question 1 and question 2), a large number of respondents also expressed the wish for the differential treatment of NHS and independent sector providers within the regime. Many respondents suggested that decision-makers should only be able to continue with the current provider or select the most suitable provider (without the need for competitive tendering) when this is an NHS provider.

> "We strongly believe that these arrangements should only be applicable to public and accountable bodies – notably the NHS – to limit the occurrence of accelerated procurement arrangements with independent sector providers." (BMA)

A small number of respondents went further and suggested that NHS statutory providers should be the default provider of NHS services, and never subject to tender exercises.

A smaller number of respondents argued that competitively tendered procurements should be the default for every service, or the default for arranging services with non-NHS statutory providers.

> "We believe that there needs to be a single simple, transparent and public process for tendering all such activity." (Spire Healthcare Limited)

"All services other than those that are currently protected (999, A&E, etc) should continue to be competed [for]." (Anonymous)

NHS England and NHS Improvement response

We are pleased that overall respondents welcome the proposed new regime, in particular the move to end the presumption in favour of competitive tendering. As recognised through the responses, the new provider selection regime will support greater integration and collaboration between NHS organisations and their partners and will reduce unnecessary bureaucracy.

Our proposals were developed in response to earlier engagement with the system, and seek to address issues caused by the current rules. A consistent message we heard as we developed these proposals was that while a change in the rules is desirable, the new rules must ensure decision-making is robust and defensible.

The steps we set out in our proposals are designed to allow flexibility, and also protect against the kinds of complacency that some respondents were concerned about. For example, where decision-making bodies are deciding whether to continue with the incumbent provider, they need to be satisfied that they can justify continuing the existing arrangements, having regard to the best interests of patients, taxpayers and the local population.

Decision-makers will not be able to continue contracts without considering how the service currently operates, e.g. by looking at the quality of care being delivered. We expect decision-makers to consider the key criteria when they decide to roll over a contract with an incumbent provider that they consider to be doing a good job – if the decision-maker judges that the incumbent provider is delivering against the relevant key criteria, then it is reasonable to assume they are doing a good job.

We are not considering either setting a limit on the number of times a contract can be rolled over or allowing contracts to continue in perpetuity. It is important that there are appropriate 'breaks' in the contract cycle, and sufficient review periods so decision-makers can review and reach a decision on the most suitable provider – this would inevitably happen during the normal contracting cycle, but this can be further clarified in guidance.

The decision to continue with the incumbent provider will also be subject to transparency requirements, where decision-makers will have to publish their intended

approach in advance and that the contract has been awarded. If they are rolling over the contract on the basis that the service is doing a good job in line with the criteria, there will also be a notice period, during which time other providers are able to make representations. Decision-makers will also need to register and manage conflicts of interest appropriately.

Our response to issues in relation to contract management is set out later in this document.

We recognise in relation to the most suitable provider circumstance the need for clarity on how to establish whether there are other suitable providers or what to do where there is no alternative provision. The regime as set out includes examples of the types of service where there is usually no alternative provision. We want to make it as straightforward as possible for decision-makers to continue with these arrangements without creating unnecessary bureaucracy in the process. Guidance will be set out for decision-makers that are genuinely unsure about whether they are in a decision circumstance where there is no alternative provision.

In respect of how suitable providers would be identified, we expect decision-makers who are responsible for the commissioning of services to understand their provider landscape and have an awareness of which suitable providers might be capable of providing services to their population. We made clear in our proposals that the service in question determines the size/geography of the required provider landscape – i.e. a local service is a local footprint, a regional specialised service is a regional footprint. Apart from this being necessary for the application of the provider selection regime, we would expect decision-making bodies to be routinely assessing the provider landscape as part of the strategic work they will have to carry out to assess the wider needs of population health management and tackling health inequalities.

We have also been clear that we expect the regime to be applied even-handedly irrespective of the type of provider. While we acknowledge the comments around differential treatment for certain types of provider, we have deliberately chosen not to frame the regime in this way, in order to avoid unequal treatment based solely on a provider's organisational origin, rather than what is best for patients, taxpayers and the local population.

We have taken on board the concerns around transparency in NHS Integrated Care Boards, particularly their management of potential conflicts of interests. It is important

to recognise that all members of the NHS Integrated Care Board will have collective and corporate accountability for the performance of the organisation and will be responsible for ensuring its functions are discharged in line with their legal duties – including decisions about selecting the most suitable provider. Providers of NHS services will also continue to be accountable in other ways:

- for quality, safety, use of resources and compliance with standards through the provider licence (or equivalent conditions in the case of NHS trusts) and Care Quality Commission (CQC) registration requirements
- for delivery of any services or functions commissioned from or delegated to them, including by an NHS Integrated Care Board, under the terms of an agreed contract and/or scheme of delegation.

While it is vital to ensure NHS trusts and foundation trusts can play their intended role in decision-making on priorities, plans and funding within NHS Integrated Care Board, we recognise that certain conflicts of interest may arise for some individuals in relation to some decisions about provider selection.

We therefore set out in guidance that representatives of NHS trusts/foundation trusts will need to recuse themselves from decisions in circumstances when the organisation they work for is a bidder in a competitive procurement process.

The new regime will provide decision-makers with the means to build better services, to allow decisions to be centred on how best to meet the needs of patients, and to better reflect the key role NHS organisations play in creating healthy, sustainable communities. The decision-makers within the new system will be statutory bodies that will be expected, and trusted, to fulfil their statutory duties. Appropriate governance will ensure NHS Integrated Care Board members act in accordance with their statutory duties when making decisions, including acting with transparency and managing any conflicts of interest.

We also asked an additional question in relation to the application of the regime and decision circumstances:

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?**

When answering this question, many respondents took the opportunity to expand on previous answers about the general appropriateness of the regime and how it should

be applied. Most commonly, people expressed opinions or asked questions about how the regime could or should be applied to particular circumstances.

Many pointed out that the flexibility already designed into the regime would mean that decision-makers could take the vast majority of approaches suggested by respondents, and that other exemptions are not necessary.

> "We believe that the regime is sufficiently flexible to meet the requirements of all of the commissioning and procurement scenarios that we would envisage encountering." (Joined Up Care Derbyshire (ICS))

Although many respondents indicated that they 'agreed' with the idea of having exemptions to the regime, the kinds of exemptions they argued for were many and varied.

There was general agreement across a variety of respondents that providing flexibility and discretion as to the approaches decision-makers can take is important, that tendering needs to be an option (which it will be) and that decision-makers need to be cognisant of the quality, safety and costs of services when deciding how to proceed with arranging services. Many respondents from both commissioning and provider backgrounds commented that the application of the regime should still enable market entry for new providers and support innovation, with tendering being an important option in helping to achieve this.

> "There are situations where genuine competition is necessary and it would be a shame if that stopped." (Arden and GEM Commissioning Support Unit)

> "There should always be the allowance to choose to go out competitively as this potential or actual does often create innovation between commissioner and the existing provider and creates a clear performance expectation to retain contracts." (Local authority)

Linked to this, a number of respondents suggested that the approach taken by decision-makers should be proportionate to the contract/service in question, rather than all decisions being forced to take a one-size-fits-all approach that may be disproportionate in some cases.

A small number of respondents suggested it may be beneficial to consider creating thresholds above/below which the regime may apply differently, or for different

approaches to be **required** beyond/below certain thresholds. Respondents suggested that a maximum duration for and/or the number of times a contract can be extended should be considered or a de minimis level be set, and that there is local flexibility below that threshold to refine selection criteria.

> "A maximum duration and/or number of times a contract can be extended should also be considered, as should tolerances on in-term contract variations." (NHS South, Central and West Commissioning Support Unit)

However, other respondents were clear that the flexibility and discretion the regime provides is one of its main strengths and this should be maintained wherever possible, and not constrained by arbitrary thresholds.

> "One cap does not fit all so flexibility with discretion could be applied with an audit trail and justification through governance arrangements." (CCG)

> "There are always likely to be exemptions based on specific contexts or need. Having this possibility will allow for the flexibility that is needed within the system. However, this again needs to be open and the reason for the exemption to be transparent and considered." (Member of the public)

In framing this question, we were particularly interested in understanding whether there are situations in which the regime may need to be bypassed or circumvented. The overwhelming consensus from respondents was that the regime should be followed in almost all instances (while noting that the flexibility inherent in the regime permits different approaches in different circumstances).

Respondents did identify a small number of other circumstances which may justify making decisions outside the parameters of the regime. These circumstances were generally about dealing with emergencies, such as:

- a new service needs to be arranged rapidly in an emergency (eg to deal with a pandemic)
- where there are urgent quality/safety concerns that pose risks to patients and necessitate rapid changes
- where an incumbent is suddenly unable to operate and a new provider needs to be found, eg a provider becoming insolvent or experiencing a sudden lack of critical workforce.

Respondents noted that these situations do occur and it is important that commissioners can respond rapidly, so exemptions are important; but that any exemptions for them need to be carefully designed so as not to be abused, and that safeguards are in place to prevent this. Suggested safeguards included transparency on instances where contracts have been awarded outside the regime due to an emergency, an ongoing review of the circumstances, and the full selection regime being applied at the earliest opportunity once the immediate situation has passed.

> "We would welcome this option for situations where an urgent need arises unexpectedly. Examples of this in our experience can be where a service is deemed unsafe and another provider needs to be found quickly, or where for various reasons a provider cannot fulfil the notice period in the contract and needs to stop a service fairly quickly." (Specialised Commissioning, North West Hub)

> "In these cases, there needs to be a simple mechanism for invoking measures which should be as temporary as possible and subject to after-the-fact governance and disclosure, when they can then be subject to the challenge. Where urgency is cited, the contract should be time-limited and bound by review periods to ensure ongoing requirements and needs are being met, but with a view that extended periods should then require formal use of the regime process." (Specsavers)

NHS England and NHS Improvement response

We intend for our regime to be followed whenever decisions are made about which provider should provide a healthcare service. We agree with respondents that any exemptions to following the regime should be minimal. We have intentionally designed the regime to allow considerable flexibility in the decision-making process, and we believe this flexibility is sufficient to allow decision-makers to make decisions in a sensible and proportionate way, whatever the service being planned. We do not intend to amend the proposals to introduce specific exemptions that allow the regime to be bypassed based on the type of provider, or the type of service being planned.

We agree with respondents who asked that it be possible for the regime to be applied in a proportionate way relative to the contract/service under consideration, and the proposals we have made accord with these comments – flexibility, discretion and proportionality are wired into the design of the regime.

We note the comments about introducing thresholds above/below which the regime could apply differently, in particular in relation to the requirements around notifications. However, transparency is paramount and on balance we do not feel it is appropriate to limit transparency about a particular decision just because that service is small in cost/volume terms. We are seeking to make the transparency processes as simple and straightforward as possible for all decisions.

We agree that there are a small number of very limited circumstances where decision-makers may need to act rapidly so as to address immediate risks to safety and quality of care, and in such instances, it should be allowable for decision-makers to act without following the steps of the regime. We also agree that safeguards are needed to ensure that this kind of rapid action is only taken in extremis, and not abused. Respondents provided some good examples of potential safeguards and we will consider these as we develop guidance.

We will consider further how to frame these exemptions, and we very much appreciate the examples provided by respondents.

Key criteria

Summary of proposal

In the engagement document, we set out a number of key criteria to be considered when decision-makers are identifying the most suitable provider or running a competitive tender:

- quality (safety, effectiveness and experience) and innovation
- value
- integration and collaboration
- access, inequalities and choice
- service sustainability and social value.

We proposed that decision-making bodies must be able to justify their decisions for arranging services with particular providers in relation to the key criteria. Furthermore, we set out that a national hierarchy of importance would not be imposed, but instead decision-making bodies should prioritise and balance the criteria for each decision made under the regime.

We asked the following question:

5 **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?**

Summary of responses

Around 80% of respondents agreed or strongly agreed that the proposed criteria were appropriate considerations when selecting providers. In particular, many respondents welcomed the inclusion of social value and service sustainability and the fact that value would not focus solely on financial considerations. There was also strong support for the idea that these criteria be applied flexibly and proportionately as appropriate to particular services.

> "I think is demonstrates a holistic approach to commissioning services and is a very beneficial shift away from the cheapest provider and a general 'race to the bottom'." (Clinician)

> "These criteria are essential and must be rigorously maintained and checked." (Patient)

> "These are a good, clear and strong set of criteria for decision-makers to use." (South Western Ambulance Service NHS Foundation Trust)

> "We would support the five key criteria as being broadly the right basis for decision-making. While it is proposed that the regime will allow flexibility over the relative weighting of these criteria proportional to the service (as is the case with the current competitive procurement regime), we would agree that all criteria must be considered in some way." (Central London Community Healthcare NHS Trust)

> "Strongly agree – when determining provider selection and service arrangement decisions the NHS should apply the broadest definition of 'value'. The specification and weighting of criteria should be approached strategically and with reference to the objectives of the particular decision, but in all cases should be referenced back to fulfilment of the NHS's triple aim: better health outcomes; better quality of care, more sustainable services." (Specsavers)

In our consultation we explained that the reason we have not proposed any national hierarchy of importance for the criteria is to ensure that decision-making bodies retain the flexibility to decide this based on the particular service they are arranging. While most respondents agreed with this, some felt that the proposals give too much discretion to the decision-making body and this could lead to some criteria being compromised.

Other respondents suggested core minimum criteria could always be considered, or that some criteria should be given greater weighting by default.

> "To ensure a degree of consistency within the flexible prioritisation of criteria, the regime should include core minimum standards that all providers must meet, including financial probity and demonstration of regulatory compliance. Guidance may consider assigning minimum levels of weighting of some key criteria to support more consistent application." (NHS Confederation/NHS Clinical Commissioners)

> "We agree with the proposed criteria, but further thought should be given to weighting them. Issues such as access and choice should be favourably weighted, as should any measure to tackle health inequalities." (Company Chemists Association)

However, others argued strongly that any weighting and prioritisation of criteria should be left to local decision-makers rather than be set nationally, and it would be helpful if local decision-makers could also add criteria.

> "It is important that local systems have the flexibility to determine their own hierarchy of criteria in the light of local population health needs. It will of course be important that decision-makers are transparent about how they have prioritised and applied the criteria." (WYH Health and Care Partnership)

> "We agree with the suggested criteria for selecting providers; however, we believe there may be times when the criteria will need to be more locally defined. While the regime allows CCGs/ICSs to set their own weighting against the criteria, we would like to see a limited amount of flexibility to add additional criteria in the selection process." (Kent Community Healthcare Foundation Trust)

Although most respondents favoured a permissive approach, there were some concerns around transparency and how rigorously and consistently the criteria would be applied.

> "The key criteria broadly cover most considerations but the question is how rigorously and thoroughly they will be applied by individual commissioners, how this will be captured for audit purposes and what recourse there will be." (Trowers and Hamlins)

> "We are concerned that without a minimum set of information the system could be gamed to fit a pre-determined outcome, removing or including information as needed rather than being based on a consistent and objective process." (SEUK)

Another theme that emerged in responses was around the value of patient involvement in NHS decision-making. Respondents suggested that decisions about services need to reflect patients' needs and preferences, and that where there are opportunities to include the views of patient groups in decisions around provider selection these should be taken.

> "The new regime is an opportunity for the NHS to give proper weight to defining, measuring and using the outcomes that matter most to patients. Across all the criteria, particularly for quality, access and social value, there should be a strong patient voice assessing potential providers." (NHS Confederation/NHS Clinical Commissioners)

Overall, many respondents were supportive of the headline criteria and the content within them, in particular around social value, sustainability and integration.

> "We welcome the broader definition of value, recognising the importance of social value in addressing health improvement." (Devon STP)

There was a general consensus that considerations around integration and collaboration were vital when making decisions around provider selection.

There were some more substantive comments around value. While many welcomed the broader angle to value considerations (rather than a focus solely on financial considerations), others wanted more explicit reference to cost and budgeting considerations.

"Please do not make the cheapest price the weighted factor when others are equally or more important." (NHS foundation trust)

"The range of criteria – in addition to value which often takes priority – are welcomed." (Yorkshire Ambulance Service)

"The best interests of patients, taxpayers and the population is somewhat woolly, and the balance between these things is always a trade off somewhere else." (Cheshire East Council)

NHS England and NHS Improvement response

We welcome the comments around the key criteria, in particular noting the broad support from a variety of respondents that the criteria we have included are the right considerations when selecting providers; the flexibility and discretion to prioritise criteria according to local need is broadly supported; and the ability to introduce additional local consideration is considered helpful.

The comments around weighting the criteria and ensuring consistent application were helpful and highlight the difficult balance between giving decision-making bodies suitable flexibility in prioritising criteria based on their local needs and the particular service being arranged, and ensuring there is a degree of objectivity in the process.

While we understand the concerns around objectivity, the reason we did not originally propose to impose core minimum criteria or minimum weightings was based on earlier feedback that suggested this would detract from one of the key principles of the regime – to give more discretion to decision-making bodies. We still believe this is the case. Decision-making bodies must be able to arrange services in a way they think best meets the needs of patients, taxpayers and the local population, and this of course will vary significantly depending on local factors. Furthermore, the range of services that need to be arranged will be diverse in nature so nationally set weightings are likely to be inappropriate in some cases.

Similarly, setting minimum weightings or core minimum criteria at a national level will lead to a loss of flexibility for decision-makers to arrange services in the way they see fit.

However, we do still expect decision-makers to reach defensible decisions in how they have assessed, prioritised and considered each of the key criteria for the

particular service they are arranging (even if that involves deciding to minimise some criteria). These decisions will need to be documented and decision-makers will need to audit themselves against compliance with these rules.

We welcome comments that referred to ensuring that the patient voice is heard as part of the decision-making process – there are many ways this can be achieved, including by ensuring that commissioners' duties on patient and public involvement will be relevant to decisions about provider selection.

One of the underlying drivers of the focus on integration in the new provider selection regime is widespread recognition that such things are driven by good leadership, investing in staff and partnership working. So, while the criteria we have proposed are important tools in ensuring that decision-making bodies consider issues like quality and innovation when selecting a provider, it is important to recognise that the regime is by no means the only mechanism for ensuring that NHS services reflect these things, and that it exists alongside other legal duties to improve the quality of services, address inequalities and promote innovation, choice, integration and patient involvement.

Transparency – notice periods

Summary of proposal

In the engagement document, we proposed that all decisions should be subject to a notice period of four to six weeks before contracts are signed, during which representations can be made and decisions challenged. The only exceptions to this notice period would be where contracts for core services are being rolled over because no alternative provider exists, eg for A&E, 999, commissioner requested services/essential services, and elective services which rely on cross-specialty working which can only be delivered by particular providers. The intent behind this is to allow time for decisions to be reviewed and scrutinised before contracts are signed.

We asked the following question:

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

Summary of responses

Over 60% of respondents agreed with our proposals for a notice period – viewing this as necessary to show transparency in decision-making and allow for decisions to be reviewed by those affected by them. Respondents offered several reasons why notice periods were important and highlighted the importance of balancing transparency with the need for decision-making processes to be efficient and not too time-consuming.

> "Decision-making that concerns public funds should always be open and transparent, and without advanced notice of contract authority intentions it is difficult to see how transparency requirements could be met." (CCG)

> "A notice period allows an interested party to bring to the attention of decision-makers relevant factors which they might have overlooked, without causing undue delay or cost." (Member of the public)

> "It is reasonable to provide a notice period in order to allow representations from other providers." (Royal College of Midwives)

A significant number of respondents commented about the ideal length of any notice period. Some argued for the shortest possible period, or even no period on the basis that one is not helpful, but the more common response was that a period of four to six weeks was potentially too short.

> "If the organisation has decided to continue with the incumbent, no notice need be given." (CCG)

> "If an established service is providing quality and value to the public/patient base then there should be no notice period and the contract roll on." (Healthcare professional)

> "We think the published notice period should be at least six weeks, to allow other providers to challenge if needed." (Social Enterprise Mark CIC)

> "Extending it to 8-12 weeks would probably be safer and in patients' interests. It would give all stakeholders time to review notifications and consider whether the ICS would benefit from feedback that could help patients, the wider NHS and taxpayer." (Association for Eye Care Providers)

Some respondents argued that there should be some flexibility and discretion about the length of notice periods, so that they are proportionate to the service or circumstance in question, rather than fixed in length.

> "The council strongly agrees with the proposal for a notice period but is of the opinion that there should be flexibility to enable variation in length of notice period." (Buckinghamshire Council)

> "The notice period for very urgent contract awards should be reduced to zero days." (North East London Clinical Commissioning Group/East London Health and Care Partnership)

Respondents also raised several practical considerations about the notice period, including:

- the need for clarity around the days/working days, rather than weeks
- clarity on what happens to notice period if there is a representation or judicial review (JR), ie does the notice period start again after a representation is decided? Does the notice period pause in the event of a JR? How long should representation take to resolve?
- clarity on where notices should be published and exactly what information they need to include
- what other forms of communication to prospective providers may be needed in addition to published notices
- clarity on the difference between the notice we are proposing about a decision to award a contract, and the relevant provisions in the NHS Standard Contract about contract terminations.

A number of respondents misunderstood the intent behind our notice period and stated that it should be longer (eg 12 months) to allow services to safely transition from one provider to another.

Finally, some respondents suggested that the length and operation of the notice period should be subject to review and change to ensure it operates appropriately, and therefore not be tied down in legislation.

NHS England and NHS Improvement response

The intention behind our proposal for a notice period was to provide transparency, to allow time for decisions to be reviewed and scrutinised before contracts are signed. The notice period we have proposed is about providing an opportunity for representations that may lead to a review of the decision – it is not intended to also be the transition/handover period, or a replacement for termination periods agreed in existing contracts, or the immediate prelude to a contract going 'live'.

We fully expect that for many services, careful consideration will need to be given to the time needed to safely transition between one provider and another, and decision-makers must have the flexibility to make decisions about this on a case-by-case basis.

We will provide further clarity about how the notice period relates to these other periods in our guidance, and reconsider the language we use to avoid potential confusion.

We agree with respondents that the notice period is vital for transparency. We note the most common responses were about making the notice period longer than four weeks, and being clear about the duration of the period, rather than giving a range.

We accept there may be benefits to a notice period of around 30 working days.

We also note the suggestion that currently the 'standstill periods' that follow a competitive exercise are shorter than 30 working days, so there may be merit in considering a shorter notice period is appropriate where a competitive exercise has occurred. We will give further thought to this as we develop the guidance.

Under our proposals, we have stated that a notice period is required for all decisions save those where a contract is being rolled over due to there being no alternative provision, or where alternative provision is available through other means (eg patient choice arrangements). In all other circumstances, decision-makers will be choosing a provider on behalf of the population and we believe it is appropriate to be transparent about the outcome of that decision.

We agree that clarity will be needed on where notices are to be published, and what they should contain. We are grateful for the suggestions made by respondents on this point, and will take these into account when establishing the practicalities of

providing notices. We also agree that we need to be able to review and revise the arrangements around notice periods once the regime is in place.

Finally, we appreciate the thoughts of respondents who pointed out the need for further clarity on the interaction between the length of the notice period, and any review/challenge process that may subsequently occur. We will give further thought to this as we develop the guidance, with consideration that notice of decisions needs to take account of the wider contracting cycle.

Transparency – further measures

Summary of proposals

In the consultation document we set out a number of steps that we expect decision-making bodies to take to evidence that they have properly exercised the responsibilities conferred on them by the regime. The document also set out what would happen in the event of challenge as the proposed reforms remove the right for competitors to legally challenge decisions as currently set out in the Public Contracts Regulations 2015. Instead representations can be made to the decision-making body once it has published its decision, with judicial review available for providers that want to challenge the lawfulness of that decision.

We asked the following question:

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

There was broad consensus among respondents that the proposed regime should be made transparent on the basis that was set out. Over 80% of respondents agreed or strongly agreed with the proposals as set out.

> "Transparency is key to not only maintaining public and internal trust but also to the integrity of each and every service the NHS provides." (NHS non-clinical staff)

> "The proposals recognise the value of transparency and are proportionate and practicable." (Member of the public)

> "[this is] public money and we are all shareholders by way of taxpayer or user of the service so decisions must be defendable and transparent." (Patient)

There were calls from a broad section of respondents for more detail to be set out around transparency requirements, with a small number of respondents specifically stating that the proposals do not go far enough.

> "The proposal does not go far enough on this issue, nor is it specific enough on the level of detail that must be published and assurance around how conflicts of interest should be managed. Transparency must apply to all providers not just public sector." (Association of Ambulance Chief Executives)

There were mixed views on appropriate levels of transparency and what should be required of decision-making bodies versus not over burdening the system with transparency requirements and requirements to publish information.

> "We agree with the duty re transparency and publication; however, the system could become over-burdened and consumed by paperwork to justify some decisions which are already exempt from the process and are noted in the proposals." (NHS Surrey Heartlands CCG)

A small number of respondents suggested that every part of the regime should be subject to transparency requirements.

> "All documents relating to selection of providers, including evidence of previous performance indicators, achievement of service objectives (or failure to achieve such), demonstration of how health outcomes have been improved, should be published in an open and transparent way on ICS/CCG websites to ensure public accountability." (Member of the public)

The main concern arising from this question was around scrutiny and the ability to challenge. Many respondents expressed concerns around the potential lack of independent scrutiny in the decision-making process and where challenges have arisen.

> "Decision-making bodies (for steps 2, 3 and 4 above) in affect will be responsible for auditing their own requirements and conducting their own compliance checks, including how complaints will be dealt with. One could

argue the independent scrutiny will therefore be omitted." (Health consultancy organisation)

"The ability to make representations only to the decision-making body itself is very weak. I foresee that unless the ability to hold the decision-making body to account for the decisions it is making is significantly increased there will be a high likelihood of judicial reviews." (Navigo Health and Care Community Interest Company)

Respondents generally thought judicial review should only ever be a last resort and would potentially not be the most appropriate route through which to bring a challenge in any event.

"In our view, it is concerning that the only route for challenge is through the judicial review process; this is a high bar and is only a mechanism to appeal the lawfulness of decisions. We would therefore recommend that NHSE/I explores the potential for an additional appeals process whereby a decision can be impartially reviewed by a third party if certain criteria are met." (NHS Providers Community Network)

"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." (Independent Healthcare Providers Network)

Respondents were also concerned about conflicts of interest in relation to challenge and more broadly.

"We are unsure whether confidence in transparency will be widespread if decision-making bodies investigate themselves in the event of challenges and complaints." (London Optical Committee Support Unit)

"It should be made transparent based on an independent judgement of transparency. The same people making the award should not be judging

whether they have done so transparently as this is a conflict." (Member of the public)

Other respondents went further and suggested that there should be some independent process/mechanism that could provide scrutiny. Some suggestions included local authorities, an independent panel and NHS England and NHS Improvement. More generally there were calls for clearer lines of accountability and detail on how compliance with the regime would be monitored.

Another key theme in the consultation responses was around publication requirements. Many respondents called for more detail around exactly what decision-makers would need to publish, where it should be published and when certain information should be published.

"It would help transparency if there was a national NHS website where notices could be published together." (North East London CCG)

NHS England and NHS Improvement response

Many respondents called for more detail around publishing requirements and there was a mixture of views about what this should entail. While we are working towards ensuring there is appropriate transparency within the regime, we acknowledge the need to strike a careful balance between ensuring transparency and accountability and not over burdening the system with extensive publication requirements, and indeed introducing more bureaucracy than is required under the current system.

The consultation document did not set out full details around publishing requirements. We are continuing to develop this area and more information on exactly what decision-making bodies will need to publish (including when and where) will be set out in guidance.

We recognise that the proposals represent a step change from the current position where providers are able to bring a challenge through the courts under the Public Contracts Regulations 2015 – this is because previous engagement has shown that the prospect of legal action erects a barrier to different parts of the system working together, as well as bringing unnecessary delays and costs to the process. We also know that under the current regime contracts are sometimes unnecessarily put out to tender because of the threat of legal challenge. These are barriers that the service has asked us to remove with the introduction of a more flexible regime based on

discretion to do the right thing in the interests of the patient, taxpayer, and local population.

It would be counterintuitive to allow the system to have more discretion on one hand but also put in place further mechanisms for challenge (beyond what is set out in the consultation paper), which would in effect fetter that discretion. However, it is also clear that there needs to be good internal governance around decision-making, and around responding to challenges where they arise, to ensure that decision-making is sound and fair and decisions are justified. We will expand on this in guidance.

We will need to ensure that the scrutiny and accountability arrangements that sit within this regime are consistent with the wider systems of accountability within the NHS. For this reason, we do not think it is appropriate to introduce independent third-party scrutiny or formal NHS England regulatory powers specifically in relation to this regime, as these would unhelpfully cut across other accountability relationships within the system. NHS England would be able to use its general powers of intervention in relation to NHS decision-making bodies in serious cases where we consider them to be acting in breach of statutory duties and intervention is appropriate.

Equality and health inequality

We asked respondents to identify whether any aspects of the engagement document might have an adverse impact on groups with protected characteristics or widen health inequalities (question 8).

The majority of respondents did not identify any specific issues in relation to the provider selection regime having an adverse impact on groups with protected characteristics. There were comments more generally, however, around health inequalities, in terms of how they would be considered as part of the key criteria but also the potential to widen health inequalities with the introduction of NHS Integrated Care Boards.

> "Equality and health inequalities can be assessed under the criteria and via contract management; the proposed regime does represent an increased risk that existing issues will continue if/when contracts are rolled over. There will also be less opportunity to understand what initiatives other providers would use to tackle health inequalities and ensure equality of access." (NHS South, Central and West Commissioning Support Unit)

Other respondents recognised the positive benefits the provider selection regime would bring:

> "Alongside the ICS focus on population health and inequalities we believe the provider selection regime provides an opportunity to address some of the health service fragmentation that drives inequalities." (Kent Community Healthcare Foundation Trust)

The role of voluntary, community and social enterprise (VCSE) organisations was also raised, and some respondents felt more should be done to support VCSE organisations and recognise the valuable contribution they play in population health management.

> "There should be a clear drive to support smaller local VCSE/charities which may not always be able to be recognised as valid service delivery options that serve particular vulnerable cohorts… There is a risk that the new regime, with a wider geographical focus and ability to renew contracts without an open process, could create additional barriers to smaller organisations engaging small providers." (The Centre for Mental Health)

The importance of patient participation was also highlighted as vital to reducing inequalities. One respondent commented that the voices of service users as well as staff need to be built into the routine governance of each organisation including to an NHS Integrated Care Board's work at place level to support service development and reduce inequalities.

Parity between healthcare and mental health services, social care (explored more in response to question 9 below) and the use of impact assessments were also highlighted by some respondents.

NHS England and NHS Improvement response

Most of the comments around health inequalities were in relation to the creation and operation of NHS Integrated Care Boards, in particular understanding local needs and also the role of VCSE organisations and public and patient participation.

In our document Next steps to building strong and effective integrated care systems across England, we recommended each system builds on or establishes arrangements to locally meet people's day-to-day care needs. These are called

place-based partnerships: a partnership between local organisations that commission and provide services to the public. Their broad aims are to improve the health and wellbeing of their local populations, address health inequalities and make best use of their shared resources.

Through place-based partnerships we expect decision-makers to consistently listen to and act on the experience and aspirations of people and communities, and how they involve people and communities in developing plans and priorities, improving population health and redesigning services.

We also expect NHS Integrated Care Boards to build a range of engagement approaches into their activities at every level and to prioritise engaging with groups affected by inequalities. It is expected that this will be supported by a legal duty for NHS Integrated Care Boards to make arrangements to involve patients and the public in planning and commissioning arrangements (the same duty as held by CCGs now), and by the continuation of the existing NHS trust and foundation trust duties about patient and public involvement.

In terms of involvement of VCSE organisations, there is no intent either through the provider selection regime or the creation of NHS Integrated Care Boards more broadly to take services away from social enterprises. 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. We will also continue to work with VCSE partners as part of our engagement on ICS implementation.

Trade deals

Summary of proposal

When first developing our proposals, we were told about many issues with the current rules, in particular with the way the Public Contracts Regulations 2015 have affected the NHS. The Public Contracts Regulations 2015 are derived from EU procurement directives and are an example of how international arrangements with other nations can impact on public procurement rules and the NHS. In our consultation, we proposed to work with government to ensure that the arranging of healthcare services by public bodies should not be included in the scope of future

trade deals, to avoid a future scenario where wider agreements reached with other nations may limit our ability to decide how NHS services are arranged in future.

We asked the following question:

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?**

Summary of responses

Over 70% of respondents either agreed or strongly agreed with this proposal, with many expressing views about the importance of keeping the NHS 'off the table' for several reasons, including concerns that the regime could not operate if subject to procurement rules arising from trade deals, and that trade deals could leading to NHS privatisation.

> "The inclusion of healthcare services in any future trade deal would go against the integration and collaboration direction of travel described in the White Paper." (University Hospitals of Leicester NHS Trust)

> "Provider and commissioner confidence in the longevity of the procurement regime (in whatever form it takes) is vital to enable collaborative long-term planning. This would be significantly eroded if there were an ongoing risk of substantial change as new trade deals are made." (Yorkshire Ambulance Service)

Some respondents noted that the NHS does have an international supply chain for goods, and this will need to be protected and maintained in whatever arrangements are reached with other nations – ie that issues affecting the arranging of healthcare services should be kept 'off the table', but not all procurement undertaken for the health service.

> "Agree, though noting that healthcare services arranged and delivered in the UK have supply chains that extend far beyond national borders. Trade deals, such as those with countries that manufacture and supply clinical consumables, will

directly impact on healthcare services commissioned by public bodies in England." (CCG)

Similarly, some respondents also made the point that the NHS's international links with suppliers, providers and overseas health workers can bring valuable extra skills, capacity and innovation to the NHS, and this needs to continue to be a possibility in future.

"Agree but need to include some safeguards that it doesn't constrain or prevent the sharing and developing of global innovative healthcare practices." (CCG)

NHS England and NHS Improvement response

We agree with respondents that it is desirable for this regime to be protected from changes that may arise from future trade agreements with other countries.

We also agree that any such protection needs to be limited to the operation of this regime, and not impinge on the NHS's international supply chains, or ability to access innovation from overseas organisations or to attract workforce from abroad.

Other comments/feedback

We gave respondents an opportunity to provide comments and feedback on other aspects of the regime (question 9). A number of topics/themes emerged from this question including:

- contracting/contract management
- choice and Any Qualified Provider regime (AQP)
- role of independent sector
- ICSs
- Cabinet Office procurement regime
- social care and agreements pursuant to s75 of the National Health Service Act 2006.

Each of these themes are covered in more detail below.

Contracting/contract management

Respondents commented on a range of issues around contracting and contract management, including the commercial capability of staff, setting limitations to contract extensions, flexibility and the use of sub-contracting.

A few respondents expressed particular concerns around the use of sub-contracting, eg:

> "The regime should only apply where there is a direct contractual relationship, ie commissioner/lead provider or lead provider/sub-contractor. Commissioners should not be able to mandate the use of named sub-contractors as a requirement for the lead provider being awarded the contract as this has the risk of commissioners using this path to circumvent the key selection criteria and shifting financial risk to the lead provider." (London Ambulance Service NHS Trust)

NHS England and NHS Improvement response

We appreciate respondents' comments around contracting and contract management. The engagement document set out the key foundations of the provider selection regime; however, further detail will be set out through secondary legislation and guidance. We expect to provide details around contract management in guidance and the comments received were helpful indicators of the kinds of issues that need to be covered.

In relation to sub-contracting the engagement document made clear that where an NHS provider is arranging for the provision of a service by another provider, then this regime must be followed when deciding the arrangement. 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. We do not expect sub-contracting to be used as a means to circumvent the requirements imposed under this regime.

Choice and AQP

Overall, there was consensus on the importance of maintaining patient choice. The Local Optical Committee Support Unity stated that "patient choice remains central as

with core primary eyecare services … where patients may choose treatment from locally based, accredited optical practices".

Some respondents made detailed comments on the use of the AQP regime. Some of these comments centred around waiting lists and providers being able to effectively 'cherry-pick' patients (usually those with less complex needs), at the expense of other patients via AQP.

> "[We suggest that] any providers that wish to be treated as an AQP must demonstrate (in a very literal sense!) that they are able to cater to all patients within a population and do not discriminate when triaging referrals – with referrals only being refused when a patient requires a multidisciplinary approach which the provider cannot cater to." (CCG)

> "While we agree that the new regime should ensure the protection of patient choice, we believe that the role of private providers within this – via AQP in particular – must be carefully balanced with the short, medium and long-term financial needs." (BMA)

In terms of the changes proposed to the AQP regime, Midlands and Lancashire Commissioning Support Unit were concerned that the removal of decision-making bodies' ability to ask local questions/use local criteria, will effectively mean that a provider that is qualified in one region could deliver services in all regions (depending on ability to deliver across geographical areas). Unison also stated that it is "disappointed" that the regime proposes to continue with AQP, albeit in an altered form. It is of the view that this encourages consumerism within the NHS which is at odds with the stated objectives of the White Paper to focus on integration and collaboration.

NHS England and NHS Improvement response

We welcome the broad consensus from respondents on the importance of patient choice remaining in place. As set out in the engagement document the patient choice regulations currently under s75 of the Health and Social Care Act 2012 will remain in place.

There were a number of comments around the operation of AQP and questions about how this may sit alongside the processes the NHS has put in place to recover the elective backlog created by COVID-19. Most of the provisions around patient

choice and AQP will be set out in secondary legislation. As with other aspects of the regime, we will take into account respondents' comments (particularly around the operation of AQP) as we develop regulations and accompanying guidance.

Role of independent sector

There were a large number of comments around the role of the independent sector, in particular around the future role of voluntary sector and social enterprises in the context of the White Paper and statutory ICS NHS bodies. There were differing views however, with some respondents calling for independent sector providers to be represented in an ICS and others stating that independent sector providers should not be able to make decisions on statutory functions. Liverpool CCG commented that more clarity is needed on how private providers and charities should be managed in any new approach. It also questioned how charities and social enterprises would gain entry to the market in future if decision-making bodies prioritise rolling over contracts.

NHS England and NHS Improvement response

As set out in other areas of this document and in the engagement document, we expect the regime to 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. Where this provides good value for money and high quality of care, this will continue to be the case under the new regime and also in the context of NHS Integrated Care Boards.

Integrated Care Systems and NHS Integrated Care Boards

Linked to the above there were a number of comments around Integrated Care Systems and NHS Integrated Care Boards more generally, including around governance, membership, and representation and more broadly their role (this consultation took place before the more recent publications on ICS design were available).

NHS England and NHS Improvement response

We welcome comments around the form and function of statutory NHS Integrated Care Boards and recognise the links between ensuring there are robust governance and transparency measures in place and the operation of the provider selection regime.

Further detail on ICS implementation has been published by NHS England and NHS Improvement. This sets out in more detail how we expect NHS organisations to respond in the next phase of system development, including the anticipated establishment of new statutory arrangements from April 2022. It describes the 'core' arrangements we will expect to see in each system and the ways in which NHS organisations will be able to flex their approach to collaboration in their local context, if the legislation is passed. It will also contain further information on governance arrangements, accountability and oversight, as well as financial allocations and funding flows.

Cabinet Office procurement regime

The Cabinet Office recently published the Green Paper Transforming public procurement on overhauling the current procurement system and replacing it with a new approach. Some respondents questioned why the NHS would not be using the new single procurement framework being proposed by the Cabinet Office and others expressed concerns that NHS trusts and local authorities will be subject to both regimes.

NHS England and NHS Improvement response

While it continues to be the case that Cabinet Office is not considering healthcare services as part of its new regime as set out in their Green Paper, we have nevertheless been engaging with Cabinet Office officials throughout the engagement exercise and will continue to do so as we develop secondary legislation and guidance. In particular, in relation to the competitive tendering process there needs to be clarity on which regime applies and we are mindful of respondents' concerns in this regard.

As we develop the detail of the regime we will continue to engage with colleagues at the Department of Health and Social Care (DHSC) as well as Cabinet Office to ensure that there is clarity across the regimes and appropriate alignment.

Social care and s75 agreements

Many respondents commented that excluding social care from the scope of the Provider Selection Regime would not help achieve the goals of integration and collaboration.

> "Local authorities are an important part of the ICS and integrating health and social care services is a fundamental part of improving population/patient outcomes… It will be made even more difficult if local authorities, as part of an ICS, are subject to a different legislative regime as far as procurement is concerned." (CCG)

> "There is no indication regarding the situation of procuring services that have an element of both [health and social care]. A lot of our commissioning includes health and social care, jointly funded by the CCGs (Health money) and HCC (LA money) from a 'pooled budget' governed by a s75. The wording in the document clearly excludes social care, so it doesn't really make it true integrated commissioning which we have been providing in Hertfordshire for many years." (Hertfordshire County Council, Integrated Health and Care Commissioning Team, Adult Care Services)

Care England also submitted a response with particular concerns around how the independent adult social care sector would be taken account of in the regime. In particular, it was unclear about how the proposals will affect different packages of care adult social care providers provide, including:

- continuing healthcare
- discharge to assess
- hospital admissions for care home residents
- designated settings.

Linked to this there were some comments around the use of s75 partnership agreements (agreements made pursuant to s75 of the National Health Service Act 2006 that allow NHS bodies and local authorities to enter into a shared commissioning arrangement).

> "More clarity is needed on how the regime will apply in the case of joint contracts between the NHS and councils, where s75 agreements are in place to pool budgets locally." (NHS Confederation/NHS Clinical Commissioners)

NHS England and NHS Improvement response

Since the publication of the consultation document we have been engaging with colleagues at the DHSC, other government departments as well as the Local

Government Association. We wish to support the integration of commissioning and avoid erecting barriers to this for those services that would benefit from being arranged under the same contract.

We acknowledge that there are many areas where health and social care often overlap. We recognise the importance of having clarity around those areas so decision-makers know which regime needs to be applied when selecting a provider.

Any decisions on how social care should be commissioned, both in relation to integration of services and more widely, are for government to take, rather than NHS England and NHS Improvement. We would like to invite colleagues from across government to consider the benefits of greater integration of health and social care as they continue to consider measures to reform the operation of the public procurement and the social care system in England.

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

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