ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

Bringing together skills, expertise and shared knowledge in UK ambulance services

NHS Provider Selection Regime Consultation April 2021

Consultation Response

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Part 1: Introduction

In September 2019, NHS England and NHS Improvement (NHSEI) 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.

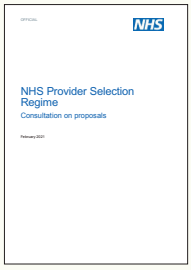
The NHS ambition for greater collaborative working has expanded and further legislative proposals have been developed. These seek to place integrated care systems (ICS) on a statutory footing by creating ICS Boards and giving them decision-making responsibility for arranging healthcare services. Representatives 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.

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. [NHSEI] 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.

In future, [NHSEI] 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.

[The] 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.

Full details of the proposals can be found here:
B0135-provider-selection-regime-consultation.pdf (england.nhs.uk)



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In brief:

The document sets out that there are broadly three 'decision circumstances' in this regime:

1) **Continuation of existing arrangements.** Where the incumbent provider is the only viable provider, and a change of provider is not feasible or necessary. **999 emergency ambulance services are noted to be in this category.** There will also be 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 decision making bodies need to publish their intention to award the contract with a 4-6 week notice period.

2) **Identifying the most suitable provider for new/substantially changed arrangements.** 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 they have reasonable grounds for believing that one provider/group of providers is the most suitable provider, they may award the contract to that provider without conducting a tendering process. This must be done in a way that is fully transparent and again the decision maker must publish their intention to award the contract with a 4-6 week notice period.

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.

The decision makers 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.

The consultation proposes a number of key criteria to be considered by decision makers when undertaking option 2 or 3 above:

- **Quality (safety, effectiveness and experience) and innovation;**
- **Value;**
- **Integration and collaboration;**
- **Access Inequalities and Choice;**
- **Service sustainably and social value.**

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The consultation makes reference to an expectation that ICS Boards and NHSEI will be subject to a number of duties in relation to healthcare provision:

- **Triple Aim Duty** - better health and wellbeing for everyone; better care for all patients; and sustainable use of NHS resources, when exercising any of their functions;
- to seek to enable patients to make choices about the services provided to them;
- to seek to continually improve the quality of services;
- to seek to promote the integration of services.

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Part 2: Summary view from the NHS ambulance sector

The NHS ambulance sector welcomes these proposals, but with a number of caveats. The resulting regime must allow the most credible provider to be selected by an ICS, or multiple ICSs together, where it progresses the collaboration agenda, provides outstanding patient care and delivers economically advantageous benefits to the system.

To have an effective set of criteria for the commissioning of NHS Services which does not create unnecessary burden through a mandatory requirement to go through a competitive tender process is much needed; but this requires a regime that is robust enough to also ensure that where competitive tendering is in the best interests of the patient, taxpayer, and system, that it is used.

There are significant local opportunities for greater integration of 999 services, Patient Transport Services (PTS), NHS 111, alongside rapid community response services and collaborations within Urgent and Emergency Care (UEC) where such a regime would be beneficial. The future delivery of the UEC Standards will be heavily reliant upon credible providers working together in delivering those services. The ability for Integrated Care Systems (ICSs), as commissioning decision-making bodies, to have a more rapid, but fair process to bringing the right partner providers together, the faster we will reach these standards in a sustainable manner.

The need to run procurement and competitive exercises is extremely time consuming and demanding particularly for an industry that is not purely commercial in its nature. These processes drive inefficient and inappropriate behaviours because they do not support ongoing investment in a service but leave organisations managing a service over 5 year windows, in fear of losing the contracts they manage – this is not good for the patient and does not deliver the best, safest or most sustainable service for the patient.

There are positive aspects which could be achieved by applying the proposals as is. Where there are health services currently being tendered for with a clear single provider, or an alliance of providers, which is best placed to deliver, it would be beneficial to reduce the administrative, legal and financial burden of competitive procurement.

The largest risk to these proposals is that innovation is stifled, and organisations are deterred from developing new and improved care products and services. If these proposals are applied poorly, there is the significant risk that local monopolies are established of single providers, or groups of providers, who hold entrenched contractual positions and who become complacent in the delivery of care.

Competitive procurement, for all its faults, can be a mechanism to encourage organisations to continue to innovate their services to deliver value-for-money in an ongoing evolutionary way. It can conversely lead to poor contracting decisions based on cost alone, as has been seen in

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relation to some NHS111 procurement decisions in the past, leading to the NHS ambulance trust having to step in at the request of commissioners and run these services where the private provider has been unable to fulfil their contract requirements.

There is a potential constraint in the regime if health services do become sewn-up in such relationships, that this will deter revolutionary improvements in healthcare, such as truly disruptive products or services if there is no mechanism or space for these to be implemented. There is a risk that this proposal may force organisations to remain within their current sphere of operation, positively enabling integration, but negatively reducing the ability for organisations to further enhance whole system care through innovation.

Overall, however, the sector view is that, applied appropriately and consistently with clear definitions and guidance, the proposed changes in this legislation will bring significant benefits in healthcare delivery and outcomes for patients.

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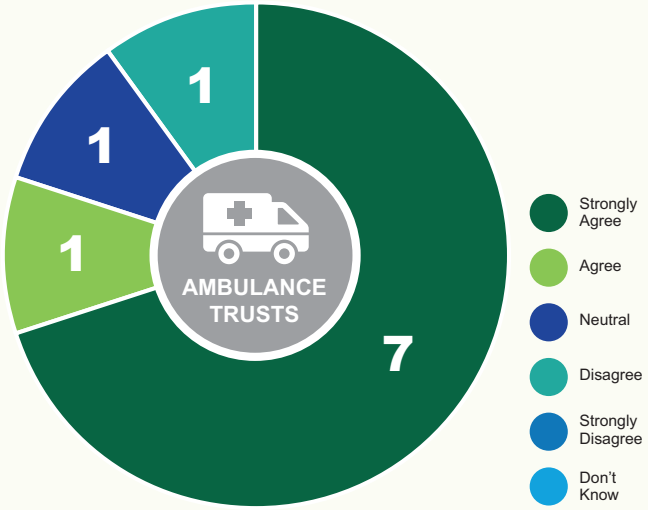
Q1. Should it be possible for decision-making bodies (eg the clinical commissioning group (CCG), or, subject to legislation, statutory ICS) to decide to continue with an existing provider (eg an NHS community trust) without having to go through a competitive procurement process?



The majority of ambulance trusts feel very strongly that whoever is the commissioning body, they should be able to continue with a service provider without the need for a competitive procurement process in circumstances where the provider is consistently delivering the right service, to the right level of quality, meeting the needs of patients, taxpayers and the system.

If there is a clear whole-system benefit derived from the relationship, then this proposal is a positive one. From the ambulance sector perspective, this would facilitate those ambulance services operating regional NHS111 Integrated Urgent and Emergency Care services and the associated Clinical Assessment Services, applying advantages of economies of scale and having oversight of cross-system service provision.

The option should remain, however, that commissioning bodies be able to run a procurement exercise should they deem it necessary e.g. for a new service where costs are unknown or perhaps as an opportunity to ask a range of providers to co-design a service – options may vary, which would be beneficial for the patient if an existing service is poor or in need of redesign. A procurement exercise allows for a detailed specification, market analysis and clear written terms.

On the whole though, the proposals would minimise the undue impact and costs associated with competitive tendering where an existing service provider is well established, providing high quality services within a contractual and service framework that is not changing. Focusing on collaborative discussion around performance and delivery would be seen to be a positive shift.

Many providers spend years working on long term strategies to deliver outstanding local care and develop long term workforce strategies. The constant threat of competition and convoluted procurement processes drives additional unnecessary costs and short-termism in investments and setting of objectives.

It should be borne in mind that there are a range of services, e.g. NHS111 and Patient Transport Services, which are currently outsourced to the private sector in some parts

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of the country, and these may well be better served from within the NHS, facilitating integration with more flexibility and saving significant time and money. So continuing with providers without the need to re tender may not always be the best option.

Consistency in the application of the five proposed criteria in the decision-making process will be essential:

- **Quality (safety, effectiveness and experience) and innovation;**
- **Value;**
- **Integration and collaboration;**
- **Access Inequalities and Choice;**
- **Service sustainably and social value.**

These measures could however be assessed subjectively, so it would be helpful to see some guidance on how these should be applied and their respective weightings.

There would need to be openness and transparency whatever the route taken, with details of the decision-making process being published, not just the decision e.g. showing weightings for the key criteria.

1. The service requirement/design specification needs to be right and clear at the outset.
2. There should be specific demonstrable evidence that meets patient safety and satisfaction levels and quality of care provision.
3. All costs – of new versus old service need to be transparent and total cost of ownership.
4. Contract terms need to be clear.
5. The contract once awarded should be managed.
6. Contracts should not be awarded due to time pressure - but when the terms and costs are agreed, transparent and clear.
7. Stakeholders need to be engaged in writing the terms and the implications of the terms.
8. There should be a clear process for how to deal with conflicts of interest within the commissioning body where the provider is also a decision-maker i.e. splitting the decision-maker from the decision-evaluator.

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All decision-making bodies involved in the commissioning of services would need to demonstrate their understanding of their remit in ensuring the regime is clearly introduced and the appropriate tests are consistently and transparently applied. This should be applied in a collaborative way, reflecting the spirit of the principles-based approach within the new regime.

Provided commissioners can demonstrate they have appropriately applied the five criteria in their decision-making, systems should be permitted to either directly choose the provider that suits the local need or choose to go through a competitive process.

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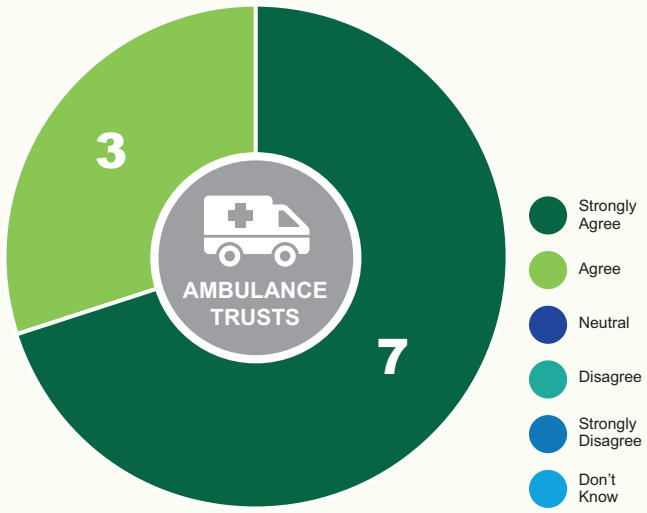
Q2. Should it be possible for the decision-making bodies (eg the CCG or, subject to legislation, the statutory ICS) to be able to make arrangements where there is a single most suitable provider (eg an NHS trust) without having to go through a competitive procurement process?



All ambulance trusts agree with this proposal – most of them strongly – and see this as building on the positives of question one, provided due diligence has been met and can be evidenced, and subject to there being a right to challenge or appeal a decision. A guiding principle should be "NHS First" with NHS funds being spent on NHS provided services, with the only exception being where the NHS cannot provide a particular service.

This proposal reduces costly and lengthy procurement processes when they are unnecessary. There will be good examples where a single provider, or alliance of providers, is best placed to deliver a service or range of services, e.g. Newcastle Urgent Care Alliance.

The feeling is that this ability allows far more collaboration potential at a local system level and allows credible providers to seek opportunities where new services are required. Providing the flexibility to continue provision of services with existing providers, alongside an improvement and innovation trajectory will enable the development of future focused services, incorporating new technologies and techniques, for the benefit of patients, taxpayers and the population.

Ensuring collaborative and broad engagement around the development of new or changing service requirements / specifications will be critical. The role of the ICS and commissioners is vital in determining the key criteria for services alongside effective understanding of providers and markets.

Where significant changes are required, the requirement of the commissioning body to engage initially with the incumbent in a collaborative way would be welcomed, to develop options and proposals for delivery that maximise the three tests around best interest and outcomes for patients, taxpayers and the population.

The focus on innovation and encouraging joint working between commissioners and providers to improve services within existing arrangements. There is a risk, however, of the unintentional consequence of stifling potential growth of other organisations.

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For example, how would an ambulance trust develop new clinical services to expand their ability to deliver patient care, where all aspects of a commissioned service are already locked into an alliance model which has no scope for change, without all parties being involved.

There will always be requirements for market testing and competitive tendering in certain circumstances – so there need to be clear tests that commissioners will be expected to apply to minimise these requirements - essentially a value for money / impact analysis assessment that is proportionate to the scale, value and type of service.

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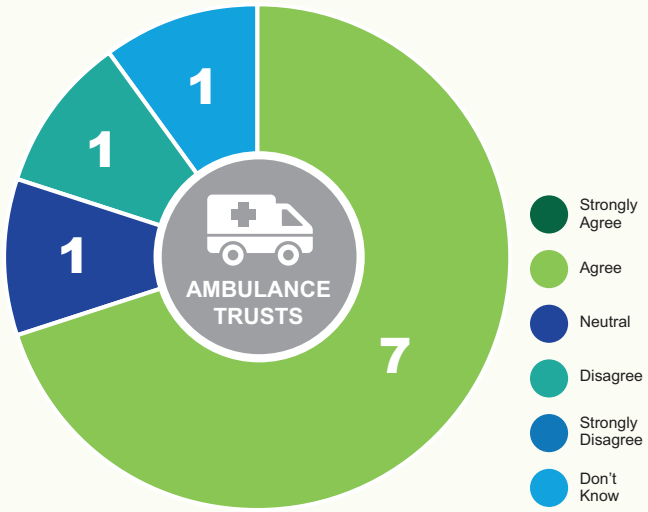
Q3. Do you think there are situations where the regime should not apply/should apply differently, and for which we may need to create specific exemptions?

Whilst the majority of ambulance trusts agree there may be circumstances where exemptions to the regime could apply, others were uncertain.



Creating exemptions could confuse the regime; the key will be the governance of the proposed duties and the accountability of organisations and systems to deliver against them.

The regime should only apply where there is a direct contractual relationship i.e. 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.

There are potential situations where the regime may need to be applied differently, for example a local ICS approach to award contracts to alternative providers for certain services that may have a sustainability effect on the remainder of the service delivery of a regional provider of services across multiple ICSs, such as the ambulance trust. If there are services which employ either highly specialist resources or have long-term investments / payback, these may need special consideration also.

A significant lesson from managing the response to the COVID-19 pandemic has been recognition of the advantages of having services like NHS111 and PTS operating within the auspices of the NHS. Historically these have been seen to be commercial contracts, which has brought with it the inefficiencies and insecurities of the repeated competitive tendering process. There is an opportunity with these proposals for the NHS to revise that position and see them as critical public infrastructure and integral to the health and social care strategy, both being vital services involved in patient access, patient care and patient flow through systems.

If there are to be exemptions allowed in applying the selection regime, in relation to urgency and patient safety for example, these decisions must be underpinned by transparency and scrutiny, particularly around conflicts of interest. 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.

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There may also need to be exemptions permitted where an organisation has developed an innovative new method of delivering care, either as a product or service, which would lead to a systemic overhaul of current practice. Essentially a 'disruptive' product or service which so revolutionises the delivery of care, whilst offering improved outcomes and value-for-money, but regarding which there is a level of commissioner uncertainty, as there always is with true innovation. There needs to be scope for commissioning bodies to be able to invest in innovation, such as in competitive procurement or innovative procurement approaches. This could be even where there are already providers in place delivering care in the same 'space'. The risk if exemptions are not allowed is that there will be a tendency to continue current practice and stifle innovation.

The proposal is not clear around the opportunities for decision making bodies to directly award to voluntary or independent sector providers outside of the regime; this therefore does represent a risk to the confidence in the approach adopted by decision making bodies. Direct commissioning from these sectors outside of the AQP process will need close alignment to conflict of interest and testing against the key criteria to avoid challenge and to ensure the three tests are being satisfied.

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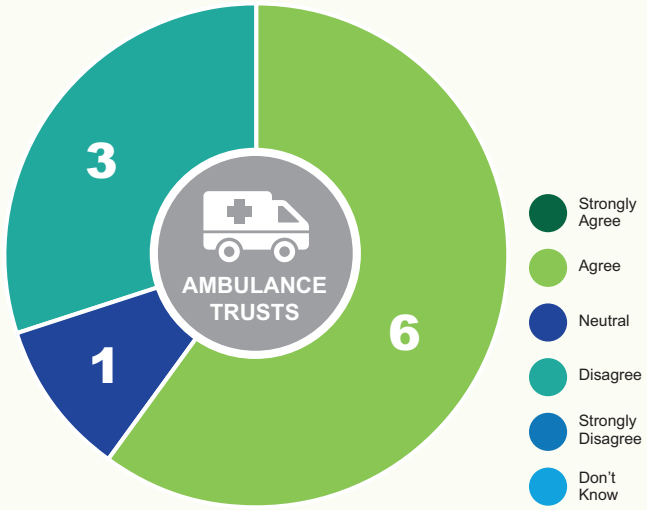
Q4. Do you agree with our proposals for a notice period?



Again, some mixed views across the ambulance sector, but the majority favouring the need for a notice period informing all parties as to the procurement intention of the commissioning body. This would be important to avoid potential legal challenges if potential providers feel the criteria for the decision-making is not sufficiently robust. Cooling down and handover periods are essential, particularly where services are large and complex.

Requiring decision makers to publish an intention to award promotes transparency, but 4-6 weeks is a relatively short timescale and consideration of where and how this is published to ensure visibility in a system will be necessary. Whilst it is accepted that decision making authorities need to be able to progress things in a timely way 4-6 weeks is not long for a provider to review and make representations if they wish to challenge; invariably that challenge process would probably initially be a request for more info from the commissioning body and that would then need to be reviewed etc. It is suggested that 8-12 weeks would be more appropriate, which is still much shorter than an average procurement process of approximately 12 months. Any notice period should be defined in terms of working days, not calendar days and also exclude the public holidays.

Consideration must be given to selected providers who may have already mobilised or recruited resources, committed investment, raised expectations with patients, communities and sub-contractors. If the decision is challenged, commissioners must have due regard for the impact on service providers preparing to deliver an agreed service.

Whilst the shift towards direct challenge to commissioning bodies will reduce the impact on NHS England and the procurement process, there is the risk that these decision-making bodies may demonstrate defensive behaviours to avoid direct challenge. The regime is helpful in providing key criteria and processes around minimising this risk, however further guidance / clarity may be beneficial to maximise the use of non-competitive procurement processes.

On the other hand, it could be considered that the inclusion of a notice period being allowed for contract award periods has the potential to create additional bureaucracy and slow the pace of provider selection, to the extent where there would be no additional system benefit over the pre-exiting competition/competitive processes. It can be envisaged that any credible provider seeking to develop market share or retain services if they are awarded elsewhere would challenge the processes, resulting in an excess of administration and legal time defending decisions. It could be proposed that rather than having a notice period there should be an appeals process available following any contract award process, not before.

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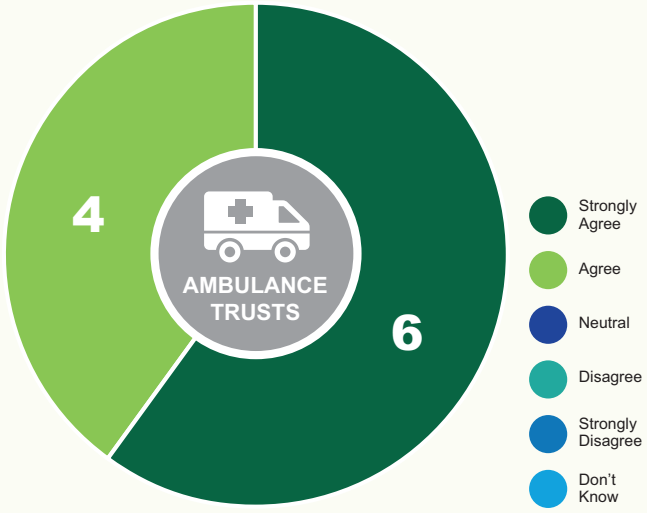
Q5. It will be important that trade deals made in future by the UK with other countries support and reinforce this regime, so we propose to work with government to ensure that the arranging of healthcare services by public bodies in England is not in scope of any future trade agreements.

All ambulance trusts agree that this process should not be destabilised by trade agreements outside of England. It is important that the arrangement of UK health services is not used as part of trade deals and is kept out of scope – otherwise the proposals in the white paper overall may be put in jeopardy and the role of the ICS put in question.



Further definition of 'healthcare services' will be required to provide absolute clarity on what is included within the scope of this regime and any future trade deals.

Specifically, the provision of NHS111 and Patient Transport Services should be classified as a healthcare service to ensure that these services are planned, developed and delivered within this regime as integral elements of NHS strategy and delivery of the Long-Term Plan.

This view does not ignore the opportunity to encourage international competitors / providers for certain services, particularly enabling innovative practice from global providers, but these deals should be agreed with the patient at the centre of the justification. Such deals should not be agreed for political gain.

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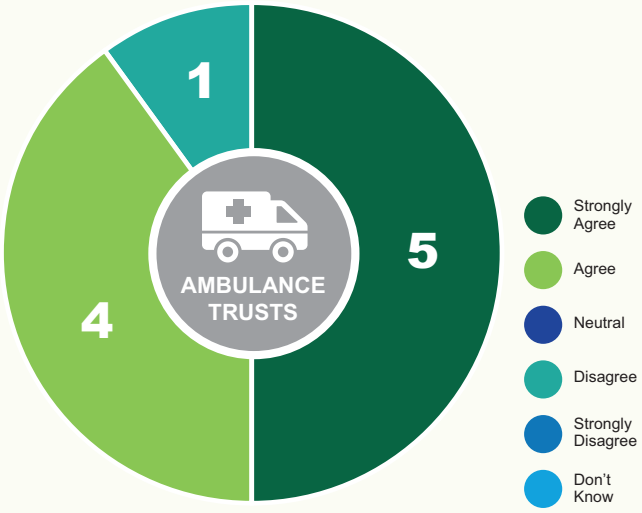
Q6. Should the criteria for selecting providers cover: quality (safety effectiveness and experience of care) and innovation; integration and collaboration; value; inequalities, access and choice; service sustainability and social value?



It is critical that all future NHS providers are selected on a wide spectrum of metrics and deliverables, not just financial and operational performance metrics.
The long-standing principles of the NHS being an anchor employer and the social implications of NHS organisations behaving in a manner that is sustainable, developmental and responsible is critical in driving down inequalities and driving up inclusion.

The proposed criteria are reasonable, but the key will be in how they are applied. They are very broad, highly subjective and open to considerable interpretation - 'value', and 'choice', for example, need to be better defined. There is a need to consider how patient choice will be affected by commissioning and the availability of services e.g. stroke and other commissioned pathways.

It would be beneficial to have clear guidance for each point, potential weighting scales and worked examples, otherwise, these criteria are so broad as to be potentially meaningless.

Another criterion could be patient need - needs may change over time and should be considered in terms of future proofing the service. Patient need corresponds to several of the existing criteria listed but is also relevant as a measure where patient care may increasingly be driven by the preferences of the patient. Value for money and financial viability should also be included as criteria.

These criteria need to also form part of the contract management process, with transparency on how the contract, once awarded, is delivering against quality requirements and an appropriate process for challenge if this is not the case. This is linked to the suggestion of having a decision evaluator with no conflict of interest evaluating this point rather than the same person or body as the decision maker.

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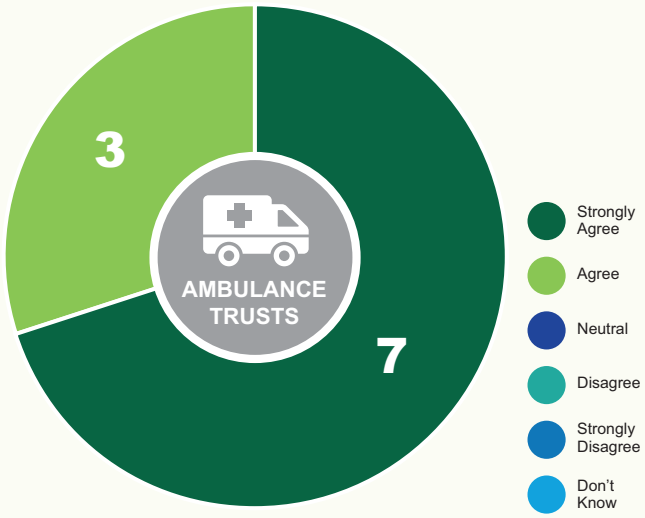
Q7. Should all arrangements under this regime be made transparent on the basis that we propose?



All ambulance trusts agree this is a fundamental change in law and transparency is key for accountability and confidence in the decisions being made. The decision-making criteria for each procurement decision must be clear, detailed, understandable and defensible. Where there is any scope for interpretation, there is scope for challenge and a need for scrutiny, otherwise there is no governance regarding the evaluation and benchmarking against the key criteria.

The proposal does not go far enough on this issue, nor is it specific enough around the level of detail that must be published by decision making authorities and assurance around how conflicts of interest will be managed.

Transparency must apply to all providers and not just public sector providers. Private sector, social enterprise, charitable organisations etc should be subject to the same requirements for transparency and other than specific elements of commercially sensitive information they should not be allowed an exemption based on a broad claim of 'commercial in confidence'. The provider landscape needs rules that apply across the board, not just for the public sector.

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Q8. 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?***

The objectives of the proposals appear to protect accessibility of services to all and therefore reduce inequality. Again, however, it is all in the application. Commissioners of services must ensure inclusiveness and accessibility are integral to each procurement decision making process.

There could be a potential adverse impact to groups protected under the Equality Act 2010 if an equality impact assessment has not taken place during the commissioning process. If communities or cohorts of people are not considered with population health management data and evidence bases, then the decision-makers are unlikely to add these criteria to specifications.

There is an opportunity for decision-makers to select providers who score highly on reducing health inequalities.

There is an opportunity for providers to partner with community-led organisations and conversely for community-led organisations to not be adequately empowered or supported to become viable providers, so the risk is in shutting out smaller, Voluntary, Community and Social Enterprise providers from the market.

There is also an opportunity for patient or voluntary representatives with no conflict of interest to evaluate services independently on behalf of the ICS to give assurance on quality.

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Q9. Do you have any other comments or feedback on the regime?

Individual feedback from ambulance trusts:

"As a regional provider across seven systems with a single contract it is a greater challenge for this Trust to be able to deliver effective collaboration with local systems. But the proposed change to legislation should offer positive opportunities for integration and working differently with other providers and systems."

"As we provide PTS and 111 we have to view these proposals through different lenses. The framework must support integration across all service lines. We must ensure that all provider contracts and KPIs are monitored to ensure achievement and corrective action implemented with regards to all health inequalities, to ensure variation is reduced and inequality gaps bridged and reduced over time. We also need to ensure that patient choice is not undermined/restricted by the Provider Regime."

"We would like clarification about whether Ambulance Trusts would be classified as a decision-making body within the ICS? Further detail is also required around the challenge process and level of detail that must be published by decision making authorities. We understand that procurement of Private Ambulance Services (PAS) would come under this regime and it is not entirely clear if external training providers and legal services are included, so clarification is required."

"Consider including a section to clarify how pilots/trials would be managed."

"Consider the criteria required or trigger points for when appropriate to escalate issues to NHSE. e.g. definition of 'serious cases'"

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