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BMA

England

Mr Ian Dodge
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7th April 2021

Dear Ian,

NHS Provider Selection Regime: Consultation on proposals

Please find attached the BMA's response to NHSEI's consultation on a new NHS Provider Selection Regime. This is an area the BMA has a strong and longstanding interest in, so I welcome the opportunity to respond to the proposals set out in the document.

As you know, the BMA has campaigned for the end of enforced competitive tendering and against the increased outsourcing of NHS contracts to private, for-profit providers for many years, on the grounds that it wastes vital time and money, fragments services, and encourages competition over collaboration. Therefore, we welcome the commitment within the proposals to remove Section 75.

However, as set out in the enclosed, we believe that simply removing mandated competition is not enough and that any replacement system must ensure proper scrutiny of commissioning decisions, encourage collaboration between NHS bodies, and establish the NHS as the preferred provider of NHS contracts.

The BMA hopes that our response is constructive and would welcome the opportunity to further discuss these proposals with NHS England.

Yours sincerely,

Dr Chaand Nagpaul
Chair of Council, British Medical Association

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BMA Response - NHS Provider Selection Regime: Consultation on proposals

Executive Summary

- Removing Section 75 is an important and overdue step which the BMA has long called for – enforced competition has wasted valuable NHS time and resources, as well as increasing the outsourcing of NHS contracts to ISPs (Independent Service Providers), leading to the fragmentation of services and undermining collaboration
- Allowing commissioners to retain existing service providers, or appoint new ones, without the need for competitive tendering has the potential to give commissioners the tools to reduce the costly disruption caused by the present procurement process, such as the NHS being taken to court by failed bidders
- However, this change also has the potential to lock in existing levels of privatisation and, without proper safeguards, could reduce the transparency of the contracting process – especially where contracts are awarded to ISPs
- To avoid the pitfalls seen during the current pandemic we believe that the NHS should be established as the preferred provider of NHS services
- Commissioners must justify the need to award a contract to an ISP (e.g. because of lack of adequate local NHS provision) as well as conduct a fully transparent competitive tender process before awarding said contract
- General Practice (under GMS and PMS contracts) and GP-led community services are NHS providers - they are not and should not be considered as ISPs
- Commissioning processes must be fully transparent, and allow comprehensive scrutiny of any new contracts agreed without tender and the reasoning behind those agreements published
- Likewise, it is essential that commissioners and providers are held fully accountable for these contracts
- It is essential that commissioning processes support the long-term viability of the NHS financially and the goals of increased integration and collaboration across ICSs
- NHS England and the Government should also take this opportunity to address wider issues caused by the previous onus on competition, including scaling back and ending the use of APMS contracts in favour of making GMS and PMS contracts the default option for new GP practice contracts
- It is crucial that all parts of the healthcare system play their role in ensuring future sustainability. The inclusion of staff training and workforce sustainability within the draft procurement criteria is thus positive and we would support their adoption in the final regime
- Any enhancement of the AQP system must be carefully balanced with the short, medium, and long-term financial needs of the NHS and not be used as a source of income for ISPs.

Introduction

The BMA has strongly opposed enforced competitive tendering since, and indeed before, the introduction of Section 75 and the 2012 Health and Social Care Act. This approach and Section 75 as its principle facilitator has led to the fragmentation of services, wasted time and resources, competition – as opposed to collaboration – between NHS providers, and the solidification of artificial barriers between services.

Therefore, we broadly welcome the central proposals for the new NHS Provider Selection Regime – namely the removal of Section 75 and the move towards a more holistic model of commissioning. We believe this is an important step towards delivering the collaborative NHS the BMA has called for, including in our vision for the health service as set out in our Caring, Supportive, Collaborative report.

Likewise, there are several wider changes within the document that we would support, including the explicit focus on integration in the proposed new commissioning criteria - it is crucial that all parts of the healthcare system play their part in ensuring its future sustainability. The inclusion of staff training and workforce sustainability within the draft criteria is therefore positive and we would support their adoption.

However, the move to a new procurement regime is a step that must be taken carefully. For its many faults, the present system does ensure that procurement decisions are subject to thorough scrutiny. As has been exemplified by a number of high-profile Government contracts handed to ISPs throughout the Covid-19 pandemic, a lack of oversight and transparency can lead to poor outcomes – in respect of finances, quality, and public confidence. Therefore, we believe it is essential that the replacement for Section 75 comes with the necessary safeguards to ensure that NHS and public health services are arranged appropriately, transparently, and with accountability, as well as with proper consideration both of the wider needs of local health and care systems and of integration.

As we argued in our response to NHS England's 2019 legislative proposals, we believe that in order to deliver this, alongside comprehensive steps to ensure the transparency and accountability of commissioning, measures should be included in the new regime that ensure the NHS is effectively made preferred provider of NHS services. This would not mean that ISPs could no longer hold or be subcontracted to fulfil NHS contracts. Rather, it would make the NHS the default option for NHS contracts and require commissioners to hold a competitive tender if they wish to award a contract to an ISP, to ensure that that decision is made as transparently as possible. As seen with the rollout of the vaccine programme, where the NHS is the preferred provider it delivers high quality and astonishingly successful results that the public can not only see, but also rely on.

Wherever possible, the BMA has advocated for a publicly funded, publicly provided and publicly accountable NHS. The growing role of ISPs in providing NHS services has long alarmed doctors. This is principally, but by no means solely, due to the destabilisation and fragmentation of NHS services that has often occurred because of it, and that ISP provision of services often represents worse value for money for the NHS. Moreover, the BMA has routinely warned of the cost to the NHS in the event of ISP contract failures or early exits. As such, we believe that a contract should not be awarded to an ISP without a competitive tendering process and that, once awarded, all contracts should be fully open to scrutiny and not be subject to commercial confidentiality clauses. This is necessary to ensure that the use of NHS and public funds is genuinely transparent.

The definition of ISP used in this response includes the private sector, ISTCs (independent sector treatment centres) and social enterprises, in line with DHSC data collection. It does not include General Practice, the voluntary sector, charities, or local authorities.

General Practice and GP-led community services are not and should not be considered private providers, they are a recognised and invaluable part of the NHS and have been since its inception in 1948. Therefore, GMS (General Medical Services) and PMS (Personal Medical Services) contract holders are rightly excluded from our definition of ISPs. However, this is not the case where GP services are commissioned with APMS (Alternative Providers of Medical Services) contracts, which allow any ISP to provide primary care and do so without the requirement for GP ownership of the contract, or the restrictions on shareholders in place for GMS and PMS contract holders.

This response is tailored around the questions posed within the document. It also outlines key, broader policy issues we feel need to be addressed.

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?

In principle, the BMA would agree that commissioners should be able to continue commissioning an existing provider without having to carry out a competitive procurement process. However, as BMA members are concerned by the level of ISP provision in the NHS - due to the risk of destabilisation and fragmentation of NHS services and poor value for money - we believe that this should apply only to public and accountable bodies, namely NHS providers, and not be a route through which services can be contracted to ISPs without the scrutiny of a competitive procurement process.

It is widely recognised that competitive tendering and current procurement rules have been extremely costly for the health service and have diverted precious public funds away from patient care. This has been especially acute where the NHS has been subject to or threatened with legal action from ISPs – such as the undisclosed sum paid by the NHS to Virgin Care in 2017 after it failed to win a contract for children's services in Surrey. While the BMA supports the move away from enforced competition, we do not believe that the removal of Section 75 of the 2012 Health and Social Care Act and the other changes set out thus far go far enough to ensure the future sustainability of the NHS and enshrine a more collaborative system.

The consultation paper sets out that the decision to continue with an existing service provider rests on the premise that the incumbent is the only suitable provider given the nature of the service in question, or the incumbent is performing well (as judged against the key criteria) and the service is not changing. The BMA agrees that it makes practical and financial sense to continue with an existing provider if they are the sole provider of the service and are performing well, but believe this option should only be available where commissioners seek to retain an NHS or non-ISP provider in place. Moreover, we are concerned that where the NHS lacks sufficient in-house capacity, for example, with mental health and elective care services, the ability to continue contracts with sitting ISPs could lock-in current high levels of private involvement in the health system.

In a similar vein, we are concerned that commissioners would have the ability to re-confirm existing ISP contract-holders without thorough public scrutiny of the longer term impact of keeping a service outside the NHS, or without exploring the opportunity to 'in-house' those services within the NHS. To avoid an overreliance on ISP provision, the BMA has been clear that it is vital that NHS services are properly resourced in order to be able to develop and expand their capacity where required.

Further clarification is needed where decision-making bodies would have to consult the set 'key criteria' set out in the consultation document to navigate the process. Where there is the potential for fast-track renewals to occur, questions remain about how the criteria will be balanced and prioritised, who will be involved in the priority setting process, and whether this evidence will be made public. It is welcome that it is intended that the criteria themselves will be made public, but the rationale used for choosing them and how they have been weighted by commissioners should also be made public. To ensure confidence in the new system, it is important that these issues are addressed.

In 2015, it was found that more than one in four governing body members of NHS clinical commissioning groups (CCGs) had ties with private healthcare providers. To remove potential conflicts of interest with private providers and to ensure effective governance arrangements, we would like to see assurances that ISPs will not be directly involved in commissioning decisions made or approved by ICSs (Integrated Care Systems) – in either their NHS ICS Body or Partnership board.

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?

Again, we broadly agree with the proposal to allow commissioners to make arrangements directly with a provider without competitive tender, where they are clearly the single most suitable provider of the given service. However, as aforementioned, 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 ISPs.

The financial position of NHS Trusts and Foundation Trusts has been a point of significant concern over recent years, with many facing substantial deficits – an issue that has, in part, been compounded by the frequent outsourcing of many of the more profitable NHS contracts to ISPs. This has often left NHS bodies with more costly-to-provide services such as ITUs (Intensive Treatment Units) and A&Es which also involve a significant degree of staff training and support, and without the 'profitmaking' services such as elective surgery to offset this. As we move to an increasingly integrated and 'system by default' approach, it is only appropriate that resources and contracts are, by default, retained within that system and within the NHS, unless a strong case for doing otherwise can be presented.

The BMA has long been concerned about the involvement of ISPs in the delivery of NHS clinical services. When surveyed in 2016, over two thirds of doctors reported that they were 'fairly' or 'very' uncomfortable with independent sector provision of the NHS with the most common reasons for concern being the destabilisation and fragmentation of NHS services.

In this spirit, and in line with NHS England's goals of integration and greater collaboration, the BMA is clear that NHS providers should be considered the preferred providers in delivering care to patients, with funding retained within the NHS to promote long term financial sustainability and true integration of the patient care pathway.

There are implied risks where services are contracted to ISPs and these services do not always deliver safe, high-quality care, or good value for money. The BMA has previously drawn attention to a series of high-profile cases that have involved the destabilisition of services, the early termination of contracts by ISPs, and the risk to the NHS in the event of private provider failure where companies hold a large number of contracts.

There are multiple examples of the cost and disruption that can be caused when ISPs have either won or been considered the preferred bidder for NHS contracts. Two in particular are highlighted here:

- **West Sussex, 2014:** an independent provider, Bupa CSH, was chosen as the preferred bidder for a £235 million musculoskeletal services contract by Coastal West Sussex CCG, amid much controversy around the effect that it might have on the local NHS services. An independent assessment, undertaken after the contract preferred bidder was announced, showed that the impact of the loss of musculoskeletal services would result in Western Sussex Hospitals NHS Trust, who had previously provided the service, falling into deficit over the next five years. Bupa CSH subsequently withdrew from the process because of the impact assessment and the CCG worked with existing providers to introduce the proposed service.

- **Hinchingbrooke Hospital, 2012:** Circle became the first ISP to run an NHS hospital when it won a ten-year contract to take over Hinchingbrooke in 2012. Just three years later the company withdrew from the contract on the basis that their involvement became "unsustainable". The deficit created during Circle's stewardship of the hospital was far in excess of the £7 million that the company was contractually liable to cover, and the NHS was left to foot the remainder of the bill.

- **Grainger GP Practice, Newcastle, 2014:** Care UK exited its five-year contract to provide GP services at the Grainger GP Practice more than two years early in 2014. This forced commissioners to seek alternative provision for the approximately 7000 patients registered at the practice, as well as a new provider of the service itself. Care UK gave no specific reason for the early exit of the contract, other than a business strategy review and discussions with commissioners.

The DHSC (Department for Health and Social Care) has previously warned of the risks associated with allowing ISPs to gain a significant market share, as the more contracts a company wins, the more severe the implications are for the NHS should that company fail to meet the terms of those contracts - as the collapse of Carillion demonstrated.

Throughout the pandemic, we have highlighted our concerns around the potential for public resources to be wasted on unnecessary private outsourcing, where there is not a clear rationale behind the decision to outsource and where the same function could have been delivered by the public sector without relying on commercial arrangements. This was evident in the case of the centralised NHS Test and Trace system, through which billions of pounds worth of contracts were awarded to private companies that held no public health expertise, and ultimately failed to provide value for money or an adequate service.

The performance of the national system appeared in stark contrast with the success of local public sector-led public health teams which have proved much more efficient at tracing contacts of positive cases. As such, decision-making bodies should be required to evidence that the public sector could not deliver the service before considering and/or awarding contracts to ISPs via a competitive tendering process.

Moreover, where contracts are awarded to ISPs, commissioners must ensure that a contingency plan is in place should the given provider exit the contract early, as seen in the case of Hinchinbrooke Hospital. This should include clear stipulations that the costs incurred by an early exit should be met by the provider and not by the commissioner – i.e. the NHS or a Local Authority.

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?

As above, we believe that the regime should apply only to NHS and non-ISP providers and that where commissioners seek to make arrangements with an ISP a full, competitive procurement process should be conducted. This is not intended to prevent such providers from winning NHS contracts altogether, but to ensure that those contracts are awarded as transparently as possible. We also wish to see transparency in contracting and financial arrangements so that they are not and cannot be kept private via clauses of commercial confidentiality.

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

The BMA agrees that a suitable notice period for commissioning intentions is an important means of ensuring transparency in decision making and allowing potential providers to query decisions within the given time. This is doubly important if NHS providers are not afforded preferred provider status.

However, further clarification is needed around what the suggested exemptions - such as urgent or patient/public safety cases - to the notice period entail. Additionally, it is worth noting that proper and timely scrutiny of contracts are no less important during an emergency, as highlighted during the pandemic, where transparency and openness have been undermined by emergency decrees, often leading to poor value for money.

More clarity is needed regarding where commissioners plan to publish their intention to award a contract to a given provider and whether this information will be available in the public domain, especially given the changes being made to CCGs. For example, will this information be published publicly on ICS websites or on dedicated commissioning portals and, if so, will NHS staff and the public be able to view this information in its entirety? The obligation to publish these details serves a crucial public function not least because patients, the public and taxpayers are entitled to scrutinise these decisions and ask questions about who might receive the contract, how the contracts have been set up, and how these funds will be used.

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?

The BMA has been clear for many years that NHS services should be exempt from any trade deals. Therefore, we fully support the goal of ensuring that the arranging of healthcare services by public bodies in England is not in scope of any future trade agreements.

It is our understanding, though, that the definition of what constitutes 'healthcare services' is fairly narrow and would potentially exclude a wide range of ancillary and core NHS services from the exemptions proposed, on the grounds that they offer a service that is in partial or full competition with a private enterprise. We would, therefore, like to see the Government take a more holistic view of what constitutes healthcare services.

As such, we believe it is important that the current involvement of international ISPs in the NHS comes under further scrutiny. There is widespread anxiety regarding unaccountable, international organisations taking responsibility for key NHS provision. These companies are seen as distant and remote bodies that have no connection or wider responsibility for the patients they serve. Therefore, NHS England and the Government should also take steps to prioritise NHS providers over international providers of healthcare services more widely as part of the changes proposed, including where international providers have UK subsidiaries, by making the NHS the preferred provider of NHS services.

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

Yes, we agree that the range of criteria set out in the document is appropriate and welcome the inclusion of integration and collaboration particularly, as well as the acknowledgement of value as more than purely financial.

It is essential that the wider impact of commissioning decisions – both on local NHS finances and longer term sustainability and on other, interlinked services – is factored into any contract arrangements, especially as ICSs seek to mature and develop deep relationships between member bodies. As the NHS progresses toward the integrated, collaborative model NHS England and Government have stated they wish to see, it is imperative that these criteria are pivotal in any commissioning process.

However, we are concerned by the decision to include a need for commissioners to consider how their decisions will impact on the wider market and its ability to provide services in the future. This appears to indicate that commissioners will be expected to factor the long-term viability of ISPs into their decision making. The BMA would be opposed to any such expectation and does not believe it is the role or duty of NHS commissioners to preserve or support private, for-profit providers.

Moreover, there are many of examples where the outsourcing of NHS services to ISPs leads to the fragmentation of those services, to the detriment of both patients and staff. As such, under the new regime, the decision to award a contract to an ISP should only be made if an NHS or publicly run body is unable or unwilling to run the given service.

In line with the aim of ensuring integration and collaboration between services, we believe NHS England should consider a further criterion centred on a provider's understanding and experience of the area and NHS landscape in which a given service sits. This would, in our view, help ensure that providers have a genuine relationship with the local community and its needs, as well as a grasp of how it could and should interact with neighbouring services.

We welcome the inclusion of environmental issues and sustainable development under the wider banner of social value. The BMA has previously called on the Government and the NHS to take specific action on both points – not least due to the size of the NHS's own carbon footprint and the increasing impact of emissions and environmental decline on public health.

The recognition of workforce within the service sustainability criteria is also a positive step. The retention and ongoing training and development of staff are essential to a well-functioning health and care system and the BMA welcomes their inclusion and prominence within the commissioning criteria.

Disruptions to training and professional development have been a long-term concern for our members, who have been impacted by changes in service providers and contract-holders. It is crucial for the future sustainability of the service that all providers contribute to training the next generation of doctors and that doctors working across all settings are able to develop professionally to ensure patient care is safe and improving. Therefore, we believe strongly that all contract holders must be held to account for their plans for and performance against this metric and welcome its inclusion in the proposed commissioning criteria.

We are, however, concerned by the lack of explicit focus on research within the criteria. As the BMA has highlighted previously, where ISPs have taken on an existing service there have frequently been knock-on and negative impacts on ongoing clinical research.

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

Throughout the pandemic, the BMA have raised concerns about the number of contracts awarded to the ISP sector under emergency procedures, bypassing not just normal tendering processes, but public scrutiny or importantly demonstrating value for money. Concerningly, in some cases, there have also been no penalties for failure to meet the terms of these COVID contracts. We do not wish to see this repeated or to continue in the future.

There are clear risks to this approach that have not been effectively mitigated and have been demonstrated by problems in performance as set out above. Concerns remain about how these contracts have been set up, who they were given to, how tax-payer money was used and the extent to which private companies and the Government can be held to account for underperformance.

According to the Public Contracts Regulations guidelines, departments must publish the details of awarded contracts within 30 days of agreement. Despite these rules, award notices for many of the contracts have yet to be published with large sums spent on COVID-19 contracts awarded to ISPs remaining unaccounted for.

The BMA has previously called for greater transparency regarding contractual agreements. This must include publishing award notices within the specified time of agreement rather than retrospectively as has been the case during the pandemic and these must be made accessible in the public domain. Public scrutiny limits the risk of fraud and is crucial for demonstrating value for money and greater transparency around spending is essential considering the risk that taxpayer money is misused or spent on poorly performing services.

In addition to this, scrutiny of providers must be the same whether they are public or private. We have long argued that where public money is involved, ISP providers of NHS services should be subject to the same requirements as NHS providers in relation to transparent reporting of

performance. Currently, ISPs are not subject to the transparency requirements of the Freedom of Information Act and can use commercial confidentiality clauses to withhold information from public scrutiny. In order for companies to be held to account, it is crucial that all NHS providers are covered by the Freedom of Information Act and that these private companies do not cite commercial confidence, to enable oversight bodies like the National Audit Office or the public to scrutinise contractual terms and conditions, and whether a contract is in the public interest or whether it is performing well against key performance indicators.

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

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

We believe it is important that the wider impacts of changes to competition law on potentially vulnerable groups and on health inequalities are being considered as part of this process.

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

AQP (Any Qualified Provider)
The BMA is concerned that the proposed regime may allow for greater provision of NHS-funded care by ISPs, via the AQP (Any Qualified Provider) process or the existing multiple Health Framework Agreements. We are conscious that NHS England has recently created a 'Health Systems Support Framework' to fast-track any outsourcing of services using a pre-approved list of providers that involve private firms including Virgin Care and Centene. We are therefore opposed to any enforced competition through AQP/Framework agreements that could potentially favour commercial companies who select profitable services and have the financial ability to undercut NHS providers at the potential cost to service quality and staff wellbeing. 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 of the NHS.

ICP (Independent Care Provider) Contract
The BMA strongly opposes the use of the ICP contract, due to a wide range of concerns regarding their potential implications for the NHS, doctors, and patients. Of those concerns, one is particularly relevant here – the possibility that a private provider may be able to hold an ICP contract and, therefore, have overarching control of local NHS services and resources over a large geographical area. This would inhibit integration by fragmenting 'ownership' of the local health and care system and risk undermining collaboration more widely. Were the proposed regime to be introduced in full, we would be deeply concerned that this may allow commissioners to hand ICP contracts to ISP providers. It is essential that this is avoided and that explicit safeguards are introduced to ensure that any such contract can and will only ever be held by NHS and publicly accountable bodies, and that it is voluntarily entered by all involved.

APMS Contract
The BMA is opposed to legislation and regulations that have led to the prevalence of APMS contracts, which enable contracts with ISPs in general practice. There is an important difference between traditional general practice, and large, remote commercial companies taking control of practices across England. We would therefore want to see permanent GMS and PMS contracts established as the default, and an end to the continued use of APMS contracts.

Staff terms and conditions
Section 7.7 of the consultation document states that providers must agree to meet the terms and conditions of the NHS Standard Contract. However, it is unclear if this also requires them to agree to employ staff on NHS terms and conditions. As we have seen with Public Health specialists moved from PCTs (Primary Care Trusts) to Local Authorities and sexual health specialists moved from the

NHS into social enterprises and other providers, those staff are frequently transferred on their original NHS contract but then, after a minimum period, moved to significantly less favourable terms and conditions.

We believe it is essential that this pattern is stopped, and that staff terms and conditions are not compromised by providers seeking to undercut the NHS under the new regime. Therefore, in the interest of staff wellbeing and retention in particular, we believe that longer-term pay and conditions for staff should be considered within the commissioning criteria, and that all staff doing the same work have the same terms and conditions of employment, regardless of their employer.

Additionally, where the application of the new regime leads to the re-housing- of services in the NHS it is essential that the terms and conditions of those staff revert or convert to NHS terms and conditions, to ensure that staff are properly and equitably treated.

Conclusion

As set out in the above, the BMA firmly believes that enforced competitive procurement has had a negative impact on the NHS, staff, and patients since its introduction and, as a result, we welcome the intention to remove Section 75.

However, we feel that this positive step must be accompanied by safeguards and assurances to protect the long-term aims of the NHS and of NHS providers, and help facilitate the wider process of integration. Principally, this should include enshrining the NHS as the preferred provider of NHS services and ensuring that commissioning is conducted with transparency and accountability.