Londonwide LMCs
The professional voice of London general practice

1 April 2021

Londonwide LMC's response to consultation questions posed in the NHSE document "NHS Provider Selection Regime Consultation on proposals"

Closing date for comments to the consultation is 7/4/21. The survey can be seen here: https://www.england.nhs.uk/publication/nhs-provider-selection-regime-consultation-on-proposals/

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

Strongly disagree | Disagree | Neutral | Agree | Strongly agree | Don't know
Please explain your answer below.

There are many positives to removing overly bureaucratic procurement restrictions. Especially where tendering process prove overly onerous, bureaucratic, complex and expensive for smaller providers, such as independent contractor GPs. The ability of existing providers to evidence safe practice, clinical excellence, efficiency, value for money, quality, innovation and other criteria (see detailed comments later regarding criteria) to secure continued contractual status, without disadvantaging providers who do not have access to bid writing teams and diverting resources away from front line service provision, is welcome.

We recognise that a more liberal and relaxed procurement regime could provide more, and more inclusive, opportunities for additional GP providers and community providers which are currently unavailable due to cost or time constraints. Any new regime must, even more than a traditional procurement process, include a formal role for clinical input and co-determination from GPs. This clinical involvement is critical in order to recognise and consider the importance of an effective interface, the critical role of GPs in coordinating care, and the necessity for continuity of care when considering maintaining an exisiting provider.

It is important that any removal of bureaucracy does not result in unforeseen consequences / perverse outcomes. And that any selection places a premium on safety as a non-negotiable priority above all other criteria considered. We would welcome the opportunity to further discuss and understand how the system would work for providers of all sizes with the intent of ensuring that appropriate national quality and assurance standards are agreed, managed and met appropriately, but without placing unwieldy requirements which detract from effective service delivery . And to understanding what safeguards are in place regarding accountability and transparency of process.

We would also welcome clarity and further discussion on the extent to which these new measures would cascade through the system, particularly as they would impact on subcontracting arrangements within and between PCNs, Federations, practices and other structures/ entities at a local level (ref s7.17/8), mindful of desires to protect community service delivery of existing contracts.

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

Strongly disagree | Disagree | Neutral | Agree | Strongly agree | Don't know
Please explain your answer below.

There are many positives to removing overly bureaucratic procurement restrictions. Especially where tendering process prove overly onerous, bureaucratic, complex and expensive for smaller providers, such as independent contractor GPs. The ability of existing providers to evidence safe practice, clinical excellence, efficiency, value for money, quality, innovation and other criteria (see detailed comments later regarding criteria) in order to secure continued contractual status, without disadvantaging providers who do not have access to bid writing teams and diverting resources away from front line service provision, is welcome.

We recognise that a more liberal and relaxed procurement regime could provide more, and more inclusive, opportunities for additional GP providers and community providers which are currently unavailable due to cost or time constraints. Any new regime must, even more than a traditional procurement process, include a formal role for clinical input and co-determination from GPs. This clinical involvement is critical in order to recognise and consider the importance of an effective interface, the critical role of GPs in coordinating care, and the necessity for continuity of care when considering maintaining an exisiting provider.

It is important that any removal of bureaucracy does not result in unforeseen consequences / perverse outcomes. And that any selection places a premium on safety as a non-negotiable priority above all other criteria considered. We would welcome the opportunity to further discuss and understand how the system would work with regard to providers of all sizes with the intent of ensuring that appropriate national quality and assurance standards are agreed, managed and met appropriately, but without placing unwieldy requirements which detract from effective service delivery. And to understanding what safeguards are in place regarding accountability and transparency of process.

There will be concerns that the centralisation of contracts and commissioning power within structures perceived to be secondary-care led structures may marginalise the presence and ability of primary care providers to influence commissioning decisions. Comfort is sought that measures will be put in place to ensure that this is not the case with regard to decisions impacting on community based general practice services and providers. Particularly in any instance where a single preferred provider selected without procurement protocols is not the existing provider.

It is not clear at present who will be responsible for the 'primary care perspective' identified at ICS level, nor whether the partnership board is the ICS Board itself or a board, with or without delated decision-making authority, in the lower governance structure of the ICS. As such, it is our considered view that whilst we agree with the concept proposed and welcome the consultation document's intention of simplifying the process of commissioning and procuring care for our patients to remove bureaucracy, it is important that such processes are seen to be without favour.

The decision-making process must be as transparent as possible. Particularly if/ when determining that there is a single appropriate provider for community-based contracts. If it is not transparent, there is a significant risk that providers perceive the ICS to be unfairly favoring trust partners on the ICS and/ or not recognising or taking into consideration the community benefit of awarding contracts to smaller providers.

It appears that the intention is that the ICS Board will be the decision-maker regarding service planning, funding allocation between providers, the contractual model, delegation of decision making to 'place' based levels, local priorities and intervening if provider do not comply with their plans. Poor decision making will have a significant impact on services, quality, performance and financial viability of providers, yet clinical leadership and decision-making authority is still unclear.

Designating a board-level executive as the lead member on primary care interface and health inequalities issues would be a welcome indicator that there is senior buy-in and support for the earlier measures outlined regarding the improvement of interface between primary and secondary care.

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?

To better answer this question, we would welcome the opportunity to further discuss and understand how the system intends to ensure that appropriate national quality and assurance standards are agreed, managed and met. As a brand-new regime is being introduced, we believe it is important that the system can both capture and benefit from positive learning and is open to challenge and discussion of problems and challenges experienced. This is critically not only as the regime is in its infancy, but on an ongoing basis so that, as the system matures, it can operate transparently equitably, and considers any necessary exemptions holistically, and in the round.

It is our hope that ICS will be empowered to depart from the increasing reliance on quantitative data to drive service improvement, and instead consider on a case-by-case basis the value of aspects of care that are less easily measured, such as the doctor patient relationship, continuity of care and relationship continuity. There is significant risk that, without GP leadership, the full complexity of general practice and the value to patients is not understood and lost to the significant detriment to patient care and community health if not adequately considered during service design/ procurement.

To that end we would call for any procurement decisions primarily focussing on contracts within general practice/ primary care/ community care settings to be made with regard to specific input from the local general practice community. GPs firmly believe in effective partnership working and collaboration, and are keen to ensure that commissioning and procurement decisions adequately consider safety and other clinical issues in the round in order to ensure that measures seeking to address and reduce health inequalities can effectively engage the bodies involved to provide joined-up care; working together with shared responsibility for reducing inequalities in and between our local communities.

Considering the reference to "test[ing] the market" at s5.1 (3), we would welcome more on the information or test deemed sufficient to trigger such a competitive procurement, who would determine that, and the way in which the process would be managed, including notice periods (see also our response to question 4).

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

Strongly disagree | Disagree | Neutral | Agree | Strongly agree | Don't know
Please explain your answer below.

We are unable to support proposals for a standard notice period. With the varying needs of existing (and no doubt future) systems, staff, and patient pathways, medication procurement, consumables and a host of other considerations running to differing timescales, some working months in advance of need, it is difficult to understand the rationale for a single, standard, short notice period, as outlined in the consultation.

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

Strongly disagree | Disagree | Neutral | Agree | Strongly agree | Don't know
Please explain your answer below.

We are unclear on the rationale for separating health procurement from the wider government procurement expertise currently housed in the Cabinet Office (s2.9). Given the lack of developed information or explanation in the consultation and accompanying paperwork, we would welcome detail as to how such separation protects UK health from being subject to consideration, dilution, or worse through future trade deals as a result of this measure.

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

Strongly disagree | Disagree | Neutral | Agree | Strongly agree | Don't know
Do you have any additional suggestions on what the criteria should cover/how they could be improved?

SAFETY
We have concerns about the grouping of safety within quality coupled with innovation. These are all very different concepts with differing impacts and considerations and, we believe, cannot be treated as equal measures when procuring clinical services. Throughout the document there is a lack of clarity about the mechanism and responsibility for prioritising or weighting key criteria – specifically with regard to safety. There is a clear need to better define the criteria and their usage, and to consider/ define the way in which they work together and how patient care and safety is maintained.

QUALITY
Where a new service is being considered and data on quality is unavailable, it is essential that decision-making bodies place primacy on safeguarding. Any new service designed should outline what the aims and objectives of the service are and how they will be measured. We need to consider how we define "quality". There is no evidence that high CQC rating equals quality: that is not the intent of the rating. Similarly, the bullets listed in the Annex as demonstrating quality actually demonstrate how well a provider can collate data and are not linked to any evidence-based markers of quality of general practice. Measurement of outcomes rather than outputs is necessary to determine quality service and safe practice.

INNOVATION

Innovation is inherently risky with an acknowledged high failure rate for true innovation, be it in the form of alternate product, service, system, or some other change. When considering healthcare services we need to be cautious that the innovation is introduced in a cautious slow manner to avoid causing harm to people. The overwhelming priority must be to introduce and maintain safe services to patients. To assess the potential value of an innovation in delivering quality is not the same as to considering the risk to a service or to service users if an innovation fails to achieve it's desired or anticipated outcome. It is unclear where the safeguards are within this process, and with patient safety to consider we maintain that having "an understanding of how performance will be tracked and risks managed" is insufficient consideration for commissioners/ practitioners, and protection for patients.

The development of innovative and agile practice is an area in which GPs and their teams excel. Looking at the recent pandemic response, patients benefitted hugely from the ability of clinical and administrative staff to maintain service and care in a safe and protected way. However, it must be recognised that innovation often comes with inherent risk. Both commissioning bodies and providers need to consider this, and any new practice or innovation should be introduced without risk to patients or other providers. Typically this means working at a pace which allows identification of concerns and mitigation, and with appropriate safeguards in place. Such care and caution is undoubtedly part of proactively developing services that are future-proofed and capable of meeting likely future health needs and cannot fall prey to a desire to be first, newest or fastest at the expense of patient care and/ or outcomes. Use of terms such as "stifle" and "new and/ or risky services" raise concern. We believe that transformation needs to be incremental and informed by learning, embedded in ongoing performance improvement. And any innovative providers or services must be safe at the point of provision, rather than tested at the expense of patient safety.

VALUE

We are unclear regarding the weightings of elements outlined under the "value" criteria. Particularly where value is determined in parallel with other criteria set within the regime. Alongside efficiency and cost the long-term benefit to patients is an essential consideration. Without that, determination of value in the context of the long-term benefit to the service provider/ system would result in an undue focus on short time/ budgetary financial value and service benefit, rather than patient benefit. It must also be considered that preventative and long-term interventions often have significant value that is only realised beyond short time financial and budgeting cycles, eg smoking cessation, BP management etc.

INTEGRATION AND COLLABORATION

We welcome the recognition that there is sometimes variance between benefits and cost and that a fixed approach to contract value can be detrimental to patient outcomes without consideration of the nuances of effective service delivery. Any such assessment and consideration must be made with a clear understanding of safe infrastructure and patient pathways.

We would also add that the citation of the "Triple Aim Duty" runs the risk of alienating staff, who are critical in achieving all of the aspired patient outcomes. As such, we believe that the focus should be on the achievement of the quadruple aim, which includes the well being of staff.

ACCESS, INEQUALITIES AND CHOICE

There is a need to recognise the pragmatic circumstances in which we are currently operating, and note that in the aftermath of a pandemic, with overwhelming workload from pent-up demand, and an exhausted workforce, staff across the system may struggle to deliver "choice" in the terms set out.

A "choice" based regime must also ensure that the needs of the population do not outweigh an individual's right to choice. The concept of choice has always been open to discussion as it is often predicated on the patient having a high degree of health/health system understanding. As this is less likely to be expressed by patientsin lower social economic groups, we see growing health inequalities when such choices are not managed in a moderated way. Before investing finite resources into "choice" there should be evidence that this will result in improved outcomes. We would welcome a discussion around where choice should be offered and the manner in which it is offered so that it benefits these less informed or confident patient and community groups.

SOCIAL VALUE

We agree that decision making bodies should consider whether and how the decisions they make about service provisions impact on organisational stability. Such considerations are key to the sustainability and viability of general practice and other community health providers, and we welcome acknowledgment that the financial stability of local services, continuity of related services, stability and sustainability of other providers, and other factors need to be evaluated as part of any revised commissioning process. We also strongly agree that if proposals are likely to negatively impact the stability, viability or quality of other services immediately or over time, decision-making bodies should consider and make public all available evidence on, how the change can be justified by the wider benefits of the proposal.

In summary, safety is non-negotiable and should be clearly indicated as such. To that end, the criteria need clear ranking/ weighting reflecting the importance of safety being at the heart of decision making.

Transparency and scrutiny

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

Strongly disagree | Disagree | Neutral | Agree | Strongly agree

Please explain your answer below.

A caveated agreement in that health commissioning decisions made under this arrangement will presumably be made utilising public funding. As such, we believe that there should be maximum transparency to enable future services to be delivered and commissioned effectively.

We are concerned that the proposed legislative reforms remove the right for competitors to legally challenge decisions, currently enshrined in the PCR and the right to challenge via Monitor (or a claim for damages) in the PPCCR. The suggested recourse of representations to the decision-making body post publication of decision, or of Judicial Review (s8.3), suggest that small and community providers such as GP independent contracts would be limited to lodging a complaint to the body already vested in the decision, or to taking forward a Judicial Review on a local matter. This is totally counter to the interest of smaller providers and patients. As such, we believe that there is further consideration needed of how appeals and complaints are handled under the proposed reforms.

General Questions

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

• have an adverse impact on groups with protected characteristics as defined by the Equality Act 2010?

• widen health inequalities?

Designating a board-level executive with clinical and primary care knowledge as the ICS Board's supported and designated lead member for escalation of concerns about any adverse impact decisions might have on groups with protected characteristics, underpinned by robust governance and processes, would ensure that any specific concerns at a locality or place-based level do not get lost within the large structures being created at the STP/ ICS system level.

Recognising that some health inequalities are relative and that circumstances can change and are not fixed, this area will require the bodies involved in providing joined-up care to work together differently through a new model of care in which all providers have responsibility for reducing inequalities in and between our local communities, and in monitoring and assessing efficacy on an on-going basis.

The vaccination programme has highlighted the need for micro-local leadership, engagement and delivery in addressing health inequalities. The development of innovative and agile practice is an area in which GPs and their teams excel, and from which patients benefit hugely. At scale working, a focus on innovation irrespective of impact, and a lack of appreciation of the skill and value of general practice can all result in negative outcomes for those with the greatest need. It is critical that wider structural changes are cognisant of these needs and are supportive of community cohesion and the maximisation of local integrated care, and the existing relationships that underpin and deliver that care.

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

Several sections within the document reference "*best interests of patients, taxpayers and population".* It is, we believe, unhelpful to group these terms as the best interests of each are not necessarily coterminous.

As per our response to question number 6, a "choice" based regime must also ensure that an individual's right to choice does not outweigh the needs of the population . And whilst we agree that any commissioning decisions must be mindful of the interests of taxpayers, the quadruple aim might on occasion determine that the best interests of a patient are not always aligned with financial or taxpayer best interests.

Throughout the document there is lack of clarity about the mechanism and responsibility for prioritising or weighting key criteria – specifically with regard to safety. There is a clear need to better define the criteria and their usage, and to consider/ define the way in which they work together and how patient care and safety is maintained. We would welcome a discussion about how choice, safety and best interests will be managed, gauged and assessed within the new regime.

In what capacity are you responding? [please tick]
Academic institute [ ]
Charity, patient representative organisation or voluntary organisation [ ]
Clinical commissioning group [ ]
Clinician [ ]
Commercial organisation [ ]
Family member, friend or carer of patient [ ]
General practitioner [ ]
Healthcare professional [ ]
ICS/STP representative [ ]
Independent provider organisation [ ]
Industry body [ ]
Local authority [ ]
Member of the public [ ]
NHS foundation trust
NHS national body [ ]
NHS non-clinical staff [ ]
NHS trust [ ]
Patient [ ]
Professional representative body [x]
Regulator [ ]
Think tank [ ]
Trade union [ ]
Other [please specify]……
If responding on behalf of an organisation:
Organisation name…Londonwide Local Medical Committees…….

Samantha Dowling
Director of Communications and Marketing, Londonwide LMCs