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Consultation response

in relation to the NHS Provider Selection Regime

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1 Introduction

1.1 Trowers & Hamlins is an international law firm with offices throughout the UK, Middle East and Far East. We advise a large number of clients across the private, public and third sectors on contentious and non-contentious public procurement matters. We have a deep understanding of the regulatory environment, as well as practice and custom in this area.

1.2 Healthcare is incredibly broad. Those active within it include Government (the Department of Health and Social Care, but MHCLG, DWP and Treasury also have roles), public bodies (Councils, NHS bodies which in itself includes NHSE/I, providers, commissioners, land owning companies), the private sector (both for and not for profit) and a broad range of service categories across NHS, private healthcare and the social care market. The sector is changing rapidly and the existing siloed approach to service delivery and funding is changing with it. We genuinely believe that Trowers & Hamlins is one of very few firms capable of moving across all of these boundaries and, therefore, capable not just of moving with the market but working with it as it evolves to the benefit of health and care systems.

1.3 We also have one of the largest public procurement teams in the UK, and our clients range from private sector developers to NHS bodies, central and local government, housing associations, contractors, consultants and investors. We have been ranked as one of the top tier practices in this area for over a decade.

1.4 We are market leaders in this field, and are committed to the development and recognition of public procurement as a strategically important area of law and practice.

1.5 Throughout the consultation period, we have been conducting discussions with our clients and contacts in order to understand and feed in practical as well as legal insights into the proposals and response. Where appropriate, our response has been informed by the feedback and comment from those discussions. Unless otherwise attributed, the views expressed in this report should, however, be considered as our own.

2 Further information

2.1 For further information please contact one of the Trowers & Hamlins' Health Team that specialise in procurement listed below:

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Responses to consultation questions

Question number	Question	Response
Application		
1.	Should it be possible for decision-making bodies (e.g. the clinical commissioning group (CCG), or, subject to legislation, statutory ICS) to decide to continue with an existing provider (e.g. 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.	Subject to appropriate checks and balances being in place, we welcome a regime which permits organic continuation of services with an incumbent provider who meets the specified key criteria. Where provision continues with an existing provider as a result of the provider having done a good job, further clarity around when the key criteria are to be applied by decision making bodies would be useful. It is suggested that when publishing their intention to award the contract with a suitable notice period, decision making bodies should also include the justifications and application of the key criteria as part of the information to be published. We note that this is not currently one of the proposed transparency requirements set out in paragraph 8.2. We would like to see a requirement to include this information which would ensure that providers are given the opportunity to make credible representations on an informed basis and ensure that the key criteria are considered and applied robustly by decision making bodies. There is also scope for the proposed regime to permit existing arrangements to continue indefinitely and potentially without regard to the key criteria, such as innovation in service provision. A long stop review date after a prescribed period of time may therefore be appropriate in circumstances where the same supplier has been in place for a significant period of time, to ensure that the key criteria continue to be met. We cannot emphasise the need for transparency against objective criteria enough: continuation of service provision without competition forecloses markets and has the potential to stifle innovation, opportunities for market entrants and diminishes the role that good, value for money procurement practice can play in NHS commissioning and procurement. We would recommend that transparency notices are used to provide the market with periodic insights into why and for how long a decision-making body intends to continue with an incumbent.

2.	Should it be possible for the decision-making bodies (e.g. the CCG or, subject to legislation, the statutory ICS) to be able to make arrangements where there is a single most suitable provider (e.g. 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	Subject to there being appropriate checks and balances we welcome an approach whereby decision making bodies can determine the most suitable provider for healthcare services without having to follow a competitive procurement process. We repeat our comments set out in the response to question 1 above, in relation to the level of information to be published by decision making bodies and the application of the key criteria. Again, we would support the use of transparency notices in order to inform the market of a decision-making bodies intention to award a contract without competition to a single provider. This should be complemented by a standstill period.
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?	See above, we suggest there may be a longstop date for contracts to continue with the same provider by application of the regime.
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	We agree with the general principle of a notice period in which providers can make representations to decision making bodies, although we do have further comments on the notice period regime from a scrutiny perspective, as explained in our response to question 7 below. We consider that notice periods could also sensibly be applied to scenarios A and B of circumstance 1 (no alternative provision/ alternative provision already available through other means). We note that under the transparency requirements set out at 8.2, decision making bodies will already need to publish their intended approach in advance and so a brief notice period could be applied at this stage, to ensure decisions based on there being no alternative arrangements are justified and robust and not based on, for example, time pressures to have service provision in place. A shorter notice period of perhaps 7 to 10 days for these particular scenarios could be sufficient without unhelpfully fettering decision making bodies' discretion to continue with existing arrangements. We also consider that it would be useful to agree a timeframe in which decision making bodies must respond to any representations or objections received from

		providers within the notice period. This should avoid matters becoming protracted and ensure certainty of process and outcome for all parties involved.
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	We agree that there should be certainty for those procuring healthcare services in how to proceed going forward. There may already be some confusion going forward on the extent that the NHS is going to be bound by the Public Contracts Regulations 2015 (PCR) and any successor legislation. We anticipate that they will still have to comply for anything other than healthcare services (such as works and supplies contracts) which are above the monetary thresholds or not otherwise exempted. Confusion in the past on whether they are captured by the PCR has caused NHS bodies to err on the side of caution and procure when they may not have been required to do so. If it is the intention that healthcare services have their own regime then it needs to be clear that such services do not then stray back within the realm of the PCR in the future. It is important that although this will be the default position, the NHS is not cut off from any opportunities which may be beneficial for the sector – it would need to be considered on a case by case basis.
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?	We agree that there should be key criteria that should be considered by the commissioning party to ensure that they are securing the best provider for the services. We query why there should not be some kind of "audit" by the commissioner of these key criteria and how they apply to the incumbent provider where there is a continuation of existing arrangements. Even where the same provider is being used, there should be scope for considering these key criteria and seeing whether the continued contract could be improved upon. We agree that the criteria should focus on value not price, as this is in line with current central government thinking. That said, guidance and upskilling in this area is needed to ensure that lowest-price tendering does not prevail in the sector going forward The key criteria broadly cover most considerations but the question is how rigorously and thoroughly they will be applied by individual commissioners, how this will be captured for audit purposes and what recourse there will

		be if they have not been properly applied (see other comments on recourse). It would be prudent for commissioners to also take into account financial standing, previous convictions and prior experience. This need not be as exhaustive as a Selection Questionnaire process under PCR but we suggest some form of due diligence should be encouraged in these important areas. There appears to be some scope to do this in Annex A but this could be misconstrued and focus on how they will perform the new services rather than what they have done before and their financial standing. See our response below on equalities.
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	In general, we agree with the record keeping and publication requirements set out in the consultation paper, which are intended to ensure full transparency in the decisions and decision making processes taken under the proposed regime. We note that further guidance as to the specific information to be published and location of publication is yet to be finalised but refer to our comments in this regard in our responses to questions 1 and 2 above. Balancing a sufficient level of scrutiny against the intended outcomes of the proposed regime is a more delicate balancing act. The current proposals provide that the main recourse for a provider unsatisfied with a proposed award decision is to make objections or representations to the decision making body who will then publish a response and set out its final decision. There is no further opportunity specified for providers to appeal that decision, other than to issue judicial review proceedings in the High Court. Judicial review is a remedy of last resort however, and the risk with the proposed approach is that, in the absence of other avenues to escalate matters, providers may seek to use this remedy more frequently and without proper grounds for doing so. Judicial review proceedings are time consuming and costly for all parties involved and an increase in such claims by aggrieved providers would only serve to waste public funds and divert resources. The legal test for judicial review claims is complex and so, from a provider perspective, judicial review may not afford providers a realistic opportunity to scrutinise decisions made.

		Further, whilst providers must make their representations or objections within specified notice periods, the consultation paper does not set out any time limits in which a decision making body must publish its response. There is therefore a risk that matters become protracted, which could be particularly prejudicial to providers seeking to challenge by judicial review where proceedings must be bought within a strict 3 month limitation period from the date when the grounds for a claim first arose. Without unduly fettering the discretion conferred on decision making bodies' under the new regime, a further stage for appealing decisions may be preferable, alongside the existing rights of intervention and scrutiny of NHS England/ Improvement and local authorities. This would also be in line with the rest of the procurement reforms currently under consideration by the Cabinet Office in respect of the PCR successor legislation: which is concentrating on pre-contract remedies and streamlining the current judicial process. The current proposals under consideration in this consultation seem to be at odds with the Green Paper proposals and could create an, unhelpful, two-tiered system to the detriment of service providers to the NHS, which in turn makes the relevant markets unattractive to investment and innovation by SMEs, market entrants etc..
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?	We would like to see key criteria that explicitly include consideration of how an organisation approaches equality both in the workplace and in the delivery of services to end users. Making it explicit increases the chances of commissioners and providers giving it sufficient gravity and status in their subsequent contract management approach. It is conceivable that services for individuals with a long-term plan may be adversely impacted by their health needs (not potentially subject to competition pursuant to this consultation) subsequently transitioning to care needs (procurable under Green Paper proposals) across the duration of the plan. One plan encompassing two different types of provision means that certain commissioners will need to juggle two potentially very different procurement routes and outcomes in a way that

		does not adversely affect outcomes to the end-user and recipient of the services. This may be simple to address in the interface between the two regimes, but any friction in the process does have the potential to adversely affect services in a way that may widen health inequalities for those citizens in areas of higher deprivation or for those with more complex needs.
9.	Do you have any other comments or feedback on the regime?	We would be interested to see how the regime will dovetail with the proposals for the revised PCR. The Green Paper: Transforming Public Procurement aims to consolidate all procurement legislation into one place yet a number of contracting authorities such as NHS Trusts and local authorities will be caught by both the PCR and the regime. To provide commissioners of healthcare services with complete confidence in how to commission services going forward, the legislation and accompanying guidance needs to be very clear and sector specific.. The risk with the PCR guidance is that it does not accommodate current practice/concerns etc. of health procurement decision-makers and their advisors. As with the wider public procurement reforms, we would recommend centralised training and user guides to assist in the transition period and beyond. Centralised templates that need to be filled out and filed demonstrating consideration of key criteria would also assist in consistency and transparency across the sector.

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