

13 October 2009

**SHA Chief Executives
PCT Chief Executives**

Gateway Reference Number: 12774

The NHS as preferred provider

On the 17th September, the Secretary of State made a speech at the King's Fund which focused on putting quality at the core of the NHS. He stated:

With quality at its core, I think the NHS can finally move beyond the polarising debates of the last decade over private or public sector provision. Let me begin with where I stand on this debate, and that is that the NHS is our preferred provider. But it is the important job of the commissioner to test whether these services provide best value and real quality.

Where a provider is not delivering quality – and the new accountability information will more readily demonstrate that – we will set out a clearer process that will provide an opportunity for existing providers to improve before opening up to new potential providers. This is fair to all as it means everyone knows where they stand and services stand or fall on the quality they provide.”

The purpose of this letter is to share with you how we propose to take this policy forward and highlight the potential implications for commissioners.

“*The NHS as the preferred provider*” is about getting the best care for patients and looking after the NHS staff who care for them. Our aim is to ensure that NHS staff are treated fairly and engaged in decisions, so that they know what is happening and when, what changes are being sought and why, and have a full opportunity to contribute to improving and re-designing the services that they provide. Service improvement and re-design should not be something which is imposed on NHS staff but something which they own and lead.

We propose to do this – as the Secretary of State announced at the King's Fund – “by setting out a clearer process that will provide an opportunity for existing providers to improve before opening up to new potential providers”. This will ensure “everyone knows where they stand and services stand or fall on the quality they provide”. In practical terms, we will provide guidance to PCTs on the processes we expect them to follow, which includes engaging with NHS organisations and their staff and trade union representatives, coupled with strengthened assurance processes.

“The NHS as the preferred provider” does not have implications for current or future 'Right to Request' proposals to set up social enterprises. We remain committed to supporting those PCT staff who wish to set up social enterprises, and neither Secretary of State's letter, nor future guidance, should preclude the establishment of successful 'Right to Request' schemes. Application and assurance processes remain unchanged.

The Secretary of State has written to Brendan Barber, the General Secretary of the TUC, outlining the *core principles* he expects commissioners to follow from now when engaging with NHS providers. To illustrate these principles and how they might be developed in practice, we have developed six draft *scenarios* which set out the processes we expect PCTs to follow henceforth as commissioning needs arise (these are shown as an annex to the letter). These scenarios will inform the development of further guidance.

We will approach the development of guidance in two stages. Firstly we will publish guidance which will supersede *Necessity – Not Nicety*. Secondly, we will issue a revised *PCT Procurement Guide* and refined *Principles and Rules of Co-operation and Competition*. All key stakeholders will be invited to help shape these documents.

Whilst we are preparing and publishing new guidance that will supersede *Necessity – Not Nicety*, we remain committed to the establishment of regional Commercial Support Units and the national Strategic Market Development Unit, which have important roles to play in supporting the development of World Class Commissioning (WCC).

In addition to the revised guidance, there will be implications for assurance processes, including for WCC and Transforming Community Services. It is too early to tell what these are likely to be but the WCC and TCS teams will work closely with the service, the SPF and stakeholders to identify and develop appropriate proposals that are robust and aligned existing assurance mechanisms.

Our over-riding principle is to provide high quality care for patients delivered by providers who offer the best care. We remain committed to the participation of independent and third sector providers where this is the right model for patients – for example, where we need new services/service models, or substantial increases in capacity, or to offer increased choice to patients or to stimulate innovation.

We are committed to treating NHS staff fairly; giving NHS providers the opportunity to meet commissioner's needs and thereby doing the best thing for NHS patients. For new or substantially redesigned services, PCTs would be expected to engage fully with the existing provider(s) and staff at an early stage, as well as other potential providers, enabling them to contribute to service specifications. Only after this would a decision on whether or not to openly tender take place. When competition is used it should be transparent,

equal, fair and proportionate to deliver the best care to meet the needs of the local population.

I hope this helps to explain the concept of “*the NHS as the preferred provider*”, in advance of the proposed revised guidance. If you would like any further information, or clarification of the above, please do not hesitate to contact your SHA system management or commissioning director, or Claire Whittington (0113 254 5619), Sebastian Habibi (0207 633 7458) or Bob Ricketts (0207 633 4209/4210) at the Department.

A handwritten signature in black ink, appearing to read 'D Nicholson', with a long horizontal flourish extending to the right.

David Nicholson CBE
NHS Chief Executive

Enclosed

1. Letter from SofS to Brendan Barber, General Secretary of the TUC

POC1_446450

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25 SEP 2009

Dear Brendan,

Thank you for the work that you and staff side colleagues have been doing with us over recent weeks. Last week in my speech to the Kings Fund I set out very clearly my position on these matters:

“With quality at its core, I think the NHS can finally move beyond the polarising debates of the last decade over private or public sector provision.

Let me begin with where I stand in this debate, and that is that the NHS is our preferred provider.

But it is the important job of the commissioner to test whether these services provide best value and real quality.

Where a provider is not delivering quality – and the new accountability information will more readily demonstrate that – we will set out a clearer process that will provide an opportunity for existing providers to improve before opening up to new potential providers.

This is fair to all as it means everyone knows where they stand and services stand or fall on the quality they provide.

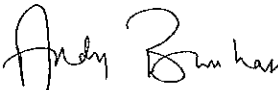
I have now seen and signed off proposals that set out what I would expect of commissioners in engaging with existing providers and their staff. These draft proposals are attached, and I would like DH and the SPF to work on finalising them along with a brief draft ‘joint statement’. I understand that there is an SPF Staff Passport meeting tomorrow, and would be very pleased if this statement could be signed off at this meeting.

The core principles which commissioners would be expected to follow are:

- **NHS and existing providers should be engaged at an early stage of service development**
- **NHS providers should have the opportunity to bid for any opportunities that are developed.**
- **Early and substantial engagement of existing providers is expected**
- **Early and substantial engagement of staff and their trade union representatives, where applicable, is expected**
- **Decisions are taken locally, but within a clear national guidelines**
- **Commissioners must demonstrate:**
 - Fairness and transparency of process
 - Clear rationale for decision making
 - Needs-driven
 - Proportionality (that the commissioner acts proportionately to the size and seriousness of any problem)
- **Commissioners are expected to secure best value and quality for patients and taxpayers**
- **Commissioners are expected to actively monitor the quality of services and to initiate a process with providers if services are not adequate**
- **The starting point for some scenarios will be the contractual mechanism that currently exists.**
- **Robust oversight and assurance of all the above through:**
 - PCT Boards
 - SHA Assurance
 - World Class Commissioning, Transforming Community Services
 - Partnership oversight through Regional Social Partnership forums

As I said above, I would like the SPF to work with us to sign off a joint statement of policy. We will then work with the SPF and other stakeholders to draft the guidance to supercede Necessity – Not Nicety and the revised PCT Procurement Framework and Principles and Rules of Co-operation and Competition.

I look forward to working with you on this and thank you again with all your help to date.



ANDY BURNHAM

Draft scenarios, to be finalised by DH and SPF

Scenario (ie. the commissioning need)	Process to be followed	Oversight & assurance mechanisms
1 Addressing underperformance	The PCT would raise its concerns and engage with the provider to address these. There would be at least 2 formal chances for the provider to improve before any engagement was made with other alt providers. Judgements would be made on the basis of clear measures of quality, including patient satisfaction. Only if there was insufficient improvement within a reasonable timescale, <i>and</i> the scale of under-performance was significant, would the PCT consider engaging with other potential providers or other solutions (e.g. franchising). If market-testing is subsequently pursued, the PCT would be expected to continue to engage the provider and its staff, and give them the opportunity to compete on a fair and equal basis.	SHA under the NHS Performance Regime; WCC assurance; SHA assurance.
2 Incremental service improvements & increases in capacity	A joint service review would be undertaken, the results of which (if agreed) would be incorporated in a revised contract. Only if provider failed to develop robust and credible plans for service improvement and the shortcomings were serious (in terms of quality and value for money), would the PCT consider engaging with other potential providers. This would only be after full engagement with the provider and its staff, and the provider having been given at least two opportunities to develop and present its service plans. Engagement would continue whilst the PCT considered other options, including market-testing. If the service is ultimately tendered, the provider would be able to bid on a full and fair basis.	WCC assurance; TCS assurance; SHA sign-off of the PCT's strategy; SHA assurance.
3 Risk of Clinical or financial un-sustainability	The PCT would work with the provider to try to address the causes of un-sustainability. If necessary, the PCT would enlist the support and help of other relevant providers within the local health system. If the problems cannot be resolved sustainably, regulatory Intervention and resolution through merger, acquisition or franchising, probably with an existing NHS organisation, is more likely to be a viable solution than the market-testing of services, though this remains an option. The assumption would be that the PCT would be acting under the SHAs' direction as part of seeking a co-ordinated solution, potentially under the oversight of the relevant regulator. The PCT would be expected to engage fully with the provider and its staff throughout this process.	SHA under NHS Performance Regime; WCC assurance; SHA assurance; appropriate regulator (depending on the circumstances).
4 New services or significant redesign of	PCTs would be expected to engage fully with the existing provider(s) and staff at an early	WCC assurance; SHA sign-off of the PCT's

	services	<p>stage, as well as other potential providers, being clear about what outcomes and/or innovation it was seeking, the reasons for change, and the processes to be followed, enabling them to contribute to shaping service specifications. Only after this would a decision on whether or not to openly tender for the new or re-designed service take place.</p> <p>. For certain services, clinical issues or safety may warrant an 'NHS only' tender. In either case, existing providers would have a fair and equal opportunity to bid.</p>	<p>strategy; TCS assurance; SHA assurance; Co-operation & Competition Panel.</p>
5	Increasing patient choice	<p>The PCT would adopt an open or managed 'Any Willing Provider' accreditation process, under which potential additional providers (including other NHS providers) could apply.</p> <p>NB: Under this scenario, existing providers (as long as they continued to meet quality, value for money and registration requirements) would continue to provide services – this is about adding to the number of providers, not displacing existing ones.</p>	<p>WCC assurance; SHA sign-off of the PCT's strategy; TCS assurance; SHA assurance; Co-operation & Competition Panel.</p>
6	Expiry of Independent/Third Sector contract	<p>The PCT would – assuming it wishes to continue to commission such a service – would tender openly. NHS providers would have a fair and equal opportunity to bid, and the PCT would engage with other existing providers beforehand.</p>	<p>WCC assurance; SHA sign-off of the PCT's strategy; SHA assurance; Co-operation & Competition Panel; competition law.</p>