Good Governance Institute

Optima Health

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Procurement and Partnership for Patients - procurement in the new Integrated Care

A report from the Good Governance Institute (GGI)

June 2022

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Procurement and Partnership for Patients - procurement in the new Integrated Care

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Section 1: Executive Summary

GGI and Optima Health have been in conversation with Integrated Care Systems (ICSs) and other NHS leaders to gain their initial thoughts and provocation around procurement within the new integrated and collaborative care world and what the changes would mean for health care providers, with particular emphasis on the procurement of digital solutions to enhance musculoskeletal (MSK) care.

This paper provides insight for ICS board members, NHS and partner procurement leads on how procurement in ICSs can be embraced across public services in a smart and innovative way. It outlines how procurement and use of digital solutions can accelerate access to care. Based on new ICS partnerships which enable collaboration and learning across sectors, we focus on practical ways to deliver excellent procurement.

It also gives insight into potential opportunities and routes into procurement for suppliers for health services across the NHS, new ICSs and Integrated Care Boards (ICBs).

In summary, our findings indicate that there is a huge breadth and depth of opportunity for the procurement of services in new ICSs and ICBs. Here are a few key highlights:

- There is an opportunity for ICSs to reconsider where services are delivered for patients. Working across the system, procuring 'traditional' MSK services in primary care instead of secondary care could reduce waiting times and improve patient pathways.
- Digital systems offer a solution. ICS procurement should consider how digital products could save time for both patients and clinicians – by reducing travel time to appointments and increasing opportunities for accelerated access to digital triage and treatment.
- Procurement that uses both data and patient engagement intelligently to manage co-morbidities can improve both delivery efficiency and patient outcomes.
- The new legislation has been designed to drive more collaboration between providers. ICBs and trust boards should see this as an opportunity to work more closely on everything, with the procurement and delivery of services at the centre of this.
- Non-NHS providers, such as local authorities, have a wealth of experience in buying and delivering services for local populations. This expertise should be harnessed and utilised in all planning and decision-making.
- Social value has been set as one of the core ICS and ICB partnership rules in the legislation. This is an opportunity for purchasers and sellers of services to reconsider whether what is being delivered provides social value at the level it should, to do the best for society and local communities while continuing to support the healthcare needs of the population.

We reached these conclusions through a mixture of desktop research, interviews with key figures in the health sector industry, and some roundtable events, attended by experts in the field.

Section 2: Introduction

The procurement and purchasing of the right services for UK citizens both locally and nationally is core to the success of the future of the NHS and its partners. By procuring in a thoughtful and integrated way, all organisations aligned with the new ICS model can have a positive and lasting impact on society.

On 11 February 2021 the Department of Health and Social Care published the white paper, *Integration, and innovation: working together to improve health and social care for all*, which sets out legislative proposals for a Health and Care Bill.[1] The bill sets out in the proposal marks a shift away from the focus on competition towards a new model of collaboration, partnership and integration across health and social care, namely an 'Integrated Care System' (ICS). ICSs will become statutory bodies with the aim to commission and meet health and care needs, coordinate services and planning to improve health and reduce inequalities[2] across geographical regions. The bill also proposes new regulations for commissioners known as the 'provider selection regime'[3]. This is intended to give decision makers a "flexible, proportionate decision-making process" for selecting providers to deliver health and care services to the public.

This paper sets out the new approach to procurement in ICSs, with key findings outlined at the beginning of each section. A set of strategic prompt questions are set out in Section 5 to support the board in growing understanding and, more importantly, achieving lasting change.

GGI exists to help create a fairer, better world. We aim to build the maturity of governance in all organisations so they can play their part in building a sustainable, better future for all - from the smallest charity to the greatest public institution and from start-ups to the well-established private sector organisations that work in partnership with the public sector and contribute to the public good.

Optima Health is the UK's largest occupational health and wellbeing provider, with over 70 years' experience delivering high quality health solutions in both the public and private sectors. Optima Health has invested in the development of clinically validated digital solutions to accelerate access to appropriate support and clinical interventions.

GGI was thrilled to be approached by Optima Health to explore the procurement of such services in the new ICSs and what new approaches and ways of thinking could do to break down procurement barriers to enable more effective opportunities for patients, citizens and ICS colleagues alike.

GGI would like to thank Optima Health, as well as all those who so generously contributed their time to take part in the discussion events and interviews that have informed the content of this paper.

Our methodology

This is a collaborative report. We brought together individuals from across ICSs: the NHS, local government, health, third sector and partner organisations. Using targeted engagement – interviews, correspondence and surveys – we researched content and connected with decision-makers, as well as undertaking a series of webinars that provided an opportunity for senior leaders to engage in cross-sector discussion.

The breadth of procurement across healthcare is considerable. With this in mind, we focused on conditions such as musculoskeletal (MSK) and mental health to better understand their positioning as a case study in the broader procurement landscape.

This research was carried out in three stages:

- Roundtables with a focus on procurement and MSK services
- Broader GGI roundtables with a focus on the future of ICSs
- Desk-based research on policy and cases of best practice

Section 3: Reducing the backlog in MSK services

Key findings – reducing the backlog in MSK services

- There is an opportunity for ICSs to reconsider where services are delivered for patients. Working across the system, procuring 'traditional' MSK services in primary care instead of secondary care could reduce waiting times and improve patient pathways.
- Digital systems offer a solution. ICS procurement should consider how digital products could save time for both patients and clinicians – by reducing travel time to appointments and increasing opportunities for accelerated access to digital triage and treatment.
- Procurement focus should be broader than delivery of service – it should consider social value. Considering the value for people in place could transform treatment and outcomes. ICS boards should look at procurement of patient support groups and other grassroot initiatives to support care.
- ICSs bring opportunities for partnership outside of place too. National digital tools and sharing of data and insight bring many solutions to the procurement and delivery of services locally.

MSK services background

Musculoskeletal (MSK) conditions such as neck pain, lower back pain and arthritis are the UK's leading cause of years lost to disability. These conditions effect over 18 million people and lead to 30% of all GP consultations in England. However, since the beginning of the pandemic in March 2020, many primary and secondary care appointments have been cancelled or held virtually. This looks to be a lasting change. Technology can now facilitate new ways for patients to access care, freeing up the time of clinicians.

However, overall, for broader health issues, GPs in the UK are now providing consultations for patients triaged for face-to-face or remote consultation on the basis of clinical need. More patients are being seen in person now than ever before. Total weekly appointments in England currently stand at seven million - one million more than before the pandemic.

With an ageing population likely to live for longer, and with chronic illness, face-to-face appointments may still be required for some patients. Primary care is currently failing to keep up with the demand and is struggling to meet the terms of the NHS long term plan for more services to be provided in a primary care community setting.

It's also important to recognise that the current investment is insufficient to fund the integration of services. Almost six million people are waiting to have hospital treatment in England according to the latest NHS monthly performance statistics. The NHS went into the pandemic with waiting lists at record levels, staff shortages of 100,000 in the health service and 112,000 social care vacancies. The number of patients on the waiting list for non-urgent hospital treatment, including surgery such as hip or knee replacement or cataract operations, rose to 5,975,216 in October 2021, the highest since records began in August 2007. In January 2020 the total was 521,408, with 436 waiting for over a year. Patients are being seen when their condition has worsened, which can make surgery more complicated.

An extra £1billion has been promised by the Department of Health and Social Care to help tackle the backlogs. An additional £160 million has been promised to help hospitals carry out more operations and cut down the waiting times. Some are criticising these figures for being too low.

It is critical that the challenge of reducing NHS backlogs is met with due diligence. Many people who suffer with chronic MSK conditions struggle to complete even simple activities and many also develop mental health issues such as anxiety and depression as a result of chronic pain.

Trust responsibilities in reducing backlogs

The Government expects the NHS to deliver around 30% more elective care activity by 2024-25 than it delivered before the pandemic and has pledged an additional £8 billion for the recovery of these services. The National Audit Office found that poorer performing NHS Trusts tended to be the ones under greater pressure. These Trusts had higher levels of bed occupancy, their consultants had to see more patients and their financial deficits were greater. This means that the NHS needs to secure the biggest impact in future years from the Trusts that have struggled the most in the past.

There have been calls from orthopaedic surgeons and MSK specialists for NHS trusts to prioritise patients who have had their illness for long periods as these conditions often deteriorate, making the surgery to help them more complicated. MSK specialists are calling on the government to establish centres that are "separate from A&E to deliver planned elective surgery around the clock."

NHS staff have told the Government they need investment in infrastructure and, most importantly, people, rather than contractual quick fixes. There needs to be investment in the healthcare support workers, nurses, physiotherapists, anaesthetists, occupational therapists, and surgeons delivering care.

A consultant in Middlesbrough started a clinic at his GP practice for joint injections to help clear the backlog of patients with MSK problems who couldn't receive this monthly treatment in hospital. The waiting time for this treatment used to be six weeks on average; it is now around seven months. Some healthcare professionals are praising the work of "first contact practitioners." It is hoped that these physiotherapists with enhanced training can treat patients without a referral, which would allow the patient to be seen quicker and reduce waiting times.

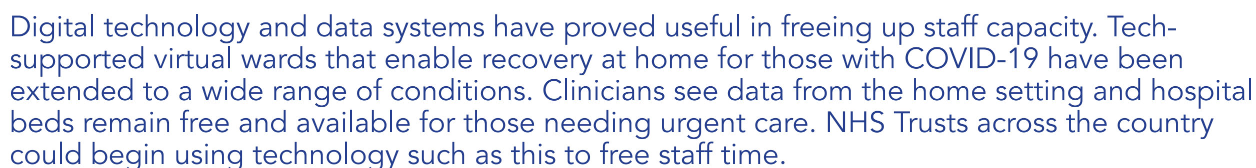
With MSK services under pressure it is important that patients learn how they can best help and advocate for themselves so as not to worsen their pain or symptoms. Many are turning towards patient groups for help. NHS Trusts could easily set these up via video calling software and allow patients to talk to each other about their pain. Not only would this allow patients to find ways of coping with their pain but it could also improve their mental health and provide them with comfort.

For Trusts to improve and accelerate their care they need funding to be placed into areas such as new beds and increasing staffing levels, while also making sure that recruitment is sustainable. However, this could take years to achieve.

It is vitally important that NHS Trusts do all they can to reduce the backlog. Queen's Hospital Romford held a special surgical outpatient clinic that saw 162 MSK outpatients in one day. Five consultants and five registrars worked on the day and were able to see everyone, helping to reduce the backlog. Approaches such as this could be replicated in most Trusts, provided staff have the required capacity.

However, having that time and capacity is rare. In 2018, joint research from the King's Fund, the Nuffield Trust and the Health Foundation painted a bleak picture of the long-term workforce challenges facing the NHS. In its summary, The Nuffield Trust said: "Across NHS Trusts there is a shortage of more than 100,000 staff. Based on current trends, we project that the gap between staff needed and the number available could reach almost 250,000 by 2030."

The problem, they said, was fuelled by poor long-term planning, the fragmentation of responsibility for workforce issues, cuts in funding, immigration restrictions caused by Brexit, and a growing tendency for clinical staff to leave their jobs early. All of these pressures have resulted in lower capacity and resource, which means reducing backlogs will be no easy task.



Digital technology and data systems have proved useful in freeing up staff capacity. Tech-supported virtual wards that enable recovery at home for those with COVID-19 have been extended to a wide range of conditions. Clinicians see data from the home setting and hospital beds remain free and available for those needing urgent care. NHS Trusts across the country could begin using technology such as this to free staff time.

NHS Trusts should also make use of national digital tools such as the NHS app to provide a personalised route into NHS services for patients, making care more convenient and driven by patients' needs. There should also be increased investment in digital technologies that frees capacity in non-clinical areas such as risk management, and in clinical areas such as the use of digital triage tools to save clinician time and money, as well as expediting access to support and providing more consistent routing, aligning care to the NHS Getting it Right First Time (GIRFT) initiative. In addition, technology allowing people to be treated at home can both free up the patient's recovery time and increase the number of people being treated. Feedback from patients is positive and more than 2,400 people a week have benefitted from this care model.

Digital solutions that in effect, reduce unnecessary activity and allows clinicians to operate at the top level of their skill-set is new and emerging and has the potential to transform the way in which services like MSK support are delivered to patients. It is recommended that procurement of such tools is supported through appropriate clinical expertise within each Trust to ensure their adoption is configured to specific working practices and that clinical efficacy is verified through alignment to the NICE Evidence Standards for Digital Health Technologies (2019).

Section 4: Primary care influence with procurement and beyond in ICSs

Key findings – Primary care influence with procurement and beyond in ICSs

- Patients seeing an expert earlier on is beneficial both for the patient pathway and to support healthcare resourcing. ICSs and primary care systems should look at ways to procure services aligned with patients from their first contact.
- Procurement that uses both data and patient engagement intelligently to manage co-morbidities improves both delivery efficiency and patient outcomes.
- The mobile phone is a key tool to engagement and treatment. Procuring services such as this that align to patient and staff can save time and money while literally putting care into the hands of patients.
- Procurement and recruitment cannot be managed separately from one another. ICSs bring with them the opportunity for more holistic procurement and recruitment approaches, to deliver better localised care.

In primary care, work is being undertaken to expand the capacity of MSK experts as first contact practitioners (FCPs), which has added expertise right at the front end. This work complements the work of GPs, as they now have MSK professionals adding to their expertise and patients now get the right advice at very first contact. Patients are now not only having their MSK care needs addressed accurately and appropriately at the first point of contact, but they're also having their wider wellbeing needs addressed with signposting to those broader services.

However, there is an argument that this can only be achieved if primary care recognises that it is a significant player in the MSK system and engages in system-level workforce planning to make sure the pipeline of MSK experts is developed. Acute Trusts and community Trusts need to bring on new graduates and train them to work beyond primary care. This brings the advantage of ensuring patients are not added to the elected backlog unnecessarily.

The ICS world, particularly its decision-making aspects, gives commissioners the power to come to a decision on the provision of services in an open, transparent, and collaborative manner. According to NHS leaders this empowers systems to better co-ordinate and gives commissioners the opportunity to use their knowledge of healthcare providers in the system to decide who is best placed to give care without having to run competitive tendering exercises[4]. In addition, the provider select regime (adopted by ICBs) will set new rules built specifically for the needs of the NHS, followed by NHS England, local authorities, trusts, and foundation trusts when making decisions to select providers where they are sub-contracting for services. It will be tailored towards NHS commissioning rather than a generic set of public contacting regulations. A result of this system is that potential providers can work together to bring better outcomes to patients, achieving the goal of the ICSs.[5]

Recruitment and first contact practitioners

In primary care, we've seen some fantastic work done over the last 18 months to two years to really expand the capacity of MSK experts working within primary care, in the capacity of MSK first contact practitioners. What that has done is added expertise right at the very front end. GPs already did a fabulous job but now they're complemented by having those MSK practitioners adding their expertise when patients first enter the healthcare system with MSK presentations. What we have seen from first contact practitioners (FCPs) working in primary care is that patients get the right advice at first contact. With first contact practitioners and the broader expansion of roles with social prescribers and healthcare coaches, patients are not only having their MSK care needs addressed accurately and appropriately at the first contact, but they're also having their wider wellbeing needs addressed with signposting to broader services.[6]

With this in mind, there's a real priority to continue in primary care to focus on that wider expansion of those MSK FCP roles. Primary care must realise it is a much more significant player when it comes to the MSK system - and to ensure the sustainability and the growth of roles, primary care need to engage in system-level workforce planning to make sure that pipeline of MSK experts is developed. We can't be in a situation where acute Trusts and community Trusts bring on new graduates, providing all the support and supervision that entails, just for primary care to pinch those experts. We need primary care to come on board and support that pipeline of workforce planning.[7]

Bolstering FCP services with workforce pipeline planning in primary care is one core element, which can be supported by embedding, embracing and strengthening personalised care champions within the community setting. Personalised care champions support the relationship between practitioner, patient and the system and so can support making the most of procuring the right services and using expertise and capacity in an intelligent, planned manner.[8]

Partnerships

One of the biggest and most important changes for procurement is the opportunity Integrated Care Boards (ICBs) bring to open up the conversation about the patient moving from primary care into secondary care and then ultimately into the community. Previously, many saw process and approach changes as patients were moved from primary into other forms of care, so understanding and managing these patient flows better will improve treatment approach across the system.

Having partnerships in place across the system as a part of the ICB will allow the opening up of real conversations exploring the most successful services being offered and replicating this across the system. It shifts the conversation from how a siloed organisation manages conditions to how services can be procured and managed across the whole system.[9]

Data sharing across the new systems is another practical way to see the benefits of this approach through procurement. Colin Scales, Chief Executive of Bridgewater Community Healthcare NHS Foundation Trust, said: "We have a pragmatic approach to take population health management data and to effect service delivery, connecting mental health, learning development and community services together, securing programmed equality, working to reduce variation in service delivery and standards, achieve consistency of outcomes, secure a resilient workforce and improve efficiency."

"We'll do this by using population health data to segment groups with multiple co-morbidities and/or complex lives to understand what they're experiencing as patients and citizens, and address a service response to better meet their needs. Co-designing connected service frameworks with partners and citizens is central to that. Supporting places and primary care networks (PCNs) to tailor services to their unique circumstances.

"This isn't about the application of a system-wide approach to deliver services. We channel our expertise as a collaborative and tune into the sensitivities of our places."[10]

Communication with patients

Technology and a digital approach to engaging with patients and communities is a solution that should be considered when procuring to help manage population health. Grant Harrison, co-founder of Reset Health, played a pivotal role in the development of the Tesco Clubcard – the original supermarket loyalty scheme. When it comes to communication with patients and service users, Grant said 'the mobile phone is the only game in town'. He added: "I think mobile phones and making social media and apps available to everyone are the gateway to scalable and impactful healthcare. They give us a chance to reach people when it will do the most good."

"Health happens every minute of every day and our phones are always there. They record and store health behaviours. They give us a chance to offer a word of support or ask a question at just the right time for each individual. Apps give clinical teams the opportunity to connect with patients when it really matters."[11]

Case study – Tesco Clubcard

The two behaviours the creators of the Tesco Clubcard wanted from the consumers were to shop more often and spend more. When considering procurement in the UK, ICBs should consider 'what are the healthcare behaviours we want people to exhibit today in the UK?'

Grant Harrison suggests three behaviours he thinks we need to see to keep people healthier and happier, which could inform the shape of the digital procurement landscape:

- One - keep curious. Keep health top of mind; keep curious about your health and how it's changing. You're not a car whose servicing is outsourced to a mechanic.
- Two - keep on doing the healthy stuff. Do more of the healthy things you already do: taking your medicine, moving, eating well, socialising with friends. You're already doing great stuff; you just need to remember what it is and do more of it.
- Three - demand more from your clinical support system, whatever that is in your area and depending on your circumstances. I hope that as health move into everyday life, people will help us all continually improve to get better outcomes.

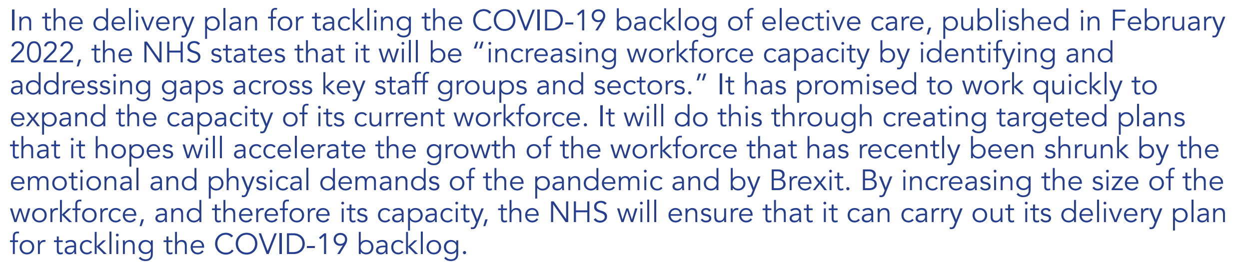
Ultimately, if ICBs give primary care services the opportunity to demonstrate that practitioners are in the best place to support commissioners develop integrated care pathways and understand that care doesn't start and stop at the front door of a particular institution, then suppliers will be in a stronger position.

NHS London Procurement Partnership said that the new ICB approach makes it incumbent for primary care and other healthcare suppliers to start understanding the patient flow and where people need to be so we can make sure we've got the right services and the right products in the right places at the right time.[12]

What can we do in community and other services?

Community services such as integrated community assessment and treatment services, (ICAT services) that have been around since 2006 are nothing new and are fairly well developed and established. In Sussex they have robust multidisciplinary teams making up the ICAT service. ICAT services can help reduce NHS backlogs by building cultures of personalised care and shared decision-making. When a patient with a moderate or complex issue comes into community services and they are assessed by a clinician who embraces personalised care and works to find the patient's values and preferences while also looking at their care history and lifestyle to find a good care plan, patients rarely go straight to surgery. Instead, patients trial the broader range of conservative measures to tackle their MSK presentations and live well despite them. If focus is put into building cultures of clinicians that embrace personalised care, that's what will achieve a real value to reducing the MSK backlog.

Patients with the most serious problems sit within the secondary care sector, which the Government is making into high volume, low-complexity surgical sites in the form of community diagnostic centres, which should add an element of capacity to surgical activity in the healthcare system.24 It is important that those working in theatres get it right first time so that the patient does not have to return. Data shows that the full amount of time booked for a patient in theatre is not always used; if organisations can use that data to hone their improvement programmes, their productivity will improve and they will get through more patients without the need for extra resource.



In the delivery plan for tackling the COVID-19 backlog of elective care, published in February 2022, the NHS states that it will be "increasing workforce capacity by identifying and addressing gaps across key staff groups and sectors." It has promised to work quickly to expand the capacity of its current workforce. It will do this through creating targeted plans that it hopes will accelerate the growth of the workforce that has recently been shrunk by the emotional and physical demands of the pandemic and by Brexit. By increasing the size of the workforce, and therefore its capacity, the NHS will ensure that it can carry out its delivery plan for tackling the COVID-19 backlog.

The NHS plans to recruit more than 10,000 nurses internationally this financial year, with an emphasis on recruiting those with experience in critical care and theatres, contributing to the existing commitment of 50,000 additional nurses. The NHS also acknowledges the importance of retaining its workforce and aims to provide a "positive experience and appropriate professional and pastoral support." There will also be an acceleration into introducing new roles, such as anaesthetic associates and first contact practitioners, and expanding advanced clinical practitioners.

In total, 17,000 NHS reservists have already answered the call to help their colleagues during the pandemic. Their skills will continue to be used as the NHS builds the new contingency staffing model. Support is being given to Trusts to make temporary staffing banks attractive by continuing to make it easy for staff to take on extra shifts, paying them promptly and supporting temporary staff by offering more permanent employment and development opportunities.

Work is also being put into running more regional pension seminars to explain the schemes to staff, with the aim of supporting them to remain in NHS employment. There has also been a push to strengthen career pathways, which has seen the involvement of Health Education England, and increasing supply for theatre staffing and addressing the root causes of sickness absence. The NHS has also developed 40 mental health hubs and allowed free access to a range of self-help apps and helplines. All of this should help the NHS to retain staff.

The pandemic has taught us how much difference we can make with better use of staff time by investing in areas like digital pathology, imaging and AI. The pandemic has undoubtedly accelerated digital transformation, both in terms of the availability of and investment in digital technology, and in terms of culture and perspective, as more organisations and service users have experienced transformative opportunities first-hand.

Technologies are fast being integrated into people's lives to predict health outcomes and support with both preventative public health approaches and long-term conditions. One example is a start-up called Healthy Help. Based on smartphone data alone, the company can accurately predict up to 200 different medical conditions and when they will happen, which it claims is almost to the same level of accuracy as an insurance underwriter's predictions. One way it does this is by measuring Strava or Apple Watch heart rate figures. This reflects evidence that variability in heart rates has a predictive impact in terms of cardiovascular risk. But the app can go further than that, through understanding where people live and regularly spend time - looking at exposure to air pollution, air quality and their impact on respiratory illnesses. Through working on preventative measures and embracing an integrated approach, we can begin to reduce NHS backlogs.

The new ICS framework will be crucial in allowing staff to work together across systems to take a more joined-up approach to workforce planning, and tackle some long-standing challenges in understanding workforce requirements, as well as focusing on the most effective ways to recruit and retain staff.

The King's Fund notes that there are four things the NHS needs to get right to reduce the backlog:

1. Co-production
2. Third sector
3. Prevention
4. Primary and community workforce.

Co-production

"Engaging people with lived experience should not be optional." It is important that those people who know what it is like to use MSK services have a voice at the table when plans into improving these services are discussed.

Third sector

During the pandemic, charities stepped up to help patients when the NHS had to respond to the national health crisis and prioritise those sick with the coronavirus. Charities set up patient helplines and dealt with an increase of calls from those unable to get help from the NHS. Every ICS should embrace this contribution.

Prevention

The NHS Confederation has stressed the importance of "turning off the tap of ever-increasing need" in order to solve the problems of the rest of the system. Prevention should not be seen as a long-term ambition of the NHS and there needs to be work to ensure that the NHS is working with local government, leisure services and the third sector to get people with joint pain moving more.

Primary and community workforce

While expensive, secondary care is vital, yet it's difficult for many to access. Investments should be made into community services that are local to the people they serve. ICSs need to harness everyone who can contribute to MSK health and use them properly. The NHS Confederation has suggested using gym, leisure centres, sports clubs and working groups to contribute to improving the health of the local population.

Section 5 - Procurement

Key findings – procurement

- The new legislation has been designed to drive more collaboration between providers. ICBs and Trust boards should see this as an opportunity to work more closely on everything, with the procurement and delivery of services at the centre of this.
- Non-NHS providers, such as local authorities, have a wealth of experience in buying and delivering services for local populations. This expertise should be harnessed and utilised in all planning and decision-making.
- Social value has been set as one of the core ICS and ICB partnership rules in the legislation. This is an opportunity for purchasers and sellers of services to reconsider whether what is being delivered provides social value at the level it should, to do the best for society and local communities while continuing to support the healthcare needs of the population.

Procurement background

The story of the current status of healthcare services procurement goes back a few years, to an ask of Theresa May's Government to see what the NHS would like to happen in order to make integration easier to achieve. At that time, the strong message the NHS gave to the Government was having to run tender exercises to manage the commissioning of healthcare services was not a good way to build integration.[13]

The view was that trying to develop a coherent health economy through a series of standalone tender processes did not work well and it was not what tendering was designed for.[14] What commissioners wanted was a more flexible way of choosing who provides care, and while it would still be a procurement activity, it did not necessarily need to be managed through the public contact regulations.[15] So, the ask was to build legislation that allows the commissioning of healthcare services to operate with a different set of rules to the general public procurement rules.[16]

Now, in 2022, we are at a point where there is a bill before parliament aiming to achieve exactly that. This bill also introduces Integrated Care Boards (ICBs) in place of CCGs. It is important that healthcare services procurement changes are made in order for ICBs to work in the way NHS England wants them to. There is a big emphasis within the ICBs for collaboration around decision-making, and that requires more flexibility. It is not going to be possible, in many cases, for ICBs to sufficiently separate their various contributors in a way that allows for a traditional procurement process, as there will be people in the room who will be providing the services, as is the nature of ICBs. A strong set of governing principles will be needed to find the appropriate balance across procurement.[17]

Changes in culture

The changes to the NHS structure will mean 250 providers moving under the umbrella of one of 42 ICBs across the country. The providers will still have autonomy, but will have the opportunity for partnership working and support from their local ICB. This is a remarkable change and even currently, there is a sense between NHS providers that they are competing with one another, let alone considering independent providers who have a shareholder motive as well.[18]

There are aspects of the bill that essentially force more collaboration between NHS providers, including shared financial targets, for example, and other shared accountabilities between Trusts within a system. Therefore, there is a de-emphasis on each trust being an island and having to look after its own interests financially, which helps unlock a notion of shared investment.[19]

There is always going to be a difference between the in-house NHS providers, who are part of the chancellor's pot of money, and those that are contracted to provide services but have business elsewhere as well. Unfortunately, that is just a fact of a system in which there are mixed providers.

One hope for the new bill is to provide a space for non-NHS providers to contribute to plans and help bring their experience of serving populations to the decision-making table, even if they are not formal decision-makers. If these providers have more of a sense of involvement and they do a good job, they are more likely to carry on being contracted with, rather than a mandatory tender coming at some point down the line for their services.[20] As a result of this, these providers may see a point in investing a bit more in the longer-term, as they could have more long-term security about their involvement in the delivery of NHS services.

GGI recently launched a report with Care England and the Homecare Association that looked in depth at the relationship between adult social care services and developing ICSs. Good work has taken place to build this relationship, but it hasn't been consistent across England. There are thoughts and opportunities within this report which should be considered when managing ICS procurement development: https://www.good-governance.org.uk/publications/papers/ics-engagement-with-the-adult-social-care-sector-in-decision-making-a-report-by-ggi-care-england-and-the-homecare-association

However, these changes in behaviour and attitudes will take time, as for the last 15-20 years, providers have been set up to compete with each other and undermine competitors. There is a lot of work being done behind the scenes to look at where providers can work together and what can be done collaboratively.[21] But it is not just about individuals, it is also about changing organisations, and that can take a bit longer.

The key is to focus on the patient and the patient journey and how that can be improved; this gets people talking the same language.[22] Once there is a real understanding of patient flows, there can be more conversations about introducing a whole-system approach to the issue. This is a huge opportunity and there is not currently enough effort being put into fleshing out the idea.

Place

Under the new health and social care arrangements, local authorities have some legal duties to arrange certain healthcare services. At other times they arrange services on behalf of the NHS, when there is a joint arrangement or joint committee agreement between commissioners at the local authority level.

The intention is that where a service has been arranged and is a mix of healthcare and social care – which is obviously very common, particularly for some mental health and children's services – that would all be commissioned under a new set of rules. The Governance setup of local authorities is exactly what it sounds like: government local. Led by democratically elected councillors, councils provide essential services to the populations they serve, from waste collection to public protection and planning. Across the UK around two million people work for local authorities, providing more than 800 different services. Thousands of councillors from these local authorities work with local people, stakeholders and partners, such as NHS, police, fire and rescue, voluntary groups, local businesses and other organisations, to agree and deliver on local priorities. The decisions are implemented by permanent council staff, council officers, who deliver services on a daily basis. It is important to be clear that when we are talking about local government as a collective, we are talking about a huge variety of activities and types of authorities.[23]

However, things get a bit more difficult when we move beyond the commissioning of health services and into wider determinants of health, such as education and housing. The decision-making, funding mechanisms and infrastructure in those spaces are very different from the health and social care space, where there is much more of a natural and sometimes, relatively seamless, alignment. However, they should at least be joined up in a planning sense.

It is not a new idea to make sure all the public services in a particular geography are trying to reach the same ends. There have been various constructs before health and wellbeing boards that were envisioned as the kinds of boards to shape those decisions. The intention with the Government's bill and the white paper on social care integration is to create more accountable structures for making decisions about how services should be coalescing around the people who need them. However, the different levels of accountability and levels of funding across the system also need to be taken into account. David Rogers, Chair of North Staffordshire Combined Healthcare NHS Trust, said:

"In the NHS Trust world, we have embedded accountability to regulators, and that's not surprising, given the need to demonstrate to Government that taxpayers' money is being well-spent. But in the world of population health a new accountability becomes significant – to the communities we serve. We need to build governance structures that recognise local accountability, and we need to learn a new language in which to communicate to those communities. This is where our colleagues in local authorities can help us, in terms of both structures and language."[24]

Implications for the future

Parliament permitting, before the end of 2022 commissioners (ICBs), NHS England, local authorities and trusts and FTs, where they are subcontracting for care services, will have a new set of rules to follow, built specifically for the NHS, to make decisions to select providers. There will still be requirements around transparency and fairness, and there will still be a need to consider quality, safety, integration and social value. Moreover, there will still be processes through which other providers can challenge the decisions of commissioners if they disagree with the providers that have been chosen. But all of that will be much more tailored towards NHS commissioning rather than a generic set of public contacting regulations.[25]

Therefore, in the future, if you work in procurement in the NHS, you will have public contract regulations-type rules for the procurement of services that are not healthcare services. This could be clerical, administration services, cleaning services or goods. However, when it comes to commissioning healthcare services, there will be a way of doing it that is tailored to the NHS. The aim is to give commissioners a freer hand and greater flexibility in how they arrange services to enable the integration of care, and also to unlock some of the other opportunities that will come with greater collaboration.[26] This represents a fundamental shift in the way the NHS has always operated. It marks a move away from the current command and control structure to a system in which power is shared and enjoyed by all system players.[27]

One of the aims of the recent proposals for legislative changes is to create a way of deciding who provides services that is open, transparent, robust and also conducive to the sort of collaborative decision-making that is intended to be at the heart of ICBs. The Health and Care Bill gives the ICBs the power to do that. In the future, ideally there will be a more flexible means for commissioners to make decisions about who provides care, with them being able to do that without an expectation that it is done through tender exercises, although that will still be an option should they want it to be.[28] Therefore, commissioners would continue with existing arrangements when a contract ends without having to retender for them if the service has been delivered well. Also, commissioners could use their knowledge of the providers in the system to decide who is best placed to give care without having to run competitive exercises. However, competitive exercises should still be possible, if needed.[29]

Sustainability and social value

There are huge challenges facing the procurement side of the system in terms of inflation, reliability of services and products, and the sustainability and social value aspects. Before the pandemic, there was a tendency to focus on price and penny pinching, and little attention paid to how procurement can do things differently.[30] Procurement professionals have a strategic function to make products and services as efficient as they can make them and help to ensure that excellent patient care is delivered by front-line teams.

The challenges facing NHS procurement include:

It is also important that the NHS becomes a better customer to its suppliers, to create an environment where innovation and collaboration flourish. If it goes back to the old ways of working without focusing on these aspects, there will be a continuation of the penny-pinching attitude to making savings. And that would result in the targets needed to help the rest of the system not being reached.[31]

Moreover, the sustainability and social value aspect of procurement is becoming increasingly important. Whereas before it was put on the back burner because it could not save money, there are now more innovative approaches to it and there are more conversations taking place about reaching net carbon emissions of zero.[32]

Commissioners have a key part to play in the strategic landscape. They can support the NHS on issues such as health inequalities, social values and sustainability, and they can drive better patient outcomes through collaboration. Environmental, social and governance issues are only going to grow in importance. Boards should champion their organisations, including information about their environmental impact and resources use in their integrated reporting, not just internally but externally too.[33]

Section 6: Conclusions and recommendations

This report outlines that the fundamental shift to systems working, and new societal norms regarding factors such as sustainability, technology and data, bring with them a real opportunity to shift the procurement regime to something that is more patient-focused.

The new emphasis on partnership working and collaboration provides an opportunity to break down barriers, but the processes and systems that would allow this to happen must be in place. A balance must be found between enabling local innovation while also looking at the bigger systems picture and supporting the sharing and opening up of procurement practices.

Choice for both ICBs and patients must continue to be a priority, managed by thoughtful competition and procurement, to foster a system that works to manage en masse while providing excellent, personalised care for patients.

New technology together with partnerships open the door to innovative solutions to triage and care delivery that weren't available just a few years ago. ICBs have the opportunity to grasp this and deliver new approaches that will transform both procurement partnerships and the patient pathway.

Opportunities for ICBs in procurement

There are various areas of opportunity for ICBs that haven't existed in previous NHS set-ups.

- Collaborative working to allow for shared conversations and governance arrangements to find solutions to cross-sector challenges.
- A whole-system approach to patient voice and advocacy that can feed into access of services and therefore what and how they are procured.
- The purchasing of services that work across systems, but also have a bespoke approach and focus for place and individuals.
- Solutions that work across primary, secondary and community care, rather than siloed approaches.
- Joint working approaches, meaning that triage and assessment could take place with a specialist practitioner immediately rather than through several layers.
- Shared data across ICBs and beyond to allow better understanding of population health and a procurement scheme that matches core local priorities.
- A joined-up recruitment and procurement approach to ensure the best use of funds across the system.
- ICB partnerships with technology companies and others who will not sit on the board to support the procurement of the right products.
- Shared and more protected approaches to managing potential issues such as inflation, reliability of services, sustainability and social value.

Mapping of ICSs

North East and North Yorkshire:

- Cumbria and the North East
- Humber, Coast and Vale
- North East and North Cumbria
- South Yorkshire and Bassetlaw
- West Yorkshire and Harrogate

North West:

- Cheshire and Merseyside
- Greater Manchester
- Lancashire and South Cumbria

Midlands:

- Birmingham and Solihull
- Coventry and Warwickshire
- Derbyshire
- Herefordshire and Worcestershire
- Leicester, Leicestershire and Rutland
- Lincolnshire
- Northamptonshire
- Nottingham and Nottinghamshire
- Shropshire and Telford and Wrekin
- Staffordshire and Stoke-on-Trent
- The Black Country

East of England:

- Bedfordshire, Luton and Milton Keynes
- Cambridgeshire and Peterborough
- Hertfordshire and West Essex
- Mid and South Essex
- Norfolk and Waveney
- Suffolk and North East Essex

South West:

- Bath and North East Somerset, Swindon and Wiltshire
- Bristol, North Somerset and South Gloucestershire
- Cornwall and the Isles of Scilly
- Devon
- Dorset
- Gloucestershire
- Somerset

South East:

- Buckinghamshire, Oxfordshire and Berkshire West
- Frimley
- Hampshire and the Isle of Wight
- Kent and Medway
- Surrey
- Sussex

London:

- North Central London
- North East London
- North West London
- South East London
- South West London

Notes

1. https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version
2. https://www.england.nhs.uk/integratedcare/what-is-integrated-care/
3. https://www.gov.uk/government/consultations/provider-selection-regime-supplementary-consultation-on-the-detail-of-proposals-for-regulations/preview-of-proposals-for-the-provider-selection-regime
4. Roundtable event – on procurement
5. Roundtable event – on procurement
6. Roundtable – MSK services
7. Roundtable – MSK services
8. https://www.england.nhs.uk/personalisedcare/
9. Roundtable – primary care
10. https://www.good-governance.org.uk/publications/insights/place-and-provider-collaboratives-cathy-elliott-and-colin-scales
11. https://www.good-governance.org.uk/publications/insights/solutions-to-the-population-health-management-challenge
12. Roundtable - procurement
13. Roundtable
14. Roundtable
15. Roundtable
16. Roundtable
17. https://www.good-governance.org.uk/publications/insights/integrated-care-boards-why-a-whole-system-governance-approach-is-key
18. Roundtable
19. Roundtable
20. Roundtable
21. Roundtable
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23. https://www.good-governance.org.uk/publications/papers/local-government-governance-explained
24. https://www.good-governance.org.uk/publications/insights/the-burden-of-hope-place-based-care-and-systems-working
25. Roundtable
26. Roundtable
27. https://www.good-governance.org.uk/publications/insights/partnering-for-success
28. Roundtable
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