GPC GUIDANCE

PROCUREMENT LAW AND POLICY – THE BASICS FOR GPs

AUGUST 2012

bma.org.uk

BMA

Introduction

This guidance gives information and advice for GPs (in their role as providers) and Local Medical Committees (LMCs). The guidance aims to give an overview of procurement policy, including:

- The NHS reforms and their impact on the purchasing of NHS services;
- Procurement law and policy;
- Procurement processes, including Any Qualified Provider;
- Arrangements for the commissioning of Local Enhanced Services in the new system;
- The roles and responsibilities of Monitor and the Cooperation and Competition Panel.

The Health and Social Care Act (2012) radically reforms the NHS commissioning system. The reforms are driven by the Government's commitment to extending patient choice and increasing plurality and competition. This emphasis impacts on how commissioners choose to purchase services, with EU legislation and Government policy encouraging commissioners to use procurement as a means to ensure competitiveness and plurality. As a result, GPs may be more likely to be required to enter into tendering processes.

Contents

What is procurement?

Procurement is a mechanism commissioners may choose to use to purchase goods and services. Successive UK governments and the European Union (EU) have developed policy governing public sector procurement with the intention of ensuring cost-effective commissioning and increasing competition within public services.

Procurement is governed by domestic and EU procurement and competition law, which outlines when procurement is appropriate and the process and timetables to be followed. Subject to these regulations, commissioners of NHS services may choose when to use procurement processes (they are not obliged to put every contract out to tender) but must be able to justify the decision taken.

1. Background – the commissioning reforms

1.1 Competition and choice

The Health and Social Care Act signalled a greater emphasis on choice, plurality and competition. This emphasis is evident both in requirements on commissioners to promote choice and plurality and also greater scrutiny of commissioning decisions to ensure competitiveness within the health service.

For example, the Health and Social Care Act gave the NHS Commissioning Board (NHSCB) and Clinical Commissioning Groups (CCGs) a duty to promote patient choice, through greater plurality of provision. From 2002 onwards the Labour government placed greater emphasis on patient choice, from the introduction of patient choice of consultant extending to patient choice of NHS provider. The current Government's main area of focus for extending choice is the any qualified provider (AQP) policy. AQP aims to extend patient choice by allowing patients referred for particular services to choose from a list of qualified providers.

The Health and Social Care Act also established Monitor as the sector specific regulator for health, with a duty to prevent anti-competitive behaviour which acts against the interests of those using health services. The Act gives Monitor the same powers as the Office of Fair Trading and the Competition Commission to investigate the application and infringement of competition rules.

1.2 Procurement in the new commissioning system

The Government regards procurement as a lever to promote plurality and ensure fair competition between providers. As a result, GP practices may be more likely to be required to enter into tendering processes, whether as part of an AQP process or where a commissioner chooses procurement to guard against charges of conflict of interest or anti-competitive behaviour.

Whilst the NHS Commissioning Board and CCGs are not obliged to put all contracts out to tender, they are required to provide clear justification for how they choose to commission a particular service. As a result, commissioners may use competitive procurement to protect themselves against charges of anti-competitive behaviour. This is particularly pertinent where CCGs are commissioning services from member practices (for example, services currently commissioned as Local Enhanced Services (LESs)). Guidance from the NHSCB explicitly states that CCGs may choose to use a procurement process as a means of managing perceived or actual conflicts of interest[1].

1 NHS Commissioning Board Guidance 'Code of Conduct: Managing conflicts of interest where GP practices are potential providers of CCG-commissioned services' http://www.commissioningboard.nhs.uk/files/2012/07/c-of-c-conflicts-of-interest.pdf

2. Procurement law and policy

Procurement law regulates how public bodies purchase services and goods. Procurement in the UK is governed by domestic[2] and EU[3] law. EU legislation distinguishes 'Part A' and 'Part B' services. Health and social care services are classified as Part B and subject to more flexible procurement rules and processes than Part A services. Non-clinical services, such as waste disposal, may be classified as Part A services and subject to more rigorous rules.

EU procurement rules pertain to public service contracts worth over £156,442. Department of Health procurement guidance stipulates that, in addition, all contracts worth over £100,000 (over the lifetime of the contract) must also be advertised and tendered[4].

Following the passage of the Health and Social Care Act, new procurement regulations are expected to be laid before Parliament in autumn 2012. These regulations will be the main framework governing how the new commissioning bodies make decisions. The NHSCB will publish guidance to accompany these regulations in winter 2012.

In addition, commissioning within the NHS must adhere to:

- The **'Principles and Rules of Cooperation and Competition'** (Cooperation and Competition Panel). These principles include the requirement that procurement processes are transparent and non-discriminatory.
- The Department of Health **'Procurement Guide for Commissioners of NHS-funded Services'** (2010).
- The Department of Health **'Framework for Managing Choice, Co-Operation and Competition'** (May 2008).

3. Procurement processes

3.1 The decision to procure

Department of Health guidance[5] states that procurement should be considered in particular where a new service is being developed or where the commissioner is seeking to secure additional capacity. The guidance is clear that if commissioners have concerns about provider performance, appropriate performance management processes should be entered into prior to taking the decision to put the contract out to tender. Department of Health guidance[6] states that any review of contracts should commence at least nine months prior to the contract expiry date to allow for thorough assessment of the service, any performance management processes required and to give enough time to secure replacement services if required.

Once a decision to procure a service has been taken, commissioners have several options as to the type of procurement to use. This decision will be influenced by a range of factors, including:

- The requirements and thresholds of procurement law and policy;
- The scale of the contract;
- Whether the service to be commissioned is a new or existing service;
- The range and interest of potential providers;
- Time pressures.

2 Public Contracts Regulations (2006)
3 The European Commission's Consolidated Directive on public procurement (2004/18/EC)
4 Procurement Guide for Commissioners of NHS-funded Services (Department of Health, 2010)
5 Procurement Guide for Commissioners of NHS-funded Services (Department of Health, 2010)
6 Procurement Guide for Commissioners of NHS-funded Services (Department of Health, 2010)

3.2 Types of procurement

The three main types of procurement available to NHS commissioners can be classified as follows:

Single tender

The commissioner offers the contract to a single provider. Single tenders are used where a contract is of minimal value or of all potential providers only one provider is judged capable.

Competitive tender

Providers compete against one another to offer the most attractive bid and secure the contract ('competition *for* the market'). The commissioner may undertake:

An open competitive tender – all interested providers are invited to tender;

A restricted competitive tender – providers express interest and the commissioner invites a shortlist of providers to tender. No negotiation takes place between commissioner and providers once tenders have been selected;

Competitive dialogue – the commissioner engages with a shortlist of providers to develop a service specification. A final tender then takes place.

Any Qualified Provider

Commissioners conduct a qualification process to qualify a number of providers to provide a particular service. When referred for treatment, patients are given a choice of provider. Payment is made on the basis of referrals made ('competition *in* the market').

3.3 The procurement process

Commissioners begin the commissioning process with an assessment of population need and a review of existing services. The principle of transparency in procurement requires that commissioners publish their commissioning strategy and intentions on their website and on **NHS Supply2Health.**

The commissioner must then develop service specifications to address identified need. The service specification should be detailed, including expected outcomes, geographical remit and quality standards. Commissioners have a responsibility to engage with potential providers. The development of the service specification should be an iterative process, taking into account provider feedback about the feasibility of the proposed service. Procurement policy dictates that the process of provider engagement must be non-discriminatory, not favouring or excluding any particular sort of provider. It is recommended that commissioners issue a Prior Information Notice (PIN) on NHS Supply2Health, notifying providers of potential procurements.

The commissioner must then decide whether to enter into a procurement process and what sort of tender to use to secure the contract. Procurement law and policy requires that the decision whether to tender is transparent and non-discriminatory. Commissioners must provide a clear justification for their decision. The rationale may take into account resource implications of the type of tender. For example, for a contract of very low value a single tender may be simpler and resource efficient compared to a competitive dialogue, however a competitive tender may lead to efficiencies in pricing of the contract.

Having decided to proceed with procurement, commissioners must advertise all tenders for clinical services on NHS Supply2Health® and, where a contract has a lifetime value of over £156,442, on the **Official Journal of the European Union (OJEU) website.** The advert should be comprehensive and include detail of pricing, tenure and outcome measurement. The advert should clearly outline the stages of the tendering process and how providers will be assessed. It is recommended that even single tender actions are advertised as this upholds the principle of transparency and reduces the risk of challenge.

4. Any Qualified Provider

4.1 The AQP policy

AQP aims to extend patient choice by allowing patients referred for particular services to choose from a list of qualified providers who meet NHS service quality requirements, prices and normal contractual obligations.

One of the stated principles of AQP is that competition is based on quality, not price. All qualified providers are paid a fixed price for a service which is either the national tariff or, where it is not covered by the national tariff, the price set by local commissioners. Providers are paid per patient treated.

AQP: The GPC position

AQP is likely to draw more private and voluntary sector providers into primary care and the GPC is concerned that the policy risks destabilising NHS services.

Early applicants to the AQP qualification process report that the process is bureaucratically demanding, which may be prohibitive for smaller providers such as GP practices. In addition, providers are paid retrospectively in accordance with the number of referrals to their service. Income is therefore dependent on patients choosing your services over those included on the list of qualified providers. These risks should be taken into consideration by practices which are planning to enter an application.

The implementation of AQP will need careful monitoring to assess how popular the AQP route is amongst commissioners. It will also be essential to examine the profile of providers undertaking the qualification process, to ensure the process is as fair as possible for practices.

4.2 Implementation of AQP

The introduction of AQP began in April 2012, allowing for a "phased" approach. In autumn 2011, PCT Clusters were required to identify a minimum of three of a selected list of community and mental health services to be delivered by an AQP approach in 2012-13. All services were covered by national or local tariff pricing. These services were chosen to reflect patient and Quality, Innovation, Productivity and Prevention (QIPP) priorities. The eight services were:

- Musculo-skeletal services for back and neck pain;
- Adult hearing aid services in the community;
- Continence services (adults and children);
- Diagnostic tests closer to home such as some types of imaging, cardiac and respiratory investigations to support primary assessment of presenting symptoms;
- Wheelchair services (children);
- Podiatry services;
- Venous leg ulcer and wound healing; and
- Primary care psychological therapies (adults).

PCT Clusters were able to choose services not included in the priority list if consultation showed them to be of a higher local priority. For example, some PCT Clusters chose lymphoedema, dermatology and ADHD and autism spectrum services.

USEFUL LINKS

More information about the AQP policy, implementation and the qualification process can be found on the **AQP Resource Centre website.**

4.3 Qualification of providers

In order to be put on the AQP list, providers have to qualify and register to provide services via an assurance process that is designed to test their fitness to offer NHS-funded services. The governing principle of qualification is that providers should qualify if they:

- Are registered with CQC and licensed by Monitor (from 2013) where required, or meet equivalent assurance requirements;
- Will meet the Terms and Conditions of the NHS Standard Contract which includes a requirement to have regard to the NHS Constitution, relevant guidance and law;
- Accept NHS prices;
- Can provide assurances that they are capable of delivering the agreed service requirements and comply with referral protocols; and
- Reach agreement with local commissioners on supporting schedules to the standard contract including any local referral thresholds or patient protocols[7].

There are four stages of qualification to become an AQP:

Stage 0: Commissioners determine which services are appropriate for AQP. The offer is made available on Supply2Health and prospective providers apply using the standard qualification questionnaire.

Stage 1: The AQP compliance team checks the applying providers' organisation, regulation, IT, financial, commercial and legal details.

Stage 2: Qualification Centres of Excellence (QCEs) or local commissioners deal with any outstanding issues from the compliance check and undertake a service delivery assessment. This includes checking that appropriate integrated care pathways have been described as well as details of clinical governance leads, processes and reporting.

Stage 3: The local commissioning body undertakes final checks before declaring a provider qualified or not qualified. Successful applicants are listed in the National Directory of Qualified Providers.

There are five QCEs that cover the eight priority service areas. They are designed to support local commissioners in assessing provider applications, including making sure commissioners and clinicians assess applications fairly and consistently, in line with best practice and regulations.

7 LMC 2012 resolution (131) available at http://bma.org.uk/about-the-bma/how-we-work/local-representation/local-medical-committees

8 Department of Health Operational Guidance to the NHS: Extending patient choice of provider. October 2011.

Case study: A practice's experience of the AQP qualification process

Our practice made an application to become an "Any Qualified Provider" of a community based Ear, Nose and Throat (ENT) service, as we had supported a partner with an interest in ENT to obtain the necessary experience and diploma. We invested a significant amount in purchasing the necessary equipment to be able to provide the service. This investment was done 'at risk' as it was not guaranteed that our application would be successful.

The specification for the AQP bid was very broad and it would have not been possible for the practice to apply on its own. We therefore worked with one of our local hospital ENT consultants, the pathology department – to ensure our service was billed separately from our GMS pathology activity – and a local pharmacist that had sufficient space to develop an audiology booth for hearing tests.

The application form itself was not difficult but it required a large amount of supporting documents which we already had but required updating. We had to agree contracts with our third party providers although we did not complete the contract process until we were finally successful in our bid. We worked on the contract negotiations with another practice who were also making an AQP bid.

We had to determine the process, structures and assurance frameworks, envisaging our hypothetical service without knowing whether we would be successful. This was also quite difficult and very time consuming. Overall the application process took 40-50 hours of work for our practice manager.

We had to re-submit the application and relevant documents because our policies were not formatted in line with the requirements of the board. It would have been helpful if they had been clearer from the outset what the required format should have been.

The bid required CQC registration, but we could not register until this year. We submitted that to the PCT as our evidence, and this was acceptable. Now we have been successful we will have to register the ENT service as well as our other GPSI services as part of our general practice CQC application this year.

4.4 Advice for GP practices

There are a number of considerations for practices to consider when deciding whether to undergo the AQP qualification process. AQP has potential to create a more level playing field than straightforward competitive tender, whereby successful bidders secure all the resource available. However, due to the 'competition *in* the market' approach adopted in AQP, successful qualification as an AQP provider does not guarantee income. Providers are paid retrospectively in accordance with the number of referrals to their service. Thus an AQP bid carries more risk for providers than a traditional tendering process, where a successful bid guarantees the contract price.

This risk should be borne in mind when practices are making the decision to undertake the qualification process. In particular:

- The qualification process has potential to be bureaucratic and time consuming. One practice estimated that the collection of supporting evidence and documentation took 40-50 hours of practice time.
- The process may involve close liaison with colleagues in pharmacy, secondary and community care, depending on the type of service in question. Practices should be prepared to enter into negotiations with other service providers to prepare a bid.
- Practices should consider the likelihood of successful qualification before investing in costly equipment or resources required to deliver the service.

The GPC will be monitoring the roll-out of AQP, including the adoption of the AQP process amongst commissioners and GP practice experience of the qualification process. If you have any feedback about AQP, please email **info.commissioning@bma.org.uk.**

5. Arrangements for Local Enhanced Services

The NHSCB will commission enhanced services currently commissioned as Directed Enhanced Services (DESs). The NHSCB will delegate to CCGs authority to commission services currently commissioned as Local Enhanced Services (LESs), as part of their statutory responsibility for improving the quality of primary care. Current resource for LESs not related to public health will be subsumed into CCG baseline allocations.

The NHSCB suggests that these services will no longer be called 'Local Enhanced Services' and will be commissioned using the NHS Standard Contract. The Standard Contract is used by NHS commissioners to commission NHS funded acute, ambulance, community and mental health and learning disability services from all types of providers. The Standard Contract is updated to reflect the requirements of the NHS Operating Framework.

Useful links
Further information about the **Standard NHS Contract (2012-13)** can be found on the Department of Health website.

Local authorities will have new public health responsibilities and will be able to commission services currently commissioned as public health related LESs, for example smoking cessation, substance abuse and sexual health services. Existing public health related LESs will be transferred from PCT Clusters to local authorities. Current baseline allocation for public health related LESs will be included in the ring-fenced public health funding local authorities will receive.

GPC position: Local Enhanced Services

Local Enhanced Services are an effective tool for commissioners to secure locally-responsive and innovative services. CCGs and local authorities should be encouraged to use Local Enhanced Services in order to expand community-based provision and achieve QIPP objectives.

The GPC questions the need to rename Local Enhanced Services, particularly where these services are commissioned through a single tender action from GP practices. In addition, it is vital that LMCs continue to be involved in the commissioning of these services. LMCs have valuable insight into the feasibility and effectiveness of proposed services, gained through extensive experience of liaising with PCTs in the development of LESs.

The procurement processes for these services will remain the same as currently applicable for LESs. As PCTs are currently required to, CCGs and Local Authorities will need to provide justification for the tendering process they choose to use; whether competitive procurement, Any Qualified Provider (AQP) or a single tender process. Competition law requiring the advertisement and tendering of contracts will, as currently, only apply to contracts with a lifetime value of over £100,000. For some services, GP practices may be the most appropriate provider of the service. As PCTs are currently able to, CCGs may make the decision to undertake a single tender action and offer the contract only to GP practices, particularly where the contract is of limited value.

Useful links
Guidance for CCGs from the NHSCB relating to the **commissioning of LESs in the new system.**

The GPC is seeking clarification about the arrangements for NHS superannuation for services commissioned by local authorities. At present, income from non-NHS bodies is not superannuable. Clearly, this would be a disincentive for GPs to provide public health services commissioned by local authorities. It is important that mechanisms are developed by which this income is superannuable and the GPC is in discussions with the NHSCB on this issue.

LMC involvement

LMCs should ensure that they are involved in the decisions taken by CCGs and Local Authorities about the commissioning of services currently commissioned as Local Enhanced Services as they currently are with PCTs. LMCs should encourage CCGs to commission local services as an efficient lever to drive up quality and achieve QIPP objectives. LMCs will need to ensure that they have close links to Local Authority commissioners in order to feed into the commissioning of these services.

6. The Cooperation and Competition Panel

6.1 The Cooperation and Competition Panel (CCP)

The CCP has a duty to advise the Department of Health and Monitor on potential breaches of the Principles and Rules of Cooperation and Competition. One element of the CCP's work is to conduct procurement dispute appeals.

6.2 Procurement dispute appeals

Where a practice believes a procurement process is inappropriate – for example, in breach of one of the 'Principles and Rules for Cooperation and Competition' such as transparency or non-discrimination – a dispute process should be entered into with the commissioner, whether the NHSCB, a CCG or a Local Authority. If this dispute process concludes and the practice remains dissatisfied with the conclusion, the case can be referred to the CCP. LMCs may need to be prepared to assist practices wishing to undertake the dispute appeals process.

For a case to be considered by the CCP it must satisfy certain criteria:

- The subject matter must be within the remit of the Principles and Rules of Cooperation and Competition;
- The CCP must be the most appropriate body to consider the issue;
- All relevant parties must have made full disclosure of relevant information;
- No legal proceedings relating to the case are ongoing;
- The dispute is not 'trivial, vexatious or an abuse of the CCP's procedures';
- The case is referred to the CCP within 25 days of the decision being taken by the commissioner.

Useful links

More information about the procurement dispute appeals process can be found on the **CCP's website.**