

# Lessons from the Vanguard: Procurement

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This short paper sets out learning from Dudley on the above topic. Its fundamental argument is simple: that NHS commissioners should be allowed to award an 'Integrated Care Provider (ICP) contract' (described below) to an NHS provider without having to undertake a large-scale procurement process. This would enable the system to reap the potential benefits of this contractual form while removing the costs of procurement and related concerns around privatisation.

The paper was produced by [Dudley Clinical Commissioning Group](#) (CCG) and its partners the [Strategy Unit](#). It draws on Dudley's experience as a 'Vanguard' site under the [New Care Models](#) programme. Readers wanting further information on this experience may be interested in the [microsite](#) produced as part of Dudley's local evaluation.

## Background to the topic

In May 2018, the House of Commons' Health and Social Care Committee issued its [report](#) on '*Integrated care: organisations, partnerships and systems*'. The report contained a detailed examination of the arguments for and against 'Accountable Care Organisations' (ACOs)<sup>1</sup> and – of closer relevance to this paper – the awarding of an 'ACO contract' by NHS commissioners. This examination drew on Dudley CCG's experience as one of the few commissioners seeking to do so.

The Committee's report noted that terminology had made the debate unhelpfully 'political'. ACOs are a prominent feature of healthcare in the United States. This triggered concerns - and associated judicial reviews - that introducing an ACO contract into the NHS was a step towards the American model. These concerns focused largely upon privatisation: that using a procurement exercise to award an ACO contract could lead to for-profit organisations running large parts of the NHS.

Yet focusing the debate on privatisation and procurement can obscure more than it illuminates. The deficiencies of the United States healthcare system are legion and well documented; so too is public commitment to an NHS that is funded out of general taxation, free at the point of use and provided largely by NHS organisations. Reforms perceived as moving away from these principles and towards anything resembling the US experience are therefore – rightly – regarded with hostility. Partly for these reasons, NHS England now has stopped referring to ACOs and adopted the term 'Integrated Care Provider' (ICP) instead. At the time of writing it was consulting on the draft ICP contract.

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<sup>1</sup> In summary: an organisation taking responsibility for a single, long-term (and so large-scale) contract with an associated budget and outcomes relating to the health of a defined population.

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This paper contributes to the debate by asking whether the NHS could realise some of the (hypothesised) benefits of an ICP contract, while avoiding concerns about ‘Americanisation’ and privatisation. It contends that the strongest arguments in favour of the ICP contract are its promotion of integrated care: not in the use of procurement and competitive pressures.

Dudley’s experience suggests a policy response based on the reformulation (or at least clarification) of procurement law to remove the requirement to use procurement as a means of awarding an ICP contract to an NHS organisation. This change would shift the terms of debate; it would also ensure that efforts remain focused on service and system development, rather than the distractions and costs associated with procurement.

## Summary of Dudley’s Vanguard programme

Dudley’s Vanguard programme set out to shift the locus of care away from hospital and into community and primary care settings. Fundamentally, the aim was – and still is - to simultaneously improve patient experience, population outcomes and system resilience. To achieve this, the local system set out a need for better integration of:

- *The workforce* – to bring previously separate teams and professionals together to better coordinate care: especially for the most vulnerable in the population;
- *Patient goals and professional actions* – to support people (especially those with long-term conditions) to define outcomes that matter to them and to plan support accordingly;
- *Contractual and financial incentives* – to align measures and payment mechanisms across the system to promote a focus on outcomes rather than activity; and,
- *Organisations* – to remove zero-sum thinking and any incentive to ‘shunt’ demand (patients) around the system rather than addressing it.

To bring about this integration, Dudley’s programme had two main strands:

1. Set up new services, new ways of working – and a better system culture - to engender and exemplify the new care model; and

2. Use of a large-scale [procurement](#) exercise to commission and contract for the new model. The end point of this would be a new type of provider organisation (the ‘Multispecialty Community Provider’ (MCP), which would hold an ICP contract.



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This paper focuses exclusively on the second of these strands; a companion paper examines the first. Yet it is worth noting here that work to establish new ways of working, while neither easy nor smooth, were largely successful. The opportunity cost of directing efforts away from this type of activity should therefore be borne in mind when considering what follows.

## **Rationale for wanting to use an ICP contract; challenges associated with procurement**

At the outset it is important to distinguish two things:

1. the potential benefits of moving the system from using current NHS standard contracts to an ICP contract; from,
2. the process by which the realisation of that change in contract is established.

On the first point, the Dudley system identified several potential benefits from the utilisation of the ICP contract. These were that:

- The ICP contract incorporates both the primary medical services contract and the NHS Standard contract. This would enable the CCG to commission both GP services and other services in a single arrangement from a single provider to support the integration of these services;
- The ICP contract is designed specifically to support integration. Furthermore, by utilising a whole population budget it aligns those services within the scope of the contract to work for the common interest of a shared population, which is a key design feature of the MCP model;
- The ICP contract utilises population-based outcome measures as the means of paying for performance, rather than the current predominant mechanism of payment for activity. This aligns the financial incentives of the organisation behind the intended objectives of the MCP new care model rather than the current mechanism which often obstruct them; and,
- By contracting for the long-term, the ICP contract creates incentives for the provider to invest in interventions which have a longer rate of return and longer-term benefits for the population. There is a stronger incentive to invest in prevention than under current contracts.

So the ICP contract offers an important contractual mechanism for enabling and supporting the integration of care in a system. It would provide a “single line of sight” between commissioner and provider; it would align resources deployed, population served and outcomes expected.

However Dudley’s experience (documented on the [microsite](#)) of the means that is currently required to implement the ICP contract - namely running a large-scale procurement - was that:

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## **Procurement created unhelpful divisions within the local system**

Dudley's Vanguard programme was characterised by two periods:

- The first, before procurement commenced, where the CCG – in its role as system leader – worked with all local partners to understand the case for change, build a shared vision and strategic direction, and initiate changes to spur and catalyse improvement; and,
- The second, once the procurement process began, where the CCG had to split itself into two arms ('procurement' and 'MCP development / business as usual'). Moreover, to maintain the purity of that split and remain within the letter of procurement law, interactions between the two CCG arms – and between the procurement arm and other parts of the local system – had to be carefully circumscribed.

The first period was more fruitful. Managerial and clinical attention was focused on improving the system's ability to meet its population's needs. Conversely, the period of procurement tended away from system integration.

In many ways, Dudley is in a fortunate position. Relative to other local systems, it is not financially stressed, it is well led and well supported; local relationships are in the main very positive. Yet it shares many of the same challenges and limitations – including limited capacity to define and lead change. Dudley's experience suggests that this capacity is not well invested in procurement activity.

## **Procurement has been an expensive - and uncertain - process**

In addition to the opportunity costs of not being able to focus on system development, the procurement process has brought direct costs. The CCG has retained specialist legal and procurement advice, in addition to investing in specific support for primary care (as a collective of nearly autonomous organisations) to enter the procurement.

In some ways, it could be legitimate to see Dudley as bearing these costs as 'R&D' for the NHS as a whole. Indeed, this was part of the rationale for pursuing a procurement. Certainly some of the products – notably the outcomes framework – could be adopted for analogous efforts. Yet this is not true for the bulk of procurement-related costs, which would have to be repeated each time such an exercise was undertaken.

Large-scale procurement does not have a proud and successful history in the NHS. In part, this is for want of the necessary skills and disciplines, but it must also be because of the complexity and inherent uncertainty of 'the product'. This problem is multiplied when considering a 10-15 year contract, in an area subject to potentially radical technical, economic, social and political change.

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## **Procurement has not helped to navigate an uncertain market**

The scale, services and risk associated with the contract on offer in Dudley meant that very few organisations could realistically play a lead role. In practice, and as the Health and Social Care Committee notes, local NHS organisations would almost certainly have to take this role (their skills could then of course be added to where specialist inputs are required).

This makes the supply side of the market a known quantity. One of the main arguments for procurement – reducing the knowledge problem of buyers not knowing potential suppliers – does not therefore apply in this case. Instead, time and resources that would have been better spent doing joint development with existing local providers (as the CCG will be doing post-procurement) were spent on the procurement process.

## **A better way forward?**

None of the above is to suggest that procurement is entirely (or always) without merit. In this case, it has led to greater clarity over risks in the local system and financial flows / business rules; it has uncovered previously hidden assumptions and has – arguably – led to faster and more formal development of contractual relationships (especially those between primary and secondary care). This seems to be an under-studied area and the system would benefit from empirical work to properly weigh out the costs and benefits of large-scale procurement.

But, in the final analysis, Dudley's experience shows that the rules should not be set as though procurement were the default route. A more efficient and fruitful route would be a change in (or national clarification of) procurement law to allow NHS commissioners to award NHS providers an ICP contract. This would allow the system to reap potential benefits while avoiding the downsides of large-scale procurement. In recommending this, Dudley's hope is that the investment of its efforts are repaid by others being able to make better use of NHS resources and take a more direct route to achieving better integration.