Written evidence submitted by The Independent Healthcare Providers Network (ICS0041)

About IHPN

The Independent Healthcare Providers Network (IHPN) is the representative body for independent sector providers of both NHS and privately funded healthcare services. Our members deliver a diverse range of services from acute, primary, and community, to clinical home healthcare and diagnostics and play a significant role in the delivery of services to NHS patients. Currently over 40% of NHS community service providers are from the independent sector, and in 2021 almost 40% of NHS ophthalmology, and trauma & orthopaedic patients were treated by independent sector providers.

Summary

With new Integrated Care Systems (ICS) set to be accountable for NHS performance and charged with spending almost £100 billion of NHS funding, we welcome the Committee's inquiry into ICS autonomy and accountability and how they will deliver joined up health and care services to meet the needs of local populations.

As the membership body for independent healthcare providers delivering NHS services, our submission will focus on three key aspects of these new systems and the importance of holding ICSs to account around:

- Fostering good governance
- The involvement of independent sector providers
- Improving performance against key national targets/initiatives

Fostering good governance in ICSs

Managing conflicts of interest

The intention behind the establishment of ICSs is for these new systems to have less central oversight and a greater deal of flexibility and autonomy in carrying out their duties. In light of this new autonomy however, it's vital that ICSs are committed to much greater transparency over how they work and the decisions they take.

Indeed, with ICSs now charged with spending almost £100bn of NHS funding, local populations and taxpayers will need to be assured that new structures are working as effectively as possible. This is particularly important at a time when the NHS is receiving significant additional funding through the new Health and Care Levy and the need to ensure this investment tackles the record high NHS waiting lists.

A key part of this drive to greater transparency is through ensuring all ICSs have strong governance mechanisms in place, so that local populations can ensure they are making decisions in the best interests of patients and deliver value for money.

The need for good governance can be demonstrated most clearly through the work of Integrated Care Boards (ICBs), who will be the key body commissioning local healthcare services. ICBs will be comprised largely of local organisations who deliver healthcare, and therefore effectively blurs the lines between who is procuring a public service and who is being paid to deliver it.

As a result, there is a danger that conflicts of interest could emerge with decisions taken to benefit providers, with limited due process and transparency over quality. For example, Integrated Care Boards (ICBs) who will be making decisions around the planning and delivery of local healthcare

services, are likely to be led by NHS provider organisations. This could lead to unaccountable "cosy local monopolies", as warned by the Nuffield Trust and Health Select Committee Chair Jeremy Hunt, which are unresponsive to local communities and fail to tackle poor performance.

The provisions in the Health and Care Act gives local systems a degree of flexibility on this issue and simply make clear that each ICB "must make arrangements for managing conflicts and potential conflicts of interest in such a way as to ensure that they do not, and do not appear to, affect the integrity of the board's decision-making processes".

Given the billions of pounds of public money ICBs will be spending, IHPN would like to see more detailed guidance for all ICBs on how they can and should robustly identify and manage such conflicts. This could include:

- Ensuring conflicts are declared throughout any process that might be likely to result in a commissioning or contracting decision taken by the Board.
- Reporting on an annual basis what conflicts of interest have been identified, how they have been managed, and the outcome of relevant commissioning processes - including contract awards to organisations with a member representative on the ICB.

Transparency and accountability around the new NHS Provider Selection Regime

The importance of ICSs having robust governance mechanisms and clear processes for managing conflicts of interest is also evident when looking at the NHS' new Provider Selection Regime (PSR) which replaces the previous NHS procurement rules.

Given that billions of pounds worth of NHS spending will be subject to this new regime, IHPN strongly supports strict requirements for transparency under the new PSR, not least due to the aforementioned presence of provider organisations on ICBs which heightens the risk of conflicts of interest unduly affecting contract awards and thereby undermining public confidence in the regime.

NHS England is currently developing guidance around the new PSR and it's important that these include clear and transparent processes around when an NHS contract is carried over/put out to tender/awarded to a providers and what criteria is used. For example, what if a decision-making body explained its decision to award a contract to a provider of poor-quality services (such as those rated inadequate by the CQC) on the balance of key criteria that saw quality rated below service sustainability? Similarly, the rationale for choosing a successful provider may simply lack any form of objective justification. We would therefore like to see statutory guidance which clearly sets out the objective information that should be used and presented by ICBs in the use of the key criteria in the PSR. As far as possible, all criteria should be informed by objective information not subjective judgement. This will help avoid a situation where decision-making bodies are able to use the key criteria as a pretext to justify any decision they wish to take, regardless of the facts of the matter. In addition, decisions around contracts should be clearly communicated, with the reasoning set out in a timely fashion.

In additional to increasing transparency, there also needs to be established processes at a national level for holding ICBs to account. As it stands, an individual or provider can only make representations about a decision of an ICB to the ICB itself which then goes on to investigate and adjudicate on its own decision. This not only gives the impression that new ICBs are a 'closed shop', or "cosy local monopolies", where provider organisations will have undue influence in decisions about services that they themselves may provide, but those organisations who feel that their concern has not been adequately addressed will have no further recourse except to court action – the very opposite of what this new regime is intended to achieve.

IHPN and other stakeholders have therefore proposed a number of alternative mechanisms to resolve the inevitable disputes that will arise in the procurement of NHS services, including giving NHS England a formal oversight role or mirroring some of the arbitration mechanisms set out in the NHS Standard Contract. Establishing a proper mechanism that prevents frivolous complaints from delaying decisions will benefit patients but that also can address and resolve decisions that are not made in the interests of patients and taxpayers without immediate recourse to court action. We welcome the recent engagement that has taken place with NHS England on this issue and look forward to seeing the updated PSR guidance in due course.

Independent health sector involvement in ICSs

The purpose of ICSs is to bring together organisations in a local area and enable them to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. For this more integrated way of working to be a success it's important that every part of the system can come together to improve the health of communities – including voluntary and social enterprise providers, and those in the independent sector. This cannot be achieved when certain providers are excluded – as Social Enterprise UK have previously said, "either we can create a system where people come together to work in the best interests of places and people, or we cannot…if we cannot collaborate and certain providers cannot be trusted, what hope is there for integration?"

This is particularly important for the independent healthcare sector given the significant role in the delivery of NHS treatment. Currently over 40% of NHS community service providers are from the independent sector, and in 2021, almost 40% of NHS ophthalmology, and trauma & orthopaedic patients were treated by independent sector providers. Independent diagnostics providers also deliver almost 10% of NHS MRI scans every year.

Moreover, the independent sector is seen as a key resource for the NHS to utilise as part of the healthcare system's recovery. This year's NHS elective recovery plan makes clear that ICSs should "include local independent sector capacity as part of elective recovery plans and will work in partnership with independent sector partners to maximise activity to reduce waiting times sustainably", and that elective care boards within each ICS should "bring together local providers, including the independent sector, to agree priorities and solve operational challenges". Likewise, the NHS' guidance to ICSs around developing new virtual wards makes clear that "given the independent sector is already a valued partner in many local health and care systems, as providers of a range of NHS healthcare services, the delivery of virtual wards is an opportunity to build on these relationships…Partnerships with independent sector healthcare providers (ISHCPs) may expand local capacity and enhance capability through strong local partnerships with existing acute and primary care providers."

Independent healthcare providers are clearly seen by the NHS as a key part of its strategy to get the healthcare system back on track and should therefore play a key role in new ICSs. While we wouldn't necessarily expect an independent provider to sit on an ICB and have a commissioning function (though this may be appropriate if they are a major local provider of NHS services), they should have a key role to play in ICS sub committees such as Elective Recovery Boards.

However, the provisions within the Health and Care Act make clear that it is prohibited to appoint an individual to an ICB or ICB sub committee if they could reasonably be regarded as "undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise". We believe this will significantly affect the quality of ICB and ICB sub committee decision making and potentially lead to whole sections of local healthcare provision

being unrepresented. This would have a detrimental impact on the elective recovery – IS providers deliver around 40% of some NHS elective specialities and the consequence of this will be that less independent sector capacity will be made available to the NHS and that utilisation of that capacity will be less effective because independent providers will not be around the table when important decisions about planning services are made. Likewise, it would have a similar impact on any committees relating to community and mental health given those sectors which are particularly diverse in terms of provision. Around ¼ of NHS mental health beds are in the independent sector, and around 42% of NHS community service providers are independent organisations.

While independent providers are seen as having a key role to play Integrated Care Partnerships (ICPs), who are charged with developing the integrated care strategy which should set the direction of the system and hence the ICB, these partnerships remain in their infancy, and it's too early to tell how well they will function in holding ICBs to account and ensuring all parts of the health system work together and improve patient care.

Involving independent providers in ICSs is also hugely important in terms of improving the safety and quality of care in a given system. The 2019 NHS Patient Safety Strategy makes clear that there should be a "whole systems" approach to patient safety that does not see artificial barriers erected between the NHS and independent sector (or indeed any provider of any kind). Moreover, regulators such as the Care Quality Commission are "provider neutral" and hold both NHS and independent providers to the same standards. This "whole systems" approach to safety and quality was also a major theme of the response to the Paterson Inquiry, where much important progress has been made in the sharing of data and information of safety issues. Likewise, the recent Healthcare Safety Investigation Branch (HSIB) report on surgical care in independent hospitals recommended that NHS England "ensures that effective processes have been implemented in integrated care systems to identify local capability and capacity of their independent acute hospitals".

It's therefore important that any ICB sub-committees and specialist networks relating to the quality and safety of services should not exclude independent providers, and that any ICS-wide patient safety initiative includes independent providers. This should include, for example, the new NHS Patient Safety Incident Response Framework (PSIRF) which sets out how patient safety incidents should be conducted. Every ICS will have a PSIRF lead who will support patient safeguarding reporting within the ICS, and therefore should ensure all providers in a local area, including the independent sector, are factored into their work. ICSs will also be establishing informal "patient safety specialist networks" to provide the opportunity to discuss "common issues, risks and challenges and support an integrated and standardised approach to improving safety". Again, these should be inclusive of all providers in an area to ensure all safety/quality concerns are raised and understood at a system level.

Improving performance against key national targets/initiatives

NHS waiting lists for both elective care and community services are at record levels. Moreover, polling continually shows that access to NHS services is the public's top concern around the health service.

It therefore must not be an issue of "if" ICSs should meet national waiting time targets and another key initiatives, but rather "how" they can get NHS performance back on track.

Looking at the elective performance for example, the NHS has a clear target to deliver around 30% more elective activity by 2024/25 than before the pandemic. However, NHS elective activity remains below 2019 levels, and despite a clear call for systems to make greater use of independent sector

provision and include them in system wide planning, a recent survey of our members found that the majority (almost 60%) of independent providers have been asked to deliver the same or less NHS elective activity than pre-pandemic, with one in four (25%) providers reporting that they have not been involved in any planning discussions about the elective recovery with their local systems for 2022/23.

Reducing the elective backlog is a national priority and therefore ICSs must work towards achieving this, with local systems held to account for any lack of delivery.

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