

Hypothetical case scenarios: **Procurement, Patient Choice and Competition Regulations**



About Monitor

Monitor is the sector regulator for health services in England. Our job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit.

Introduction

This document sets out how the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 might apply to six hypothetical case scenarios.

These case scenarios are not intended to address all of the issues that might arise under the Regulations, but to highlight some of the core issues that each of the scenarios appear to raise and the key factors that are likely to be relevant to the question of whether or not the conduct is consistent with the Regulations. Whether or not conduct is consistent with the Regulations will ultimately depend on the precise facts of the case.

These scenarios are intended to be used for illustrative purposes only and should not be used as a statement of the law. We may adapt or build on these as our experience grows.

Case 1

Local authorities are responsible for commissioning sexual health services and clinical commissioning groups (CCGs) are responsible for commissioning related services such as termination of pregnancy services (ToP services). A local authority and a CCG decide to enter into a joint commissioning arrangement for sexual health and ToP services. A five year contract with an existing provider has come to an end. There are other providers in the area that could provide sexual health and ToP services. However, the CCG and local authority are happy with the current services. There is high patient satisfaction, outcome targets for reducing sexually transmitted infections are being met, teenage pregnancies have reduced and chlamydia screening has improved within a reduced budget. The provider also has a strong relationship with other organisations including local GP practices, mental health services, social services and local schools. This has had a positive impact on vulnerable young people in the local area in particular with the different organisations working closely together to address their complex needs. Both the CCG and the local authority are concerned about a risk of fragmentation and a loss of continuity of care and believe that the expense of a full retender is greater than continuing with the existing provider. They decide to extend the contract for another five years. This view is supported by the local Healthwatch. Would this decision be compatible with the Regulations?

Answer

The Regulations do not apply to local authorities. However, CCGs are required to comply with the Regulations when procuring NHS health care services. This means that where CCGs work with local authorities to commission a combination of health care services and public health services jointly, the CCG will need to ensure that any health care services are procured in a way that is consistent with the requirements of the Regulations. This will even be the case where it is the local authority that takes the lead in any process of selecting providers and awarding contracts. These requirements include, in particular:

- the requirement, when procuring services, to act with a view to **securing the needs of people** who use the services and **improving the quality and efficiency** of the services including through the services being provided in an **integrated way** (Regulation 2);
- the requirement to procure services from those **providers that are most capable of securing the needs of health care service users** and **improving the quality and efficiency** of services and that provide the **best value for money** in doing so (Regulation 3(3));
- the requirement to consider appropriate means of **improving services** including through **enabling providers to compete** to provide services and **allowing patients a choice of provider** (Regulation 3(4));

- the requirement to secure that arrangements exist to **enable providers to express an interest in providing any services** (Regulation 4(4));
- the requirement to act in a **proportionate** way (Regulation 3(2)); and
- the requirement to act **transparently and not to discriminate** between providers (Regulation 3(2)).

The CCG will also need to consider whether Regulation 5(1) is relevant. Regulation 5(1) provides that a commissioner may award a new contract for NHS health care services to a provider without tendering the contract where the services are capable of being provided only by that provider.

There are a number of issues the CCG will need to consider in deciding how to proceed including:

1. The CCG will need to evaluate the needs of the local population for ToP services and assess how best to secure those needs. The CCG will need to consider how it can secure the needs of all of the population for which it is responsible, including those vulnerable members with more complex needs. Given that the contract with the existing provider has been in place for five years, the CCG will need to consider whether the needs of the population for ToP services may have changed during this period and what it might be able to do to improve ToP services, before deciding whether to continue to contract for the same service specification.
2. There is high patient satisfaction with current services, targets for reducing sexually transmitted infections are being met and teenage pregnancies are falling within a reduced budget. The provider also has a good working relationship with other organisations that provide health care and social care services in the area and also with local schools and this is having a positive impact on vulnerable young people in the area in particular. This may suggest that the existing service specification is working well. Nevertheless, in determining the appropriate service specification the CCG is likely to want to do some verification to make sure that there is not scope for further improvement.
3. The CCG will also need to consider whether services could be improved by allowing patients to choose between more than one provider. Choice could be introduced by using the Any Qualified Provider (AQP) approach or by entering into contracts with more than one provider (including the existing provider). This could incentivise providers to improve their services to increase the number of patients that choose them over other providers. For example, providers might increase the speed at which they provide test results to patients, extend their opening hours or improve their amenities. The CCG is not required to extend patient choice, but would be expected to have considered the advantages and disadvantages of doing so in reaching a decision on how to procure the services.

4. The CCG will also need to consider how it might address its concerns over fragmentation and continuity of care. There are a number of ways in which the CCG could seek to make sure that sexual health care and ToP services are provided in a joined-up way, including with other services. The current provider has strong working relationships with various organisations. The CCG should consider what it can do to make sure that these relationships are preserved and/or that new relationships with these organisations are established by any new provider or providers. For example, the CCG could require potential providers to supply evidence of how they would cooperate with providers of other related services (including mental health, primary care, education and social services) and build appropriate requirements into its contracts, such as requiring multi-disciplinary coordination meetings and integrated IT systems. The CCG should also consider what it can do to make sure that any cross-agency arrangements that have been put in place for particular individuals that are working well are carried forward as part of any new arrangement entered into by the CCG.
5. The existing provider is not the only provider in the area that is capable of providing sexual health care and ToP services. Regulation 5(1) will not therefore be relevant. Before reaching a decision on whether or not to competitively tender the services, the CCG will need to be satisfied that the existing provider is the most capable. In practice, the CCG will need to be confident that the provider is best placed to meet the ToP services needs of the local population and that it delivers the best value for money. The CCG is happy with the provider's performance. There is high patient satisfaction and the services are well integrated with services provided by others, for example. However, the CCG will need to satisfy itself that another provider or providers could not do even better and drive further improvements in services. The CCG will need to think about the evidence it will require to reach a decision. Even where the CCG decides that the existing provider is the most capable, it should still consider whether it might get better value by running a competitive tender process. The CCG expects that the expense of a full retender would be greater than continuing with the existing provider. The CCG should consider whether a tender process could be designed so that it secures the benefits of a contested process but is proportionate.
6. The CCG would also need to consider what steps it should take to ensure that providers can express an interest in providing the services and to satisfy itself that it has acted transparently and has not discriminated against other providers. The CCG might consider, for example, announcing its intention to extend the contract on its website and Supply 2 Health before doing so, setting out the key elements of the contract and the reasons why it considers it appropriate to continue with the existing service, so that other providers are aware of its intention and able to express an interest in providing the services. In the event that the CCG receives

expressions of interest, it would need to ensure that its engagement with providers is consistent with its duty of equality. Depending on the circumstances of the case, this may include running a competitive tender process.

Case 2

A CCG is commissioning an INR (anti-coagulation) locally enhanced service from its local practices. The CCG's view is that the lower cost and direct link to dosage and clinical responsibility means that GP practices should continue to be the provider of choice by virtue of the registered list. This view has been tested independently to avoid conflict of interest and subsequently agreed by the health and wellbeing board. The CCG plans therefore not to put this service out to market, but to continue with the current arrangement of contracting with all of the local GP practices. Would this be consistent with the Regulations?

Answer

The CCG would need to ensure that it is acting consistently with the requirements under the Regulations, including, in particular, those listed in the response to case 1 (above). The CCG would also need to make sure that it does not act inconsistently with the prohibition on awarding a contract where conflicts (or potential conflicts) between the interests involved in commissioning the services and providing them affect (or appear to affect) the integrity of the award of the contract (Regulation 6).

There are a number of issues the CCG will need to consider in deciding how to proceed. In particular:

1. Before reaching a decision whether or not to subject the INR (anti-coagulation) service to competitive tendering, the CCG will need to consider whether the GP practices are best placed to provide these services or whether there is another category of provider that could deliver an equivalent or better service. There are a number of reasons why the CCG considers that the GP practices are the provider of choice in this regard, including lower costs and the direct link between the main services provided by GPs to their patients and INR (anti-coagulation) services. The CCG would need to be satisfied that these factors mean that the INR (anti-coagulation) services provided by GPs would inevitably be superior to those provided by any other category of provider. The CCG will need to rely on relevant evidence including, if necessary, independent expertise in reaching this view. The CCG has had its view independently tested. The CCG would need to make sure that this was done by an independent organisation that is recognised as having the relevant expertise. The CCG's view has also been endorsed by the health and wellbeing board. The level of analysis and third party input that the CCG should obtain will depend on a number of factors including the extent to which the view of the CCG is generally accepted by the wider clinical community.
2. The CCG should also consider what steps it should take to ensure that other providers can express an interest in providing the services and to satisfy itself that it has acted transparently. The CCG should consider, for example, announcing on its website and on Supply 2 Health its intention to commission the services from GP practices and its reasons for doing so once it decides that the services will be commissioned as GP services, so that other categories of provider are aware of its intention and able to

express an interest in supplying the services themselves. In the event that the CCG receives expressions of interest from different categories of provider, it would need to ensure that its engagement with these providers is consistent with its duty of equality. The CCG might also consider approaching some other types of provider – eg, community service providers at an early stage to understand whether they consider that they are able to provide equivalent (or better) services and if so how.

3. The CCG will also need to consider what steps it must take to manage the conflict of interest resulting from the financial interest that the member GP practices have in awarding the contract to GP practices instead of other categories of provider.
4. There are a number of different ways of managing a conflict of interest. The INR (anti-coagulation) services are being obtained from all of the local GP practices. It is therefore unlikely to be practicable simply to exclude the conflicted individuals from being involved in relevant decisions and actions. In the example, the CCG has independently tested its view that GP practices are best placed to provide INR (anti-coagulation) services and this has subsequently been agreed with the health and wellbeing board. Although it will depend on the exact circumstances of the case, including the nature of the independent review, these steps may well be sufficient to manage the conflict of interest and prevent it from affecting or appearing to affect the integrity of the award of the contract.
5. Finally, the CCG will also need to ensure that it creates an appropriate record of how it has managed the conflict of interest.

Case 3

A PCT went out to market three years ago for a community dermatology service. A new provider was chosen and is now well integrated with local practices leading to lower costs, educational sessions with primary care and good effective links with third sector organisations. The contract is due to come to an end but the CCG feels that as the service is working well, the cost of a completely new tender process would be high and it has decided, after analysing the market, that it would prefer to retain the current provider. This view is supported by the health and wellbeing board. There are a number of available dermatology providers in the area including one provider that has approached the CCG directly and has expressed an interest in providing the services.

Answer

The CCG would need to ensure that it is acting consistently with the requirements of the Regulations, in particular those listed in the response to Case 1.

There are a number of issues the CCG will need to consider in deciding how to proceed. In particular:

1. The contract with the provider has been in place for around three years. The CCG has carried out an analysis of the market in deciding that it would prefer to stay with the current provider. As part of this analysis, the CCG would be expected to consider what dermatology services it should procure bearing in mind the needs of its local population (which might have changed since the existing contract was let) and whether, and if so how, those services could be improved (even if the CCG considers that the service is working well). It may be that the CCG concludes that the existing service specification is appropriate, but the commissioner should consider whether improvement is possible.
2. In this context, the CCG should also consider whether services might be improved by entering into a contract with more than one dermatology provider so that patients can choose between different providers. This might incentivise the providers to improve their services in order to get patients to choose to receive their treatment at their facilities instead of somewhere else and also improve access for patients by making it possible for them to get treatment closer to their home or work. The CCG could choose to extend AQP or enter into contracts with a small number of the most capable providers. The CCG is not required to extend patient choice, but would be expected to have considered the advantages and disadvantages of doing so in reaching a decision on how to procure the services.
3. The CCG should also consider whether dermatology services could be delivered in a more integrated way alongside other services (eg, primary care services at local GP practices and mental health services). The example suggests that the existing provider is well integrated with local practices leading to lower costs, educational

sessions with primary care and good effective links with third sector organisations. However, the CCG should also consider whether it can improve integration further. The CCG should also think of ways in which it could both introduce patient choice and ensure the delivery of care in a joined up way, for example, by requiring any providers to coordinate effectively with providers of related services, such as, for example, requiring multi-disciplinary coordination meetings and integrated IT systems and requiring providers to carry out other forms of good practice such as educational sessions as a condition of providing the services.

4. There are a number of dermatology providers in the area, including one provider that has indicated an interest in taking over from the existing provider. The CCG will need to consider what steps it should take to ensure that all potentially interested providers are able to express an interest in providing the services and to satisfy itself that it has acted transparently and that its engagement with each of these providers is consistent with its duty not to discriminate between providers.
5. In the event that the CCG decides not to open up the services to the AQP model, the CCG will need to ensure that it selects the most capable provider or providers to provide the services. The existing provider was selected following a tender process carried out three years ago and the CCG thinks the services are working well. However, the CCG will need to be satisfied that three years on, the provider is still the most capable dermatology provider and that there is not another provider that would be a better alternative. The CCG would need to have evidence to support its view.
6. Given that the CCG is aware that there are a number of different providers in the area and that one of them has indicated its interest in providing the services, the CCG should consider whether it would be appropriate to run a competitive tender process in order to ensure that all providers have an equal opportunity to bid for the services and to enable the CCG to compare the relative ability of the providers to deliver the service specification.
7. The CCG believes that the cost of a new tender process would be high. The CCG must ensure that the procurement process that it selects is proportionate. However, given that the PCT carried out a procurement process three years ago, it may be possible to run a competitive tender process at a relatively low cost, for example, by using knowledge and materials developed from that process as a basis. This would limit the main costs of procurement to advertising the contract and evaluating bids.

Case 4

A local acute hospital provides a wide range of elective and non-elective care. CCGs in the local area have concerns over the neurosurgery services provided at the hospital, in particular, the data around the average length of stay of neurosurgery patients at the hospital. The hospital is the only provider in the area that has been designated a major trauma centre. Patients admitted through the trauma centre require access to a range of related services, including neurosurgery. The CCGs initiate a detailed review of the services involving clinicians at the hospital as well as other relevant experts from outside the local area. A collective view is reached that major changes are needed to the way that neurosurgery is provided at the hospital. The CCGs therefore modify their arrangements with the hospital to reflect these changes. Is this consistent with the Regulations?

Answer

The CCGs would need to ensure that they are acting consistently with the requirements of the Regulations, in particular those listed in the response to Case 1.

There are a number of issues the CCGs would need to consider in deciding how to proceed. In particular:

1. The CCGs will want to consider what clinical expertise they need to rely on in deciding how services can be improved. The CCGs have involved clinicians and out of area experts in the review. These could include providers of the same services in other parts of the country. The CCGs would also need to have regard to best practice and relevant clinical guidance (such as Royal College guidance).
2. Given the clinical interdependencies between neurosurgery and other services in the hospital, including the major trauma unit, the CCGs would want to consider how neurosurgery could be delivered more effectively alongside these services. This could include, for example, requiring better coordination between the neurosurgery team/clinicians and the other teams/clinicians responsible for other aspects of a trauma patient's care.
3. Whenever CCGs decide to make a significant change to an existing service, they should consider whether there may be another provider that is better placed to meet the interests of patients such that it would be appropriate to run a competitive process to select a provider or whether it would be appropriate to open up the services to patient choice where it does not already exist (for elective services).
4. The neurosurgery services are provided on both an elective and non-elective basis. Patients have the right under the NHS constitution to choose the organisation that provides their NHS care when they are referred for their first outpatient appointment with a service led by a consultant. The outcome of the review by the CCGs of neurosurgery at the hospital will not affect the right of patients to exercise this choice. Patients will continue to be able to choose which organisation to go to for their first

outpatient appointment with a neurosurgeon (or member of a neurosurgeon's team).

5. In relation to non-elective neurosurgery (where patient choice does not exist), the CCGs will want to consider whether the clinical interdependencies between neurosurgery and other services provided at the hospital mean that it is necessary for the neurosurgical services to continue to be provided by the hospital. CCGs will be expected to have regard to relevant guidance (such as Royal College guidance) and to seek the advice of recognised experts, as appropriate, in deciding whether and to what extent services are clinically interdependent in this way. If the CCGs establish that neurosurgery must continue to be provided by the hospital in order for the major trauma unit to provide safe and effective trauma services to patients, a competitive process to select a provider will be unnecessary.
6. The CCGs would need to consider what steps they should take to ensure that they have acted transparently and in a non-discriminatory way throughout the process. The CCGs might consider, for example, announcing their intention to make changes to the way neurosurgery is provided at the hospital on their websites and on Supply 2 Health at an early stage and inviting third parties to comment on the proposals.

Case 5

There are currently three hospitals in the area with a full A&E department. Another hospital in the area has an urgent care centre. There has been a significant change in the size and demographic of the local population over recent years and a significant amount of time has passed since the services were last reviewed. CCGs have a number of concerns over the way A&E services are currently provided. In particular, waiting times at one of the A&E departments are much higher than the national average and a significant proportion of patients attending all of the local A&E departments have minor injuries or illnesses, which the CCGs believe could be dealt with more effectively and efficiently at an urgent care centre or an out of hours primary care provider. However, the CCGs are concerned that changing the way that A&E services are provided may impact on the availability of other services provided by the hospitals. The CCGs in the area decide to carry out a detailed review of services. What must the CCGs do in order to comply with the Regulations?

Answer

The CCGs would need to ensure that they are acting consistently with the requirements of the Regulations, in particular those listed in the response to Case 1.

There are a number of issues the CCGs would need to consider in deciding how to proceed. In particular:

1. The CCGs will need to assess the need of the local community for A&E services. The size and demographic of the local population has changed significantly over recent years and it is a long time since A&E services were last reviewed. The CCGs will therefore need to consider whether those changes mean that the needs of the local population are different to what they were when services were last reviewed, including, for example, whether the demand has shifted to different locations within the area and whether the nature of the services that the population requires has changed.
2. The CCGs will need to have regard to the different needs of health care users in the area including those that attend A&E with minor injuries and illnesses as well as those presenting with more serious health care issues when deciding what services to procure and how to procure them. The CCGs should also consider the particular needs of vulnerable or socially excluded members of the population and how they can make sure that all members of the community have equitable access to services. This could include, for example, making arrangements to address any linguistic or cultural barriers that might make it difficult for some people to access services.
3. The CCGs should consider what input and evidence they need to rely on in assessing these needs and deciding how best to address them. For example, the CCGs would want to consider what level of engagement with the general public, local patients and patient groups, carers and local clinicians and relevant experts would be beneficial.

4. The CCGs are concerned about the impact of reconfiguring A&E services on the availability of other services. The CCGs will need to ensure that the local community continues to have access to all of the services that it requires following any procurement decision.
5. CCGs should consider, for example, what other health care services need to be available on-site in order for providers to be able to treat patients admitted to A&E safely and effectively and how they can ensure that patients will continue to have access to those services. This might involve making sure that the providers selected to provide A&E services will provide all of these related services or that the services will be available on site from a number of different providers co-located on the same site or located sufficiently nearby to meet patient needs. CCGs should consider what evidence they need to rely on in determining what services are clinically interdependent in this way. CCGs may want to consider utilising experts from outside the local area.
6. The CCGs will also need to consider the knock on effect that any decision to terminate services at one provider may have on its ability to provide other services. For example, the CCGs should consider whether there are any services provided by the existing providers that may no longer be viable if those providers no longer have A&E departments (for example, because a significant proportion of the patients receiving those services are admitted to the hospital through A&E and the remaining volumes are not sufficient to sustain the service). If there are such services, the CCGs will need to consider what steps they can take to ensure that these services continue to be available to patients that require them (including considering whether these services are provided or could be provided by a different provider).
7. The CCGs should also consider how the quality of A&E services in the area might be improved. The CCGs have identified problems with waiting times and with the type of injuries and illnesses that patients are presenting with at A&E. In deciding how to address these issues, CCGs should consider what evidence and expertise they need to rely on. This may include discussing possible solutions with local clinicians, referring to relevant best practice guidance and reviewing initiatives that have been implemented in other parts of the country facing similar difficulties.
8. The CCGs should also consider whether A&E services could be improved by being delivered to patients in a more joined up way with other services, including, for example, services (such as emergency surgery and pathology) that patients may require during their admission to the A&E department and follow up care provided to patients in the community or at their local GP practice following discharge. They may also consider what steps might be taken to ensure that professionals and teams from different disciplines within and across organisations work more effectively with each other so that the care that patients receive is joined up.

9. The CCGs will also need to be satisfied that the providers that they choose to provide the services are the most capable of delivering their overarching objective under the Regulations to secure the needs of local health care users and improve services and that deliver best value for money in doing so. They will also need to ensure that the process that they adopt to select future providers is fair and transparent and provides interested providers an equal opportunity to express an interest in providing the services.
10. It may be that the CCGs are able to identify those providers that are interested and able to provide the services (or able to develop the capacity to do so) and to ascertain the most capable providers in the context of their review of current service provision. However, the CCGs should consider whether there may be advantages to running a more formal tender process.

Case 6

A five year contract for the provision of community ultrasound services has come to an end and the commissioner is deciding what to do next. GPs have generally referred low risk patients to the community provider and higher risk patients directly to the local acute hospital because of the availability of experienced consultants and additional diagnostic equipment which higher risk patients are more likely to require following an initial ultrasound. GPs are satisfied that the arrangement has resulted in improved access to services. However, the CCG has concerns about the quality of services being provided by the community provider. In particular, there have been a high number of false positive tests resulting in many scans being repeated and, in some cases, unnecessary procedures being carried out on patients. Although the local trust has offered access to clinical radiologists to provide second opinions, the terms of the contract have made it difficult for the sonographers at the community provider to access these. Finally, a number of high risk patients attending the community provider requiring urgent follow up specialist care have experienced delays in getting that care.

Answer

The CCGs would need to ensure that they are acting consistently with the requirements of the Regulations, in particular those listed in the response to Case 1.

Among the issues that the CCGs need to consider in deciding how to proceed are:

1. The CCG will need to consider the needs of the local population for ultrasound services and how the existing service might be changed to improve the quality and efficiency of services to better meet those needs. The CCG will need to consider the different risk that patients that require an ultrasound may present in order to ensure that the services that it procures and the way it procures them means that everyone obtains the type of service that they need. This includes ensuring that patients that need to access follow up services are able to do so. The CCG should also consider the accessibility of services. In particular, GPs have identified that having ultrasound services available in the community has improved access.
2. The CCG should also consider how both the quality and efficiency of services can be improved. The CCG has identified a number of problems with the way ultrasound services are currently provided in the community including high false positives (resulting in unnecessary scans and procedures being carried out on patients), inadequate access to suitably qualified staff to provide second level reviews of scans and delays in follow up appointments for patients requiring urgent care.
3. The CCG will need to consider how these issues could be addressed in order to improve quality going forward. It might consider, for example, amending the

service specification to require more accurate scanning and reasonable access to suitably qualified staff and requiring potential providers to submit detailed plans on how they will ensure high quality efficient services. The CCG should also consider what due diligence would be appropriate to test the robustness of these plans and to ensure more generally that the providers are in practice capable of delivering against the service specification, including whether they have (or are able to obtain) the necessary infrastructure and staff to be able to fulfil the contract. The CCG would need to consider what evidence it would need to rely on in deciding how service quality might be improved (including how quality can be measured). The CCG should review relevant guidance, such as NICE recommendations (including on new technologies such as the use of contrast ultrasound). The CCG may also want to seek input from recognised experts (including on how to measure the quality of an ultrasound service).

4. The CCG might also consider building requirements into its contracts to ensure that service quality is monitored throughout the contract and that any concerns over quality are brought to its attention and addressed. The CCG could consider establishing a mechanism by which multi-disciplinary teams could notify the CCG of any inappropriate referrals or any unnecessary scans or procedures performed as a result of ultrasound reports prepared by the community provider to assist in the ongoing monitoring of the quality of the services.
5. The CCG will need to consider what steps it should take to ensure that patients that use the ultrasound services have access to related services, including further diagnostics or treatment where these are required and to ensure that all of these services are provided in a joined up way with the ultrasound services. The CCG may want to consider, for example, whether it would be clinically beneficial for services to be provided at one stop clinics offering access to a range of services. These could be staffed by a single provider or multiple providers. The CCG may also wish to consider how services provided in the community might be delivered in a more integrated way alongside related services provided by the local acute hospital. The CCG might also consider how ultrasound performed in the community is able to work as part of a multi-disciplinary team with access to specialist opinion to review significant ultrasound findings. The CCG could think about what steps it might take so that the patient pathway from the community provider to the acute hospital does not lead to delays in treatment, for example. The CCG might consider, for example, requiring a community provider to share images and reports with the trust and to agree a process for referring patients requiring specialist care that is not available at the community provider.
6. The CCG should also consider whether services could be improved by introducing patient choice, for example by entering into a contract with a

number of different providers of ultrasounds or by opening up the services to AQP in order to incentivise the providers to improve the quality of the services that they provide. For example, providers might increase the speed at which they provide ultrasound results to patients and their GPs or extend their opening hours. The CCG is not required to extend patient choice, but would be expected to have considered the advantages and disadvantages of doing so in reaching a decision on how to procure the services.

7. If the CCG decides not to open up the services to AQP, it will need to consider what process it should put in place to select a new provider in order to ensure that it awards the contract to the most capable provider or providers. Given the problems that the CCG is experiencing with the current provider, the CCG should consider whether it would be appropriate to run a competitive tender process to identify interested providers and compare their relative ability to provide the services. This would also help to ensure that all interested providers have an equal opportunity to express their interest in providing the services. If the CCG decides to competitively tender the services, it would need to ensure that this process is run in an open and fair way and that all potential providers have an equal opportunity to bid for the services.



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