Brighton and Hove Referral Management Service
Frequently Asked Questions for Shareholders

What happened during the negotiations between BICS and the CCG?

- BICS, Beaconsfield and Charter who jointly run the current RMS were requested by the CCG to reduce the costs of the current contract in the spring of 2014.
- The current contract is a block contract of 60,000 referrals, with peer led triage provided on a proportion of referrals. This contract **already excluded** MSK and Dermatology triage, but it did manage the process of picking up the referrals from the Choose and Book (C&B) system and delivering them to the software systems used by the MSK and Dermatology Teams.
- The CCG needed to remove the MSK and Dermatology referrals from the contract as they were commissioning pick up and triage from C&B separately in different contracts. There was no differentiation in the price for different types of referral.
- The CCG approached the RMS and suggested a 58% price reduction, based on a simple reduction in activity for the remaining part of the contract term which was 18 months.
- The RMS team set out to the CCG that this price reduction was not possible as the costs of triage for Dermatology and MSK were not included in the contract price and the costs of picking these up from C&B and passing them to the new provider was a very low cost.
- The CCG returned with an offer for the remaining part of the contract term which represented a 27% price reduction.

Why did BICS and the partner practices not accept this?

- The offer was only for 18 months of the remaining part of the contract term.
- At that stage we were not confident that we would have been able to make the efficiencies to absorb this reduction in price, the staffing and triage costs to deliver the service were in excess of £650k without any premises, non-pay, or other overhead costs
- We were struggling to recruit staff to lead the service given that the contract had so much instability.
- We believed that a procurement would be a better option for us overall and provide more stability in the longer term.

What happened in the procurement process

- **Market Testing**

The CCG started a procurement process and tested the market with a Request for Information from all suppliers. This stated that the possible financial envelope would be £350k – 450k. We responded saying that we could not deliver within this envelope.

- **Invitation to Tender**

An ITT was issued, which stated that the envelope would be £1.5m over 3 years, £500k per year. The ITT set out that any bid that was over this envelope would not be accepted, including that quality and value for money would be evaluated between compliant bids.

- **BICS bid**

We submitted a bid over the financial envelope £1.8m approx. and were disqualified immediately.

Your team are experienced at bidding? How did you decide what should be in your bid?

In building our bid we considered the comprehensive evidence supporting the effectiveness of "real time peer led triage." We also reviewed our patient feedback results which told us that patients value our "never passing the buck" approach and commitment to stewarding them through their journey. With the emerging autonomy of the GP clusters we aimed to give them as much clinical responsibility and control over their referral management as possible. Our bid described a process to gradually devolve some of this clinical responsibility – aiming for GP and nurse led triage to be cluster-based. We knew that the price mattered and we simply were not able to reduce the cost to the £500k per year.

Why did BICS submit a non-compliant bid?

- Our understanding of the specification, its desired outcomes and our knowledge of what makes for effective referral management meant that we struggled to find ways to deliver in the envelope, i.e. peer led triage as the most evidence based effective model.
- The specification was not radically different to the current service specification; the amount of triage required in the first year was not different to the current service.
- The staff costs for the current service are £400k and the triage costs are £150k. Although we had made a large number of efficiencies on the automation of parts of the process, we still were not able to offer this service any less than £680k per year, reducing as the triage reduced. Our model was a Cluster led and embedded delivery in year 2 of the contract.
- We did develop an alternative bid, which was a 95% nurse led triage process with GP oversight, and just came in within the envelope, however we were not confident in our ability to deliver it, having not tested the market for nurses, and did not want to

commit to something that did not have as strong as evidence base or that we were certain we could deliver.

- We also considered submitting a bid and for it to be loss making and not bidding at all.

What consultation did you carry out in your decision making?

- We consulted on these and other options with a range of staff, triagers and we sought the advice of some external advisors (in line with our existing confidentiality agreements)

- We consulted staff and triagers on our approach. Staff were strongly advising to put in a bid that was affordable and delivered the quality that they care about. Triagers were involved in the discussions and were aware of the possibility of submitting a bid over the financial envelope.

Why did you not discuss this with shareholders?

It's very difficult for us to discuss tenders openly with everyone. Once we commit to a tender process we are then bound by the confidentiality of that procurement process. When the formal process started the evaluation criteria was not clear to us, it became clear as we asked questions of the commissioners during the procurement process. We also did not want to be seen to be raising questions about the procurement process in an unhelpful way. You could say we felt caught between a rock and a hard place!

Did you not consider the risk that an external private provider might win this contract?

Yes we did. We were aware that probably the only providers who could deliver this contract at this price was a multi-national or global provider, who's scale meant that they could absorb the costs of the transfer of the TUPE staff, which is approx. £400k.
We overall did not feel it was right to submit a bid at a loss or a bid that we could not deliver.

I don't feel this is very transparent, how can you improve transparency in BICS decision making?

We are really sorry if you feel that we lacked transparency about this process.

It's very difficult in a competitive procurement environment to have open conversations about our choices. Like all NHS providers we are not in an equal power relationship with our commissioners, who have the power to decide whether or not to procure our services. Also when we undertake a tender we are bound by the rules of that process.

We are very open to discussion about how to improve the transparency over our decision making; shareholders are invited to join us at any time in our Executive team meetings,

Board meetings. If there is a way that we can get shareholder input without scuppering a future procurement or breaking our confidentiality agreement with our commissioners when we enter into a procurement we guarantee you, we will implement it. We will seek legal advice on how we might do this in future.