Oxfordshire
Clinical Commissioning Group

Oxfordshire Clinical Commissioning Group
Board Meeting

Date of Meeting: 29 March 2018	**Paper No: 18/19**

Title of Paper: CCG Assurance Framework for implementation of a Provider Collaborative approach to complex commissioning

Paper is for: (please delete tick as appropriate)	**Discussion**	✓	**Decision**	✓	**Information**	

Purpose and Executive Summary:
In recognition of both the operational and financial challenges facing the Oxfordshire system in 2018-19 and beyond, the CCG is keen to explore the opportunities available to formalise the collaborative arrangements emerging with local providers to support improved experience and outcomes for Oxfordshire residents in a more sustainable manner.

In doing so, it is critical the CCG exercises its legal obligations and ensures there is a clear framework within which we can mobilise the service improvements required and facilitate the CCG commissioning services on an outcomes, rather than a transactional basis.

This paper sets out the structure for delivering outcomes based commissioning using a provider collaborative approach. It is written as a standard generic framework which can be applied to any re-commissioning exercise where transformation and integration of services across a range of pathways/providers is a key consideration.

GP Members present do have a potential conflict of interest as partners/shareholders in practices that are operators (or within a group thereof) of services commissioned by the CCG, some of which may be subject to re-commissioning. However there is no specific service or pathway being discussed at this time and so there are no conflicts of interest for any of the Board Members in discussing and agreeing the generic framework.

The paper was discussed at the February CCG Executive meeting and is recommended to the Board.

Financial Implications of Paper:
None

Action Required:
The Board is asked to consider and agree the process described in the framework.

OCCG Priorities Supported (please delete tick as appropriate)	
✓	Operational Delivery
✓	Transforming Health and Care
✓	Devolution and Integration
✓	Empowering Patients
✓	Engaging Communities
✓	System Leadership

Equality Analysis Outcome:
Not applicable

Link to Risk:
Not applicable

Author: Lou Pattern, Chief Executive, OCCG

Clinical / Executive Lead: Kiren Collinson, Clinical Chair, OCCG

Date of Paper: 28 February 2018

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CCG Assurance Framework for implementation of a Provider Collaborative approach to complex commissioning

1. Introduction to the opportunity

1.1 Context

The operational and financial challenges facing the NHS and Social Care are well known and Oxfordshire is no different to other systems in needing to review and consider how it currently commissions services and best exercises the opportunities available to improve outcomes, efficiency and affordability through alternative and new mechanisms going forward.

We have previously worked with local providers collaboratively, both NHS and voluntary sector organisations, to improve patient outcomes and financial resilience; examples of this include the Mental Health Outcomes Based Contract and our 2017/18 System Risk Agreement. However, as our operational and financial challenges increase, as too must our ambition to support new ways of working that better meet the needs of the population we serve. By adopting the principles aligned with Integrated Care Systems, we will be better placed to deliver its strategic aim to commission fully integrated services by 2020.

The CCG's commissioning arrangements need to adapt and centre on population management and outcomes, rather than the transactional approach more commonly adopted when commissioning services; the latter often resulting in a fractured approach to care with multiple handoffs and duplication. This is not the most effective or efficient use of our limited workforce and financial resources and does not provide the best patient experience.

Building upon the transformation work undertaken to date, enhanced by our learning and reflections from the recent public consultation exercise and the experiences of Vanguards and Integrated Care Systems, the need to pursue the transformation and sustainability agenda has not lessened and as such we must consider the opportunities and mechanisms to deliver the outcomes required in a different way.

To address this and deliver the opportunities available, we need to work more closely with local providers who share our ambition for better integration of services and to refocus efforts on commissioning outcomes.

Whilst the concept of Outcomes based Commissioning (ObC) is not unfamiliar, as we consider the needs of the Oxfordshire population and emerging programmes of work, we need to establish a process to support a consistent, open and transparent approach to secure agreed outcomes.

To support this, the CCG has developed the below generic framework that can be applied to any programme to enable more collaboration with local providers, encouraging the formation of Provider Collaboratives. The framework is intended to facilitate the CCG working more closely with Provider Collaboratives in developing new models of integrated care for a range of outcomes in a manner fully compliant with procurement legislation.

1.2 Purpose

The paper below outlines the framework including the requirements sought from any Provider Collaborative for the capability assessment 1 and 2 providing assurance to the Governing Body of the process in place in line with the Public Contracts Regulations 2015 and the NHS Procurement, Patient Choice and Competition (No2) Regulations 2013.

The paper also sets out the structure for delivering outcomes based commissioning with Provider Collaboratives to deliver improved outcomes for our population.

The key success factors that need to be delivered through this process are:

- Improved outcomes for patients;
- Seamless patient journey/experience irrespective of their care needs (i.e. health or social care);

- Health and care services that are accessible;
- Health and care services are local where appropriate;
- Health and care services place a focus on prevention; and
- Health and care system sustainability through reduced system cost

The CCG believes that delivering these benefits will require significant transformation and will need to be implemented by a wide range of health and social care providers working seamlessly together. This will require integrating service provision to sustain quality and outcomes, and transforming pathways, removing non-value adding costs will be a key success factor, as will the realignment of risk and reward across the system to incentivise the right behaviours.

The Provider Collaborative will have to work across traditional service/organisational boundaries to deliver the range of pathways, and commissioners will ideally seek to pool budgets as appropriate across health and social care.

The CCG recognises it does not have all the answers, and neither can it achieve these ambitious outcomes without significant collaboration with the providers.

1.3 Assurance framework – approach

The CCG has been considering the approach to implementation of local pathways of care delivered at population level with defined outcomes through collaboration of providers. This is in line with the national new models of care programme including Vanguards and Integrated Care Systems.

In summary it is proposed to move away from 'silo' style service delivery models with multiple providers on individual activity and finance based contracting models, towards a model that incentivises outcomes. This new type of contracting will reward the right behaviours and align risk with control and influence, giving providers more flexibility to target resources and investment to better meet the needs of patients. This is outcome based commissioning (ObC).

Outcome based commissioning and contracting will enable the CCG and providers to break down organisational boundaries to deliver services in a way that is seamless, proactive, efficient and centred on the patient.

Benefits of ObC:

Increased focus on whole person care	• Aligns incentives across the care economy to deliver the outcomes that matter to patients and the public • Rewards outcomes and not just activity – outcome based commissioning puts resources in the right place in the system to maximize value
Enabling collaboration and integration	• Improved patient experience through reduced fragmentation • Providers are supported, and incentivised, to collaborate in order to deliver whole person care • Delivery of improved models of care

Realising efficiencies in the system	• Promotes investment in prevention, quality improvements and working practices • Can reduce duplication across the system • Opportunities to deliver care in lower cost settings

The key features of Outcomes Based Commissioning and Contracting are:

Feature	Description
Provider Collaborative within an Integrated Care System	The contract will be awarded to a Provider Collaborative within an Integrated Care System which will be responsible for delivering the care (which will be defined by the scope of services and outcome framework) for our population over the contract term. The concept of accountable care and Integrated Care Systems is relatively new to the NHS. The most commonly described model is one which brings together a variety of providers to take responsibility for the cost and quality of care for a defined population within an agreed budget. The Provider Collaborative could take many different legal or organisational forms ranging from loose alliances / partnerships in which providers retain their own autonomy but agree to collaborate, to fully integrated networks of providers, or even new companies or other corporate bodies being established as joint ventures by providers. Different NHS bodies have different powers and abilities to participate in different corporate structures. Some NHS contracts (APMS in primary care) may not be held by some organisations. The legal form of the Provider Collaborative will in part be determined by which bodies are involved and what services are to be awarded. The main contracting arrangements are likely to be one of: 1) A joint venture entity set up by the providers either to provide the services itself, or to sub-contract with the existing providers; 2) One provider as the lead provider with other providers as sub-contractors; 3) Alliance contracting arrangement between the providers. Consideration should be given to the need for potential performance and/or financial guarantees. The structure and governance of the Provider Collaborative will need to allow the participants to adopt a culture of accountability and collaboration within and across health and social care organisations.

Payment based on outcomes	A proportion of payment to the provider(s) will be earned based on meeting a set of patient centric outcomes as well as outcomes for population health and system effectiveness. As the use of payments by results / local and national indictors has expanded, an element of variable payments has become common across NHS contracting, and is recognised as a method by which the CCG may seek to bring about clinical quality improvements and drive transformational change. The objective is to shift service planning and delivery away from traditional activity based contracts, provider orientated intervention models, to one that is focused on the needs of patients and is outcome focused.

Capitated and population based health management	The CCG will move away from using historic long standing contracting arrangements and payment mechanisms (block and payment by results) and work towards capitation budgets for the population. This new approach will support and enable providers to invest proactively in maintaining and managing services based on population needs. It provides an opportunity for transformational change and to integrate service provision around the patients.
Contract length	To allow a Provider Collaborative sufficient time to demonstrate improvement in patient outcomes the contract duration is likely to be longer than traditional contracts, with a standard recommendation (subject to approval on a case by case basis) that contracts should be let for an initial period of 5 years, with extensions options for any period, or periods, up to a further 5 years.
Patient choice	Patient choice will need to be considered in the design of the service delivery model.
Interoperable IT, data and informatics	The approach has three broad informatics functions: • Better care by empowering service users through care (and self- care) planning and managing personal budgets. • Better care delivery and supported professionals through information sharing with and between care settings to inform efficient and effective professional decision-making and the right tools to improve efficiency and productivity. • Better outcomes through expert analytics and tools for the CCG and providers to plan, implement and manage integrated care, including data warehousing and dashboards capability. • Moving to an integrated community based platform which works across primary and community based services. Alongside this, access to reliable, rich and informative data is important for: • Correctly setting up of payment mechanisms - for example in establishing population cohorts and a weighted capitated system. • Robust performance management - the need to be able to robustly measure performance, quality of care, outcomes and efficiencies. • Providers - as the accountable carer, to understand how to improve outcomes for their patients and where to aim interventions. • Measuring effectiveness of activity and interventions on outcomes and quality, with a feedback loop to inform future decisions. • The development of appropriate data sharing agreements and arrangements between provider and commissioner stakeholders.

1.4 Demonstrating capability

CCGs are bound by procurement law. The CCG is clear it will need to comply with the Public Contracts Regulations 2015 and all other relevant regulation and guidance.

In designing any process the CCG needs to be cognisant of potential conflicts of interest arising and ensure that appropriate protections are put in place from the outset as appropriate. The programme

will be managed in line with national guidance *Managing Conflicts of Interest in the NHS* – NHS England (February 2017). Conflicts of interest will be given a high priority within the programme.

To enable the identification of the Provider Collaborative in our current provider landscape the CCG has developed a Capability Assessment process. There are 2 key stages of the assurance framework.

Stage 1: Identifying the Provider Collaborative
Through the release of a formal Prior Information Notice (PIN), the first stage of the process requires the CCG to identify the provider pool (or individual providers) who are then assessed in order to identify the Provider Collaborative to deliver the outcome based contract for the population of Oxfordshire.

Stage 2: Capability Assessment - This is a two part assessment for the identified Provider Collaborative designed to evaluate the ability of these organisations to work on challenges they are currently facing in the health and social economy. It will also test providers' alignment with the CCG's vision and the providers' ability to deliver services.

- **Capability Assessment 1** - This assessment will seek evidence and demonstration of the providers' appetite to deliver the integrated service collaboratively. The CCG will be seeking:
  - Evidence of senior leadership for an outcomes based approach from each participating organisation
  - Evidence of commitment from the respective provider boards to engage in an effective collaborative working amongst Providers throughout the supply chain
  - Evidence of commitment of resources in the implementation phase to reflect the transformational approach
  - Evidence of appetite for transformational change evidenced by commitment to a level of ambition sufficient to deliver a significantly different model of care
  - Evidence of shared governance across the Provider Collaborative including detail of any risk/gain share agreements

- **Capability Assessment 2** - This assessment focuses on the providers' collaborating to further develop and agree detailed solutions for new ways of working required to achieve the outcomes for the new service model. This will include (but is not limited to):
  - Vision and delivery of the transformational model of care including collective responsibility of accountability across the pathway
  - Evidence of achieving improved patient outcomes
  - Mobilisation and Transition
  - Financials including contracting and price and proposed risk/gain share
  - Enablers – workforce/premises/information management and technology

2. Assessment options

2.1 Provider identification

The first stage of the process requires the CCG to identify the provider pool (Provider Collaborative) that will be assessed in order to best support the various priorities identified within this framework.

Subsequent to the release and evaluation of a Prior Information Notice, a number of different options for the identification of the Provider Collaborative are to be considered against each service area including:

- **Option 1** - All local and commissioned providers i.e. all commissioned providers with their core business in Oxfordshire
- **Option 2** - All commissioned service providers for the Oxfordshire population (including providers based outside Oxfordshire); or

- **Option 3** - All potential providers

The CCG recognises that general practice is integral to the delivery of the services, and wish to engage with them in the assurance process. The CCG will therefore be looking to primary care through GP federations to be part of the solution.

Whilst the CCG is seeking the widest possible provider pool to assess, it is recognised that, in light of the overarching objective of delivering Oxfordshire-wide, person-centred care, there are a number of issues that needed to be considered. These can be summarised as:

- Operational risks examples include –
  - stability of the local health economy
  - impact on quality and sustainability of services
  - collaboration

- Process risks examples include –
  - Practical concerns around robustly assessing a large volume of providers within the required timeframes

- Legal risks examples include –
  - There are additional procurement law risks inherent in the assurance process itself. These risks arise in relation to the CCG's obligations under the Public Contract Regulations 2015 and the NHS (Procurement, Patient Choice and Competition) (No 2) 2013
  - Any material change to the requirements could mean the need to re-start the process.

2.2 Evidence to support an approach

In making a recommendation to move forward with one of the three options detailed in section 2.1 above, the CCG needs to consider and evidence a number of procurement-related issues as follows.

2.2.1 NHS Procurement, Patient Choice & Competition (no 2) Regulations 2013

- Whether the CCG has considered competition, integration and choice
- Whether the CCG's process for redesigning services is transparent and open:
- Whether the CCG is taking active steps to move toward implementing improvements for patients;
- Whether the time taken to extend or renew the contract appears reasonable;
- Whether the CCG has weighed the possible benefits or drawbacks of considering alternative commissioning approaches, including alternative providers, in the interim period against the possible benefits or drawbacks of waiting until services are redesigned.

2.2.2 Public Contract Regulations 2015

- Will this be a change to an existing service, and will the change be material?
- Has the service been previously procured?
- What evidence is there of market interest/capability?
- Is there exceptional urgency?
- Does the service have a strong interface with an existing service(s)?
- Is there only one provider (or group of providers) and can this be evidenced?
- Are there concerns about destabilisation of existing services?
- Evidence that the Public Sector Equality Duty will be met
- Evidence that the objectively defined critical success factors required for the service will be best delivered through collaboration

2.3 Evidence to support an approach

A full analysis of benefits and risks associated with each of the three options detailed in 2.1 above should be undertaken by the programme board to inform the decision making process.

Option 1

Benefits	Risks
• • • •	• • •

Option 2

Benefits	Risks
• • • •	• • •

Option 3

Benefits	Risks
• • • •	• • •

Provider pool

After consideration of the risks for each service area to be implemented under the framework, an option should be elected taking into account:

- the need to balance the various operational, process and legal risks described above and;
- which best meets the needs of the CCG in delivering its objectives.

Key features of the provider pool include:

- An understanding of the local health and care system;
- Ensuring stability of the current system;
- Maintaining an element of competition;
- Retain ability of new parties to enter the market via sub-contracting;
- Requiring providers to be accountable for transformation and the delivery of outcomes;
- Maintaining choice and competition in the delivery of services;
- Delivering in-year system benefits; and
- Recognising existing estate that will need to be maintained and utilized.

Provider selection criteria

Criteria used to identify the provider pool include:

- Does the provider possess the necessary regulatory/legal qualifications to deliver any of the in-scope or associated services?
- Does the provider have a good understanding of health and/or social care services in Oxfordshire?
- Is the provider currently providing a service which is critical to the delivery of the coordinated person centred care (in terms of nature or volume of provision)?
- Does the provider have ownership or use under license/lease of infrastructure that is understood to be essential to providing coordinated person centred care?
- Does the provider provide in-scope health or social care services to a significant proportion of the Oxfordshire population?
- Does the provider have proven established working relationships with other providers of health and social care services across Oxfordshire?
- Has the provider shown evidence of collaborative working across Oxfordshire?

2.4 The role of Primary Care

The CCG recognises the importance of primary care, in particular general practice, in the delivery of outcomes for a population. To support the providers, the CCG is aligning their commissioning intentions with those of NHS England through the Primary Care Commissioning Committee. The CCGhas been working with primary care as a sector, through the development of the programme to raise awareness of the strategic review and the opportunities it offers in the implementation of new models of care. General Practice is represented at the Primary Care Commissioning Committee.

Given the importance of primary care to the success of service delivery, the CCG will also expect the Provider Collaborative to start to engage with primary care directly and early in the process. The CCG does not have a preference for the commercial model that may develop between providers and primary care providers. Indeed, the range of primary care providers may form part of a care delivery chain or may be represented as part of a partnership (or other commercial structure such as contracting via a Federation (with a separate legal entity) or with a more loose alliance framework) as part of the Provider Collaborative.

2.5 The role of Social Care

As with primary care, social care provision will be core to meeting the outcomes of the population. It is therefore the intention of the CCG to commission, where possible, integrated services between health and social care. The CCG intends to always have early discussions with commissioners at the County Council and where appropriate will consider social care services in the scope of implementation of appropriate service areas.

2.6 The role of the third sector

The CCG believes that the third sector plays an important role in the delivery of health and social care services and it is their expectation that it will continue to do so. Indeed, the CCG believes the sector's role is critical to the delivery of outcomes and there is an expectation that investment may increase. It is envisaged that like primary care providers, providers will be engaging with the third sector for the appropriate pathways.

3. Other priorities for consideration

A Provider Collaborative is expected to deliver the same vision of integration as the CCG. A number of

enabling work streams will therefore likely be flagged in the supporting Business Case including estates, IM&T and workforce.

- IM&T – it is anticipated IM&T development and implementation will become the responsibility of the Provider Collaborative, however this should be tested on a case by case basis.

- Estates – The CCG sees the effective use of the estate as being a key enabler in the delivery of whole system change, integration and sustainability. Traditional boundaries across the primary, community and secondary estate will have to be overcome, with flexible innovative solutions being required to deliver whole system benefit.
    - How they will work together to deliver value from the estates portfolio;
    - The analysis and evidence they will use when planning a solution;
    - How their estates planning will inform their transformation planning; and
    - Any quick wins they can identify as priorities in the short term to deliver benefit or improve patient experience, service quality and/or affordability.

- Workforce - The Workforce element of the programme is considered to be an area of both significant risk (owing to its complexity) and opportunity. The CCG will seek a Provider Collaborative that looks at innovative ways of delivering the new models of care through skill mix and where appropriate developing multispecialty team to deliver the holistic care.

4. Development of the contract

The Provider Collaborative will be expected to deliver the agreed outcomes in addition to adherence to the NHS Standard Contract, National and Local Quality requirements (for example standards such as waiting times, SUI Reporting). The collaborative will also be required to work with the CCG during the lifetime of the contract on service changes associated with delivering the identified outcomes.

The measures in the contract are likely to be developed over time to reflect the level of maturity of the contract and degree of service transformation expected at each stage. Any changes and variation to these will need to be agreed by the Provider Collaborative.

The outcome framework is a core component of an outcome based contracting mechanism. However there are a range of other components that are developed in parallel and refined together as the final contract is developed. These include the financial envelope, the scope of services and commercial/contract structure. These are discussed in more detail below.

5. Finance

The agreed outcomes will be combined with a payment mechanism in the form of an outcomes based capitated payment approach. This means that a proportion of the total contract value will be determined by performance against the indicators in the agreed outcomes framework. Key indicators and their outcomes will be incentivised to give the Provider Collaborative the opportunity to receive financial payments for successful delivery of outcomes within the proposed contract. A significant component of the contract development is the financial review. The core components of the financial review include the:

- financial envelope for the contract;
- capitation approach and relationship to demographic changes over time;
- financial components of the contract including financial incentives and their relationship to the outcomes; and
- risk/gain share.

5.1 Approach

A detailed financial review will be conducted that, together with the outcomes framework, commercial and contracting considerations and the scope of services will define the final financial envelope, inform the payment mechanism and develop detailed financial projections for the CCG including contract illustrations based on the outcomes and indicators.

The key activities are:

- Agree the financial baseline, i.e. a breakdown of spend by budget/service lines and demographic groups, including how much spend is going to be outside the contract. Key considerations include:
    - Allocate to in/out of scope for outcome based contract;
    - Identify age profiles for spend by service line; and
    - Reconcile with CCG budgets (top-down) and the sum of individual contracts (bottom-up).

- Demographics: Understand the population being served, as well as any mis-matches between different services (such as health and social care).
    - Confirm relevant population;
    - Quantify mis-matches between registered and resident populations; and
    - Agree demographic projection basis with Public Health.

- Produce a projected financial envelope by combining the financial base-case, demographics, scope and services to build a picture of the future on both capitated and total bases. This includes comparison of the do-nothing projection, CCG affordability and funding projections, and an appropriate range of future scenarios. Key considerations include:
    - Apply demographic projections to the financial base-case;
    - Capture other projection assumptions – e.g. inflation and QIPP savings; and
    - Defining the future scenarios to model.

The contract illustration work will commence once the outcome framework and indicators have been developed sufficiently to enable financial quantities to be applied to them.

6. Governance and regulatory considerations

6.1 Governance

The CCG governance arrangements and associated forums are currently being reviewed; however robust governance arrangements to support programmes of this nature will be critical with roles, responsibilities, lines of reporting and decision making processes clearly defined and recorded. Programme governance arrangements will need to align with the revised CCG governance arrangements once confirmed.

6.2 Regulations and guidance

As part of the re-commissioning process the CCG is considering relevant governance and regulatory guidance to ensure the process meets the requirements of EU and UK procurement law.

Consideration has been given to two regulatory aspects in particular, and these are summarised in Appendix 1.

NHS England's Integrated Support & Assurance Process (November 2016) is a relevant consideration to the process, and Appendix 2 provides a checklist against which the CCG will need to test itself to ensure compliance with the ISAP process, irrespective of whether the ensuring process is judged

'novel and/or complex'.

7. Capability Assessment and Evaluation Criteria

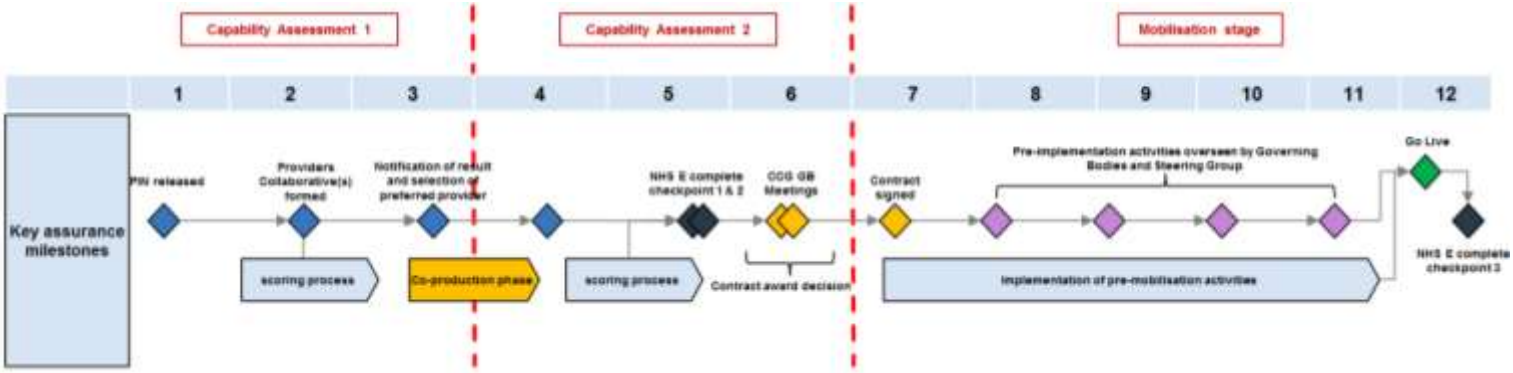
7.1 Description of overall re-commissioning process

As described in section 2, the objective of the re-commissioning process is to implement a number of transformed service areas as prioritised under the programme.

The CCG is identifying providers, and will seek interest in order to coordinate a response to the capability assessment for the range of service areas to be implemented.

The capability assessment is composed of a two stage process. The capability assessment will test the ability of the Provider Collaborative to work collaboratively both strategically and operationally. The capability assessments will give the Provider Collaborative the opportunity to demonstrate to the CCG that they have the ability to meet the future challenge of delivering the pathways through delivery of outcomes.

In the event of failing the capability assessments, the CCG will re-consider their approach to the identification of providers, which may include a further competitive process. By participating in the Capability Assessments the Provider Collaborative will not be precluded from participating in any future procurement process as a single organisation or in partnership with any other organisation(s).



7.2 The Capability assessments

The Provider Collaborative will be required to respond collectively to the capability assessments. However, constituent providers do not all have to play the same role but should contribute in a proportionate way that reflects the impact they can have (or want to have) on the first element of the Capability Assessment.

The Provider Collaborative may also identify other providers or organisations that would, or could, play an important role in delivering an integrated service solution for the CCG, for example, an IT delivery partner or GP federations who may not be a current incumbent but would be beneficial as part of the integrated service. Further, the CCG is agnostic about any future organisational form or the role any single organisation would play in future commercial arrangements. For example, one organisation could take on the role of prime contractor with the others as subcontractors in the care delivery chain or two or more of the organisations may form a contractual joint venture sharing the risk and benefits associated with service redesign and delivery. What is important to the CCG is that there is a single contractual counterparty.

The focus of each capability assessment is described in table 2. The full requirements for Capability Assessment 1 are set out in the following pages of this document, with outline detail on Capability Assessment 2 provided in Appendices 3 & 4.

Table 2:

Capability Assessment 1	This assessment is designed to test the ability of the Provider Collaborative to work together collectively on challenges that are being faced in the health economy. The Provider Collaborative will also need to define elements of their new governance structure for jointly delivering transformed services.
Capability Assessment 2	The Provider Collaborative will need to develop a full service solution with workforce and benefits realisation plans fully described. Investment and reimbursement models will be set out by the CCG which should inform the commercial and organisational models proposed by the Provider Collaborative.

7.3 Structure of Capability Assessments

As mentioned in section 5.2, capability assessment 1 is designed to test the ability of the Provider Collaborative to work together on challenges faced by the health economy. It will also require the Provider Collaborative to set out details of their governance arrangements for working together in the near-term (to address the immediate challenges facing the health and care economy), and in the long-term, (when managing the outcome based contract as a Provider Collaborative).

In order to pass capability assessment 1 providers must provide the evidence as outlined in the assessment criteria.

7.4 Capability assessment 1 - New Governance model

This asks the Provider Collaborative to develop a written Memorandum of Understanding (MoU) which defines elements of their new governance model. There are two sets of information expected to be included in the response, they are:

- The “core” components which describe the governance of the Provider Collaborative in the near term
- The “future” components, which describe the long-term governance structure in more detail

The quality of the response to capability assessment 1 will be evaluated on scale of 1-5, where 1 is “no score warranted” and 5 is “excellent”. Providers will need to score a 3 or “adequate” in both the “core” components and “future” components to pass capability assessment 1.

Assessment 1	**New governance model**
Description	The Provider Collaborative should work together to develop their new governance model for coming together as a Provider Collaborative and taking

Assessment 1	New governance model
	on the responsibility of managing all the health and social care. A single written response is required from the Provider Collaborative, in the form of a memorandum of understanding (MoU), which clearly, and formally, describes their proposed governance model and how it will work from a strategic, commercial, legal and operational perspective. The MoU should contain signatures from the entire Provider Collaborative.
CCG expectations	The CCG will not be prescriptive in the design of the governance model or the resulting MoU. They are looking to test the ability of the Provider Collaborative to identify the key areas that they need to address to deliver an integrated whole system solution. Of paramount importance to the CCG is that the Provider Collaborative has carefully considered their options, can clearly articulate their governance arrangements and how they best meet system requirements. **"Core" components** The CCG has identified areas that the MoU is expected to cover; these are listed below under "core" and "future" components. The components listed here are not exhaustive and it should be stressed that the Provider Collaborative may include any components they believe are important. As a minimum the CCGs will expect the MoU to describe the following core components: • Objectives of the Provider Collaborative; • Governance arrangements including: o Management arrangements including representatives of each provider on any board/partnership group; o Decision making principles; o Voting arrangements; o Responsibilities of the members of the Provider Collaborative; o A description of how changes to the 'consortium' membership be managed; and; o A description of how the consortium will resolve disputes between its members. **"Future" components** The CCG would expect detail on how the Provider Collaborative would function from a legal, commercial and operational perspective. These are the emerging arrangements that the Provider Collaborative may implement. The CCG recognises these may change and will not be binding. Therefore, the "future" components of the MoU may include: · The proposed contractual structure (e.g. lead provider, joint venture, alliance, etc.) for the 'Consortium'. Ideally this will be adequately described so that it is clear how the arrangements will align to the main Commissioning Contract; · As the consortium will operate across traditional provider boundaries, the access of the consortium to all relevant equipment, premises, staff and the cover of the consortium by insurance must be addressed; · Dependent on how the consortium operates, and what services/functions are to be carried out by the Provider Collaborative, there may be TUPE transfers of staff between organisations including, if functions were to be transferred from the CCG from them to providers or the Provider Collaborative. In this case the CCG will need to follow the TUPE processes; · Any proposed risk sharing arrangements;

Assessment 1	New governance model
	· The proposed financial flows; · How changes to the services be managed including case scenarios of how they will identify and manage service changes (e.g. a significant funding switch which will impact on one provider or introduce a new service/provider); · A clear process for incident and complaint management; · Governance arrangements in relation use and development of the totality of the health economy estate portfolio (primary care, community and acute) to deliver best value; · Quality and safety arrangements; and · National performance and legislative requirements. · Exit arrangements from members The MoU should state what role each provider will take on and each provider should sign up to their role. It should be noted this role can be active or passive as each provider wishes it to be as long as this is agreed by the Provider Collaborative.
Interim submission requirements	A draft version of the MoU must be submitted. This draft version **must** include, as a minimum, an explanation of the governance structure of the Provider Collaborative. More detailed information on legal and commercial arrangements is not expected at this stage, but may be included. It is understood that this document will need time to evolve and for others to become part of the governance structure. The draft must include the arrangements the Provider Collaborative plans to take to come to the final structure and a timeline for this plan. The MoU must be submitted alongside a signed document confirming all providers have contributed to and agreed with the submission of the draft MoU. The draft MoU will then be discussed with the Provider Collaborative.
Final submission requirements	A single MoU between all organisations should be submitted. The MoU must be signed by all members of the Provider Collaborative to demonstrate that all providers have contributed to and have agreed with the submission.
Pass/ Fail	To pass the capability assessment 1, all providers must sign a single MoU and the quality of the MoU must be judged to be “good” by the CCG. Providers will receive a fail if the quality of the MoU is judged to be “poor” despite the fact that all Providers have signed it. The quality of the MoU for both the “core” and “future” components will be evaluated in accordance with the scoring criteria below

7.4.1 Scoring of Capability Assessment 1 – New governance model

The “core” and “future” components of the MoU will be evaluated on a 0-4 scale. The Provider Collaborative must score at least a 2 on both the “core” and “future” components to pass capability assessment 1.

The definitions for each score for both components are given in the following table.

Rating	Score	What this means for the “core” components of the MoU	What this means for the “future” components of the MoU	Result
Excellent	4	The MoU is fully comprehensive and has been completely thought through. It adds value to the process unforeseen by the CCGs and more than meets the criteria with a clear description of the role of each provider.	A fully comprehensive MoU which adds value to the process and more than meets the criteria as described.	Pass
Good	3	The MoU has been well thought through and includes a comprehensive governance model covering a range of core components with a clear description of the role of each provider	The MoU has been well thought through and includes a comprehensive governance model covering a range of future requirements.	Pass
Adequate	2	The MoU has been thought through and includes a governance model looking at some key core components with a clear description of the role of each provider	The MoU has been thought through and includes a governance model looking at some key future requirements.	Pass
Weak	1	The MoU is vague in content and only briefly covers the components suggested or any new components. It does not include a clear description of the roles of each provider.	The MoU is vague in content and only briefly covers the components suggested or any new components.	Fail
No score warranted	0	There is no meaningful content within the MoU and it does not comment on the components suggested or any new components. It does not include a description of the roles of each provider.	There is no meaningful content within the MoU and it does not comment on the components suggested or any new components.	Fail

7.4.3 Capability Assessment 2 - performance and delivery

Capability Assessment 2 includes a requirement for a full service solution with transformation, workforce and benefits realisation plans fully described by the Provider Collaborative.

Investment and reimbursement models as well as a detailed commercial model will also be required. An outline of Capability assessment 2 is provided as Appendices 3 & 4.

Criteria 2	Performance
Description	The Provider Collaborative must work together, collaboratively, to develop cross-organisational processes, protocols and propose solutions to deliver the integrated pathways. This is a test of the Provider Collaborative's collective ability to come together and deliver an integrated system benefit including investment and reimbursement models as well as a detailed commercial model.
CCG expectations	The CCG expects the Provider Collaborative to work together collaboratively to achieve the outcomes and KPIs set under each pathway. This will require working with primary care in particular general practice, the third sector, and social care.
Final Submission Requirements	Collaborative response to each of the questions, including investment/reimbursement model across the pathway and detailed commercial model.
Pass/ Fail	The Provider Collaborative must pass the criteria. The scoring of the criteria is being finalised and will be presented to providers for each pathway.

7.4.4 Instructions to the Provider Collaborative

The Provider Collaborative will be required to work together on a single response to both capability assessment 1 and 2. The Provider Collaborative should constitute itself legally and organisationally as it sees fit whilst paying particular attention to any regulatory, legal and financial or tax implications that might arise from the chosen form. The CCG will reserve an absolute right to reject the Provider Collaborative's chosen legal form if that form is not considered to be in the best interests of the local population.

The CCG wants to encourage collaboration and integrated working arrangements, through Capability Assessment 1. Providers will should work together to carry out the activities asked in the assessment.

The Provider Collaborative should also work with General Practice via the GP federations, the voluntary sector and social care providers as appropriate to meet the requirements of the capability assessment.

7.4.5 Provider co-production

The CCG strongly believes in the idea of genuine co-production with the Provider Collaborative. Co-production workshops, as led by the Provider Collaborative, will be held throughout the Capability Assessment process.

7.5 Communication of results

The results of the capability assessment will be communicated to the Provider Collaborative at regular checkpoint meetings which will be established for each service.

APPENDIX 1 – CCG procurement law duties

1. The legal framework of the CCGs' procurement and related commissioning duties

CCG procurement duties – healthcare services

1.1 The Light Touch Regime ("LTR") will apply if the value of the healthcare service contract (as set out in Schedule 3 of the Public Contracts Regulations 2015 (the "2015 Regulations")) will exceed the threshold for the application of the LTR of £589,148.

1.2 The LTR generally requires the CCG to advertise the opportunity (in OJEU or via a PIN), run a fair and transparent tender process treating all bidders equally, and to issue a contract award notice following the process.

1.3 If a LTR process is required, the CCG would have the freedom to design a process and would not be bound to follow one of the prescribed processes set out in the 2015 Regulations (provided that the process was fair and transparent etc.). Other requirements of the 2015 Regulations would apply however, for example, the requirement to keep a detailed audit trail and to produce reports on the process.

1.4 It is clear that there would not be a legal requirement to run a prescribed process. It would be possible to design a process that could both be simple and quick.

1.5 The 2015 Regulations allow for use of the Negotiated procedure without prior publication procedure (Regulation 32) in specific circumstances, which are as follows (there are other exemptions as well as those explained here – although the other exemptions are less likely to apply):

"…where the works, supplies or services can be supplied only by a particular economic operator for any of the following reasons:—

(i) the aim of the procurement is the creation or acquisition of a unique work of art or artistic performance,

(ii) competition is absent for technical reasons,

(iii) the protection of exclusive rights, including intellectual property rights

but only, in the case of paragraphs (ii) and (iii), where no reasonable alternative or substitute exists and the absence of competition is not the result of an artificial narrowing down of the parameters of the procurement"

1.6 The position under (i) and (iii) of the test is highly unlikely to apply to any healthcare procurement process. This means that it is most reasonable for the CCG to argue that they are not required to conduct a tender process if both "competition is absent for technical reasons" and that "no reasonable alternative or substitute exists and the absence of competition is not the result of an artificial narrowing down of the parameters of the procurement".

1.7 The urgency exemption may be available in certain circumstances. Care should be taken when applying the urgency exemption as it is very narrow, namely: "*Insofar as is strictly necessary where, for reasons of extreme urgency brought about by events unforeseeable by the contracting authority, the time limits for the open or restricted procedures or competitive procedures with negotiation cannot be complied with*."

1.8 It is well established that the provisions of EU law will override any contradictory domestic law (such as the NHS Procurement, Patient Choice and Competition (No2) Regulations 2013).

<u>The NHS Procurement, Patient Choice and Competition (No2) Regulations 2013 (PPCC Regulations)</u>

1.9 Notwithstanding the requirements under the 2015 Regulations above, the CCG will still be required to comply with the PPCC Regulations.

1.10 The 2015 Regulations should take precedence when determining whether a process is required to be run in the event the value of the contract exceeds the LTR threshold.

1.11 The PPCC Regulations came into force in April 2013, and impose a range of requirements on the CCG, and apply irrespective of the value of the contract in question.

1.12 The PPCC Regulations need to be considered carefully and the key regulation is regulation 5. Applying the regulation to the CCG, it states:
"A CCG may award a new contract for the provision of healthcare services for the purposes of the NHS to a single supplier without advertising an intention to seek offers from providers in relation to that contract where the CCG is satisfied that the services to which the contract relates are capable of being provided only by that provider."

1.13 The CCG should consider the potential market for the relevant services.

1.14 On one interpretation, it is possible to read the PPCC Regulations as introducing a requirement to place a service out to tender in any circumstances where there is more than one capable provider, regardless of whether or not there is a cross border interest in the services in question and irrespective the value of the services.

1.15 If there is genuinely only one capable provider, the PPCC Regulations provide that CCG may use that reason to exempt themselves from the requirement to conduct a tendering process (the "one capable provider exemption").

1.16 If the PPCC Regulations are read in a less restrictive way, a CCG may consider the one capable provider exemption as simply being an illustration of one of several circumstances in which it would be open to a CCG not to put services out to tender. The meaning of "capable provider" is not defined in the PPCC Regulations and is open to a number of interpretations.

1.17 Whether or not a provider is "capable" will depend somewhat on the requirements specified by the CCG. The scoping of the CCG's requirements will need to be based upon objectively justifiable criteria, and not constructed so as to manufacture a situation where only a particular provider can provide the services in question.

1.18 NHS Improvement's Substantive Guidance on the Procurement, Patient Choice and Competition Regulations (December 2013) (the "Substantive Guidance") stresses that decisions as to how to best secure services in the interests of patients are for the commissioner, and that NHSI will not interfere with such decisions unless those decisions are reached by consequence of a sufficiently serious breach of the PPCC Regulations.

1.19 However, the Substantive Guidance does not provide a CCG with a clear direction as to when it will or will not be appropriate to conduct a competitive tender process. The Substantive Guidance instead provides lists of factors, compliance with which is indicative that the CCG has met the requirements of the PPCC Regulations.

1.20 The Substantive Guidance stresses the importance of demonstrating a clear audit trail of the rationale for each decision made (including any decision whether or not to conduct a competitive tendering exercise in relation to an opportunity).

1.21 Under the PPCC Regulations the CCG must comply with the following duties, amongst others:

"The relevant body must procure the services from one or more providers that:

(i) are most capable of delivering the objectives referred to in regulation 2 in relation to the services, and

(ii) provide best value for money in doing so." [Regulation 3(3)]

"When procuring health care services for the purposes of the NHS, a relevant body must act with a view to:

(i) securing the needs of the people who use the services,

(ii) improving the quality of the services, and

(iii) improving efficiency in the provision of the services.

including through the services being provided in an integrated way (including with other health care services, health-related services, or social care services)." [Regulation 2]

"In acting with a view to improving quality and efficiency in the provision of the services the relevant body must consider appropriate means of making such improvements, including through—

(i) the services being provided in a more integrated way (including with other health care

services, health-related services, or social care services),

(ii) enabling providers to compete to provide the services, and

(iii) allowing patients a choice of provider of the services." [Regulation 3(4)]

1.22 The Substantive Guidance provides further information on how CCGs can meet their duties under the PPCC Regulations in relation to integrated care. In the context of integrated care:

"There is no single model for addressing these challenges and ensuring that care is delivered in an integrated way. What unifies the models for the delivery of integrated care is that all of the different services accessed by a patient care are delivered in a seamless way from the patient's perspective, regardless of whether they are provided by different professionals within an organisation or different organisations altogether" [page 30]

"Some models for integrated care may involve the creation of an "integrated pathway" for all or a number of services that a patient requires. This might be structured in a number of different ways. For example, a commissioner may procure an integrated pathway from a single provider responsible for delivering all aspects of the patient's care, or it might appoint a "lead" or "prime" provider that is responsible for delivering some of the services itself and arranging for other providers to provide the remaining services, or it might commission services from an "alliance" of providers that will work together to provide different elements of the patient's care. The extent to which these models are likely to deliver better integrated care and their impact on competition and choice will need to be considered by the commissioner on a case-by-case basis" [page 32/33]

1.23 In view of the law and guidance outlined above, each case will need to be considered on its own merits; there is no express exemption from running a competitive tender when services are commissioned in an integrated way.

1.24 The key question is therefore whether the CCG can justify that there is only one capable provider. A failure to be able to justify this could lead to a challenge being brought to NHSI, with a supplier arguing that there has been a breach of the PPCC Regulations.

1.25 In deciding whether it needs to run a procurement process to select a provider for services, the CCG will need to consider the most appropriate way of procuring the services so as to comply with law and guidance, and the number of potential providers. To do so, a detailed market assessment could be carried out.

1.26 The Substantive Guidance also suggests potential justifications as:

1.30.1 Only one provider has (or is able to develop) the necessary infrastructure and/or capacity to provide the services in question.

1.30.2 It is necessary for services to be co-located in order to ensure patient safety as a result of clinical interdependencies between the services in question and there is only one provider

that is able to provide all of the services. The commissioner should consider, before arriving at this conclusion, whether it would be possible for some of the services to be provided by different providers from the same location.

1.30.3 It is not viable for providers to provide one service without also providing another service and there is only one capable provider that is capable of providing both services.

1.30.4 There is only one provider that can meet an immediate, temporary clinical need. Such a need is only likely to arise in exceptional circumstances, for example, on clinical safety grounds such as where services have been suspended following regulatory intervention or in response to a major incident.

1.31 It also states that an advert may not be required where:

1.31.1 A commissioner carries out a detailed review of the provision of particular services in its local area in order to understand how those services can be improved and, as part of that review, identifies the most capable provider or providers of those services.

1.31.2 Where the benefits of publishing a contract notice would be outweighed by the costs of doing so.

1.32 The PPCC Regulations do not, therefore, mandate that a tender process has to be run. If the CCG can justify that there is a robust rationale for not tendering then this may be able to stand up to challenge (clearly depending on the strength of the rationale). The decision will therefore depend on the circumstances and therefore it is possible for the CCG to argue the position either way.

<u>Interaction between the LTR and the PPCC Regulations</u>

1.33 The safest position is to ensure that the CCG considers the LTR exemption to requiring a call for competition (regulation 32) as taking precedence over the justifications in the PPCC Regulations for not tendering if the value exceeds the LTR threshold. It has been argued that in complying with the LTR there is a risk that a provider could challenge a CCG for failing to comply with the PPCC Regulations, for example where the LTR requires a tender but under the PPCC Regulations an argument could be made out that a tender would not be required. A challenge is unlikely to be successful given the supremacy of EU law.

1.34 If the CCG complies with the LTR then it is highly likely that the CCG will also comply with their requirements under the PPCC Regulations. The same cannot be said for the other way round – it is not necessarily the case that if the CCG complies with the PPCC Regulations that it would comply with the requirements of the LTR if the value of the contract exceeds the LTR threshold.

<u>An existing contract/amendment to an existing contract</u>

1.35 In considering whether a contract could be varied, the CCG, as a contracting authority for the purposes of procurement law, needs to consider Regulation 72 of the 2015 Regulations.

1.36 Regulation 72 of the 2015 Regulations deals with variations to existing contracts and whether procurement law needs to be considered.

1.37 Regulation 72 has a number of tests that need to be considered. It is drafted so as to set out what will not be considered to be a material variation, and therefore by definition, if the CCG cannot fall within Regulation 72, the proposal will be deemed to be a material variation. If there is a material variation, the CCG is faced with a new contract opportunity that it would be required to procure in line with its procurement law duties (such duties are set out in detail above).

1.40 Regulation 72 is set out below as there are a number of scenarios that may apply.

(1) Contracts and framework agreements may be modified without a new procurement procedure in accordance with this Part in any of the following cases:—

(a) where the modifications, irrespective of their monetary value, have been provided for in the initial procurement documents in clear, precise and unequivocal review clauses, which may include price revision clauses or options, provided that such clauses—

(i) state the scope and nature of possible modifications or options as well as the conditions under which they may be used, and

(ii) do not provide for modifications or options that would alter the overall nature of the contract or the framework agreement;

(b) for additional works, services or supplies by the original contractor that have become necessary and were not included in the initial procurement, where a change of contractor—

(i) cannot be made for economic or technical reasons such as requirements of interchangeability or interoperability with existing equipment, services or installations procured under the initial procurement, and

(ii) would cause significant inconvenience or substantial duplication of costs for the contracting authority,

provided that any increase in price does not exceed 50% of the value of the original contract;

(c) where all of the following conditions are fulfilled:—

(i) the need for modification has been brought about by circumstances which a diligent contracting authority could not have foreseen;

(ii) the modification does not alter the overall nature of the contract;

(iii) any increase in price does not exceed 50% of the value of the original contract or framework agreement.

(d) where a new contractor replaces the one to which the contracting authority had initially awarded the contract as a consequence of—

(i) an unequivocal review clause or option in conformity with sub-paragraph (a), or

(ii) universal or partial succession into the position of the initial contractor, following corporate restructuring, including takeover, merger, acquisition or insolvency, of another economic operator that fulfils the criteria for qualitative selection initially established, provided that this does not entail other substantial modifications to the contract and is not aimed at circumventing the application of this Part;

(e) where the modifications, irrespective of their value, are not substantial within the meaning of paragraph (8); or

(f) where paragraph (5) applies.

(2) Where several successive modifications are made:—

(a) the limitations imposed by the proviso at the end of paragraph (1)(b) and by paragraph (c)(iii) shall apply to the value of each modification; and

(b) such successive modifications shall not be aimed at circumventing this Part.

(3) Contracting authorities which have modified a contract in either of the cases described in paragraph (1)(b) and (c) shall send a notice to that effect, in accordance with regulation 51, for publication.

(4) Such a notice shall contain the information set out in part G of Annex 5 to the Public Contracts Directive.

(5) This paragraph applies where the value of the modification is below both of the following values:—

(a) the relevant threshold mentioned in regulation 5, and

(b) 10% of the initial contract value for service and supply contracts and 15% of the initial contract value for works contracts,

provided that the modification does not alter the overall nature of the contract or framework agreement.

(6) For the purposes of paragraph (5), where several successive modifications are made, the value shall be the net cumulative value of the successive modifications.

(7) For the purpose of the calculation of—

(a) the price mentioned in paragraph (1)(b) and (c), and

(b) the values mentioned in paragraph (5)(b),

the updated figure shall be the reference figure when the contract includes an indexation clause.

(8) A modification of a contract or a framework agreement during its term shall be considered substantial for the purposes of paragraph (1)(e) where one or more of the following conditions is met:—

(a) the modification renders the contract or the framework agreement materially different in character from the one initially concluded;

(b) the modification introduces conditions which, had they been part of the initial procurement procedure, would have—

(i) allowed for the admission of other candidates than those initially selected,

(ii) allowed for the acceptance of a tender other than that originally accepted, or

(iii) attracted additional participants in the procurement procedure;

(c) the modification changes the economic balance of the contract or the framework agreement in favour of the contractor in a manner which was not provided for in the initial contract or framework agreement;

(d) the modification extends the scope of the contract or framework agreement considerably;

(e) a new contractor replaces the one to which the contracting authority had initially awarded the contract in cases other than those provided for in paragraph (1)(d).

(9) A new procurement procedure in accordance with this Part shall be required for modifications of the provisions of a public contract or a framework agreement during its term other than those provided for in this regulation.

1.42 The tests should be considered carefully and applied to the specific circumstances in question if the CCG seeks to vary an existing contract.

Other duties

1.43 The CCG also needs to consider it's legal duties around statutory consultation, and its

compliance with the Public Services (Social Value) Act or the Equality Act. The CCG should also ensure that it considers potential conflicts of interest arising and ensure suitable protections are put in place.

2. Is the CCG required to advertise?

2.1 In considering this question the CCG will need to consider its procurement duties set out above for each contract.

Healthcare contract above £589,148

2.2 If the contract is a healthcare contract over the LTR threshold then, on the face of it, unless the CCG can justify that "competition is absent for technical reasons" and that "no reasonable alternative or substitute exists and the absence of competition is not the result of an artificial narrowing down of the parameters of the procurement, then the CCG will be required to comply with the LTR and advertise the opportunity.

2.3 It may therefore be difficult for the CCG to justify not tendering (i.e. running some form of process) under the LTR. The difficulty in assessing the "technical reasons" exemption, however, is that this is currently untested in case law. Whilst similar wording has previously applied, the case law in this area predominately relates to supply contracts, rather than services contracts. The position is much easier to understand for supply contracts – there could easily be technical reasons why there is only one supplier who can provide a particular solution/comply with a technical specification. This is not so straight forward for services contracts, particularly when it is clear that there are a number of suppliers in the market who provide similar services across the country.

2.4 Consequently, unless there are technical reasons why the services must be provided only by the existing suppliers, there may be a significant risk of challenge if the opportunity is not advertised and some form of process run.

3. The risks of not advertising/Potential challenges

3.1 As with most procurement decisions, the CCG needs to consider the level of risk of a challenge materialising and of that challenge being successful.

3.2 If the CCG is considering awarding a contract to the existing suppliers then these suppliers are unlikely to challenge a decision by the CCG not to advertise the opportunity under the 2015 Regulations/ PPCC Regulations.

3.3 However, the same cannot be said for other NHS bodies, or perhaps other private sector providers, who could seek to challenge a decision not to comply with the CCG's procurement law duties.

3.4 The CCG should also consider the likelihood of a challenge materialising. It is possible for both NHS organisations and private providers to challenge the CCG. It may be the case, however, that NHS organisations considering challenging may have "political" pressure applied to them if they are considering challenging. Whilst the potential for challenge cannot be avoided, these considerations should be fed into the CCG's risk assessment.

Challenge under the LTR

3.5 A challenge under the LTR would be brought via the courts, rather than to NHSI (see section on the PPCC Regulations below). The remedies under the LTR are, however, currently subject to much debate as there is uncertainty as to the application of some of the remedies set out in the 2015 Regulations to LTR contract opportunities.

3.6 What is clear is as follows:

3.6.1 If a contract has been signed following a process or without a process being conducted, and a successful challenge is brought, the challenger could be awarded damages for their loss of profit (based on a loss of a chance) that they would have received should they have been awarded the contract, but for a breach of the 2015 Regulations.

3.6.2 Before the contract is signed, but following the announcement of an award decision, if a challenger issues a Claim Form at Court, the CCG would be automatically prevented from signing the contract with the "successful" bidder until either a substantive hearing takes place, the claim is withdrawn, or the CCG successfully applies to Court to lift the automatic suspension.

3.6.3 It would be open for a Court to set aside the process/decision if the Court found a breach of the 2015 Regulations.

3.6.4 A challenger could seek an injunction to prevent the CCG from taking a particular course of action at anytime.

3.7 What is less clear is whether the remedy of ineffectiveness would apply to a failure of the CCG to advertise the opportunity. This has not, as yet, been tested. The remedy could apply, but this is far from clear cut and the subject of much debate.

3.8 The remedy of ineffectiveness results in a contract being held void, a fine being levied (the value of which should be effective, proportionate and dissuasive), other consequential remedies may flow (for example damages to the successful provider) and also a process may be required to be run. The relevant ground for ineffectiveness that is likely to apply is where the contract has been awarded without prior publication of a contract notice in any case in which the regulations required the prior publication of a contract notice.

3.9 An ambiguity arises in these circumstances as under the LTR the CCG is able to publish a PIN, rather than a contract notice to commence a process and therefore the argument is that as the CCG would not be required to advertise the opportunity with the prior publication of a contract notice, but could use a PIN instead, the ground of ineffectiveness does not apply.

3.10 This is an important issue as if the remedy of ineffectiveness is available, the risks of failing to advertise are clearly more significant than if it is not. Damages claims are notoriously difficult to quantify as the challenger needs to show that they have lost a chance, and the Court will then assess the damages by reference to its assessment of the percentage loss of chance and chances of success of the challenger. This is clearly difficult to determine and/or predict in advance of a final Court hearing. Challengers are therefore faced with an uncertain calculation as to the potential level of damages. For example, should a provider challenge any failure to advertise they, and ultimately a court, would need to determine the chances that such provider would have been successful had a tender been run and secondly, what the loss of profit would have been. Much could depend on what the anticipated profit margin is of the supplier. Contrast this with simply showing that there was an opportunity that should have been advertised, but was not.

3.11 There would remain a risk of challenge to NHSI for a breach of the PPCC Regulations. The CCG's primary focus should be on compliance with the LTR as we consider it unlikely that NHSI could realistically determine that the PPCC Regulations trump the LTR.

APPENDIX 2 – NHS England – Integrated Support & Assurance Process checklist

Stage	Checkpoint questions	State your answer and support with evidence	Author to the answer
Strategy - Making the case for change	**Checkpoint 0 - Early Engagement**		
Whilst developing a strategy	Does the contract trigger the ISAP?		
	Has the case for change been articulated?		
	Has there been appropriate patient engagement or is this planned?		
	What services are included and are they representative of a complex contract?		
	What is the proposed size of the complex contract?		
	Has all possible growth in services over the life of the contract been considered? Do planned consultations cover this?		

	Where multiple commissioning agencies are involved (e.g. multiple CCGs, NHS England direct commissioners, Local Authorities), are all parties in support of the collective approach?		
	What process is intended to be used to procure the services and how will quality, value for money and provider capability be tested?		
	What is the timetable for the ISAP?		
	Has the CCG considered the ISAP and designed the procurement process accordingly?		
Procurement - Provider selection	**Checkpoint 1 - Go to procurement**		
Just before formal procurement starts	Are the plans in line with the NHS Five Year Forward View and applicable frameworks?		
	What benefits is the complex contract expected to achieve for care quality and sustainability and how will they be achieved? Is it a good option for patients and the local health economy?		
	Have the necessary preparations and documents for procurement been completed, including evaluation criteria and methodology?		

	Has appropriate engagement with providers, other commissioners and stakeholders taken place including impact assessment and identification of reasonable mitigations?		
	Has all possible growth in services over the life of the contract been included in the documentation and been consulted on?		
	Has a robust procurement plan been developed and sufficient resources allocated to deliver it?		
	Have any potential subcontracting arrangements been considered and is there a process to consider foreseeable changes to subcontracting?		
	Where an area's Sustainability and Transformation Plan (STP) plan is well developed, are the procurement plans aligned to it? Where it is less well developed, is the strategic intent a good fit to challenges in the local health economy?		
	Where the planning footprint for service configuration is larger than the STP footprint (such as for specialised services) have the plans been tested for congruence with plans at that multi-STP level and issues resolved?		

	What impact do the plans have on the potential viability of commissioners and other providers and how will this be managed?		
	What are the CCG's plans for monitoring performance and managing the complex contract?		
	Has the CCG considered the impact of the complex contract on patient choice and competition, and how will potential risks be mitigated?		
Mobilisation - Managing the go-live	**Checkpoint 2 - Concluding the procurement**		
At preferred bidder stage but BEFORE contract is signed	Has the board effectively mitigated key risks and established effective processes for the continued management of these risks post transaction?		
	Is there a robust and comprehensive plan for delivery of the contract, including integration and realisation of other benefits?		
	Is the integration plan sufficiently supported by clear lines of accountability, governance processes, delivery milestones and dedicated resource?		

	Has the provider met all regulatory and legal requirements (including Monitor licence and CQC registration), and is it planning the contract with reference to good practice guidance?		
	If relevant, are sub-contractual arrangements in place and suitably robust, and is risk appropriately shared?		
Service delivery - Managing ongoing service delivery	**Checkpoint 3 - At point of service commencement**		
Just before service starts	Has the board effectively mitigated key risks and established effective processes for the continued management of these risks post transaction?		
	Is there a robust and comprehensive plan for delivery of the contract, including integration and realisation of other benefits?		
	Is the integration plan sufficiently supported by clear lines of accountability, governance processes, delivery milestones and dedicated resource?		
	Has the provider met all regulatory and legal requirements (including Monitor licence and CQC registration), and is it planning the contract with reference to good practice guidance?		

	If relevant, are sub-contractual arrangements in place and suitably robust, and is risk appropriately shared?		

APPENDIX 3 – Capability Assessment 2 outline

The Process
This stage will consist of two separate elements that will run concurrently with each other – co-production and Assurance.

Co-production
Co-production will comprise of eight elements or milestones, each of which must be successfully completed in order to pass overall. These elements are designed to ensure that the co-production process will be undertaken successfully and achieve the aims originally set out for this stage, namely to engage pro-actively with necessary stakeholders across the region in order to set out how the services will be properly integrated and agree a finalised specification with the CCG. The co-production element of the stage will be provider-led and CCG-assured; committing all parties to an approach to system working that empowers the Provider Collaborative. The individual elements are as follows:

1. **Project Team** – the Preferred Provider must have submitted a list of all relevant members of staff assigned to working on co-production, including roles and contact details.
2. **1st co-production Event** – the first scheduled, Provider-led co-production event must have been held successfully, as judged by the CCG.
3. **Engagement Plan** – following completion of the first co-production event, the Preferred Provider must set out a plan for how they will undertake the remaining engagement process with other relevant providers/stakeholders.
4. **Progress Reporting** – a mechanism for providing on-going feedback to the CCG on progress against the Engagement Plan must be agreed and implemented to the CCG's satisfaction.
5. **Agreed Specification** – by the end of the co-production stage a final specification must have been agreed by both parties.
6. **2nd co-production Event** – at the end of the stage the Preferred Provider must hold a second co-production event summarising the work that has been undertaken during the period and how this aligns to the issues identified at the first event.
7. **NHS England Gateway Approval** – the proposed service and final specification must successfully complete the relevant sections of the NHS England gateway approval process.
8. **Co-production Report** - the Preferred Provider must submit a final report detailing the work undertaken during the co-production period which demonstrates that the necessary outcomes required have been achieved. As part of this the Preferred Provider must also set out how the new service will be developed during the course of the contract, based on the feedback gained during the engagement process.

Assurance
The assurance process will consist of a due diligence checklist split into nine specific areas related to key work stream areas, with each area consisting of a number of sub-criteria designed to enable the CCG to seek assurance as to the chosen provider's capability to provide a safe and high quality service prior to contract award. Each sub-criteria will be assessed on a straight "pass/fail" basis and will list the supporting evidence used e.g. copies of policy documents, certificates etc. to make that determination. All areas must be assessed as a "pass" in order for the Project Board to make a recommendation to proceed to contract award.

Assurance Framework Assessment Areas

Area 1 **Vision** – confirmation that the Preferred Provider has a clear vision in-line with that of the CCG, along with a clear plan for the development of the service over the lifetime of the contract.

Area 2 **Capability/Performance** – confirmation that the Preferred Provider has the necessary capability and experience to provide the required service.

Area 3 **Clinical Governance/Quality** – confirmation that all necessary safeguards, policies and

processes are in place to ensure the safety and quality of the service.

Area 4 **IT** – confirmation that there are appropriate systems and plans in place to ensure the necessary functionality of the service, particularly in regards to the call centre and interoperability with the wider urgent care system.

Area 5 **Workforce** – confirmation that the service will be appropriately staffed and managed with a sufficiently skilled workforce in place. This will include verifying that suitable plans are in place to manage any necessary TUPE transfer from the existing provider.

Area 6 **Finance** – confirmation that the provided costings are within budget, realistic and in-line with the proposed service model set out by the Preferred Provider. Also confirmation that the Preferred Provider offers value for money and is likely to achieve the required contribution to the STP footprint.

Area 7 **Commercial** – confirmation that the Preferred Provider has accepted the main terms of contract and is in a position to sign once the remaining details have been finalised and agreed.

Area 8 **Information Governance** – confirmation that the Preferred Provider meets the necessary minimum IG standards and has appropriate plans and processes in place to deal appropriate with information transfers across the urgent care network.

Area 9 **Mobilisation** – confirmation that a detailed and appropriate plan is in place covering the required milestones and resources required to ensure service go-live.

Timetable for co-production and Assurance

The co-production and Assurance stage will run according to the following timetable:

Milestone	**Date**
Announce result of Preferred Provider to stakeholders. Invitation to Preferred Provider to commence co-production stage.	
1st Bidder co-production Event	
co-production of service specification with Preferred Provider and regional stakeholders	
2nd Bidder co-production Event	
Assurance of co-produced service specification and preferred provider mobilisation plans	
Authorisation to proceed with preferred provider & co-designed service received from Programme Board	
Approval of contract and service from Governing Bodies	
Contract award and mobilisation commencement	
Service launch	

APPENDIX 4 – Capability Assessment 2 - Assurance Framework

Stage	Element	Requirement	Evidence	Project Lead	Date	Outcome
Assurance	Vision	Detailed description of service model in line with project aims				
		Clear plan for development of service of lifetime of contract				
	Capability/Performance	Financial stability and sufficient resources demonstrated.				
		Appropriate insurance in place.				
		Record of experience providing related services.				
		Record of good performance.				
		Record of experience in providing integrated services.				
	Clinical Governance/Quality	Clear governance structure in place.				
		Clear patient feedback mechanisms/processes in place.				
		Clear systems for disseminating learning				
		Appropriate safeguarding training in place.				
		Appropriate safeguarding policies in place covering each of the following: • Safeguarding vulnerable adults • Safeguarding children • Allegations of Abuse/Maltreatment against an employee • Chaperone • Prevent • Privacy, dignity and respect • Assessing capacity and deprivation of liberty safeguards				
	IT	Appropriate systems in place to meet service requirements.				
		Appropriate systems in place to ensure interoperability with wider system.				

	Workforce	Detailed description of workforce.				
		Acceptance of and appropriate plan in place for TUPE.				
		Appropriate recruitment policies in place.				
		Appropriate training/staff development policies and plans in place.				
	Finance	Detailed costings provided and checked to ensure accuracy and sustainability				
		Bid within budget for every CCG				
		Value for money demonstrated/contribution to STP footprint				
	Commercial	Acceptance of NHS standard contract.				
		Acceptance of payment structure.				
		Acceptance of national KPIs.				
		Organisational structure/legal set-up				
	Information Governance	IGSoc Compliance: a) IG Toolkit v.13 level 2 b) Part of the N3 network and use of NHS.net e-mail account for encryption compliance if sending/receiving NHS data				
		ICO Registration to comply with DPA				
		Location of data storage within the EEA.				
		Cloud based storage (if used) compliant with the G-Cloud Framework.				
		ISMS certified to ISO27001 or sufficient plan in place to achieve this.				
		Key sub-contractor(s) compliant with NHS IG requirements and appropriate data sharing arrangements in place.				
		Policies/procedures in place for the safe sharing of data across the relevant network or appropriate plan to ensure this.				

	Mobilisation	Detailed mobilisation plan provided covering all required elements.				
		Appropriate resources identified and allocated.				
		Location of appropriate premises identified.				
Overall						

Notes
The purpose of this assurance framework is to provide evidence that the appropriate due diligence has been undertaken on the Preferred Bidder prior to being awarded a contract sufficient to assure of its capability/suitability.

The above list of requirements serves as a template checklist of the areas required to be assessed prior to a final recommendation to award being made to CCG Governing Body; however each usage of the framework will be adapted to the specific needs of the service area being assessed.

APPENDIX 5 – Template Prior Information Notice (PIN) as a Call for Competition

SECTION I: CONTRACTING AUTHORITY

I.1) Name and addresses *(repeat as many times as needed, please identify all contracting authorities responsible for the procedure)*

Official Name:	
National registration number (if applicable):	
Postal Address:	
Town:	
NUTS Code: http://simap.ted.europa.eu/web/simap/nuts	
Postcode:	
Country:	
Contact Person:	
Telephone:	
Email:	
Internet address(es) Main address *(URL):*	
Address of the buyer profile *(URL):*	

I.2) Joint procurement

The contract involves joint procurement	Yes ☐ No ☐
In the case of joint procurement involving different countries, state applicable national procurement law:	
The contract is awarded by a central purchasing body	Yes ☐ No ☐

I.3) Communication

The procurement documents are available for unrestricted and full direct access, free of charge, at (URL) *(please provide this information here or, where applicable, in the invitation to submit tenders)* ☐ (URL) _____ OR Access to procurement documents is restricted. Further information can be obtained at (URL)

(please provide this information here or, where applicable, in the invitation to submit tenders) ☐ (URL) _____	
Additional information can be obtained from:	☐ the abovementioned address ☐ another address *(please provide)*
Tenders or requests to participate must be submitted:	☐ to the abovementioned address ☐ to the following address *(please provide)*

I.4) Type of the contracting authority

Ministry or any other national or federal authority, including their regional or local subdivisions	☐
National or federal agency / office	☐
Regional or local authority	☐
Regional or local agency / office	☐
Body governed by public law	☒
European institution / agency or international organisation	☐
Other type *(please specify)* _____	☐

I.5) Main activity

General public services	☐
Defence	☐
Public order and safety	☐
Environment	☐
Economic & financial affairs	☐
Health	☒
Housing & community amenities	☐
Social protection	☐
Recreation, culture and religion	☐
Education	☐
Other *(please specify)* _____	☐

SECTION II: OBJECT

Scope of the procurement

II.1.1) Title:	
Reference number *(if applicable):*	
II.1.2) Main CPV code:	
Supplementary CPV code *(if applicable – repeat as*	

many times as needed)	
II.1.3) Type of contract:	Services
II.1.4) Short description: (no more than 1000 characters)	
II.1.5) Estimated total value *(if applicable, as far as information is already known)* *(for framework agreements – estimated total maximum value for the entire duration of the framework agreement)*	Value excluding VAT [ ] Currency [ ]
II.1.6) Information about lots This contract is divided into lots: Tenders may be submitted for: Maximum number of lots that may be awarded to one tenderer: The contracting authority reserves the right to award contracts combining the following lots or groups of lots:	Yes ☐ No ☐ All lots ☐ Maximum number of lots ☐ One lot only ☐ *(if applicable)* *(400 Characters)*

II.2) Description

II.2.2) Additional CPV code(s)	
II.2.3) Place of performance - NUTS code:	
Main site or place of performance: (no more than 200 characters)	
II.2.4) Description of the procurement (no more than 4000 characters)	
II.2.6) Estimate Value	

Value excluding VAT: *(for framework agreements – estimated total maximum value for their entire duration)*
II.2.7) Duration of the contract or the framework agreement
Exact ☐ Range ☐ - Duration in months ☐ Start: _____ - Duration in days ☐ End: _____ Duration: _____
II.2.13) Information about European Union Funds
The procurement is related to a project and/or programme financed by European Union funds Yes ☐ No ☐ Identification of the project: _____
II.2.14) Additional information (no more than 400 characters)

II.3) Estimated date of publication of contract notice: *(dd/mm/yyyy)*

SECTION III: LEGAL, ECONOMIC, FINANCIAL AND TECHNICAL INFORMATION

III.1) Conditions for participation

III.1.4) Objective rules and criteria for participation *(1000 Character limit)* List and brief description of rules and criteria:	
III.1.5) Information about reserved contracts:	☐ The contract is reserved to sheltered workshops and economic operators aiming at the social and professional integration of disabled or disadvantaged persons ☐ The execution of the contract is restricted to the framework of sheltered employment programmes (only in the case of contracts for ceratin health, social and culture services covered by Article 77 of Directive 2014/24/EU) ☐ Participation in the procedure is reserved to organisations pursuing a public service mission and fulfilling the conditions set in Article 77(2) of Directive 2014/24/EU

III.2) Conditions related to the contract *(if applicable)*

III.2.1) Information about a particular profession *(1500 Character limit)*	☐ Execution of the service is reserved to a particular profession (include reference to the relevant law, regulation or administrative provision)
III.2.2) Contract performance conditions *(optional information)* *(1000 Character limit)*	
III.2.3) Information about staff responsible for the performance of the contract:	☐ Obligation to indicate the names and professional qualifications of the staff assigned to performing the contract

SECTION IV: PROCEDURE

IV.1) Description

IV.1.1) Form of procedure	☐ Open procedure ☐ Restricted procedure ☐ Procedure involving negotiations ☐ Award of a contract without prior publication of a call for competition in the Official Journal of the European Union in the cases listed below (please complete Annex D1)
IV.1.3) Information about framework agreement or Dynamic Purchasing	☐ The procurement involves the establishment of a framework agreement In the case of framework agreements, provide justification for any duration exceeding 4 years
IV.1.10) Identification of the national rules applicable to the procedure	Information about national procedures is available at: (URL)
IV.1.11) Main features of the award procedure *(500 character limit)*	

IV.2) Administrative Information

IV.2.1) Previous publication concerning this procedure	*(One of the following: Prior information notice; Notice on a buyer profile – insert OJEU ref number)*
IV.2.2) Time limit for receipt of expressions of interest *(dd/mm/yyyy as far as is known)*	
IV.2.4) Languages in which tenders or requests to participate must be submitted	
IV.2.5) Scheduled date for start of award procedures *(dd/mm/yyyy as far as is known)*	

SECTION VI: COMPLEMENTARY INFORMATION

VI.2) Information about electronic workflows

☐	Electronic ordering will be used
☐	Electronic invoicing will be accepted
☐	Electronic payment will be used

VI.3) Additional information *(4000 character limit)*

This notice is an information gathering exercise rather than a call for competition in its own right, and therefore publication or response does not commit the Commissioner or respondents to a future procurement, nor provide any process exemptions or preferential treatment to any parties expressing an interest. The Commissioner will not be liable for costs incurred by any interested party in participating in this exercise.

Interested providers will be able to view this engagement notice via the 'current tenders' list on in-tend. https://in-tendhost.co.uk/scwcsu/aspx/Home

Or you should be able to go directly to this particular notice by following the link below:
https://in-tendhost.co.uk/scwcsu/aspx/ProjectManage/XXX

In order to return the questionnaire, you will need to 'express an interest' and register on the system and then upload the completed questionnaire to the placeholder provided.

On registration, please include **at least two** contacts to allow for access to the portal in times of absence.

The Services are healthcare services within the meaning and scope of Annex XIV of Directive 2014/24/EU ("the Directive") and Schedule 3 to the Public Contract Regulations 2015 ("the Regulations"). The tendering process will be conducted in accordance with the requirements and flexibilities provided by Articles 74 to 76 of the Directive, and Regulations 74 to 76 of the Regulations. The Authority will run a transparent tender process, treating all bidders equally. For the avoidance of doubt, the Authority will not be bound by the Regulations or the Treaty on the Functioning of the European Union or any other regulations or legislation except for the specific parts or circumstances that apply to the procurement of these Services.

Neither the inclusion of a bidder selection stage, nor the use of any language or terms found in the Directive or Regulations, nor the description of the procedure voluntarily adopted by the Authority ("Open", "Restricted", "Competitive Procedure with Negotiation", "Competitive Dialogue" or any other description), nor any other indication, shall be taken to mean that the Authority intends to hold itself bound by the Directive or Regulations, save by the provisions applicable to services coming within the scope of Annex XIV of the Directive / Schedule 3 of the Regulations. The services are healthcare services falling within Schedule 3 to the Public Contracts Regulations 2015 ("the Regulations") which are not subject to the full regime of the Regulations, but is instead governed by the "Light Touch Regime" contained within Chapter 3, Section 7 of the Regulations (Regulations 74 to 77).

VI.4) Procedures for review

Review body Official name:	
Postal Address:	
Town:	
Postcode:	

Country:	
Email:	
Telephone:	
Internet address: (URL)	
Body responsible for mediation procedures Official name:	
Postal Address:	
Town:	
Postcode:	
Country:	
Email:	
Telephone:	
Internet address: (URL)	
Review procedure Precise information on deadline(s) for review procedures: *(4000 character limit)*	
Service from which information about the review procedure may be obtained ***(if applicable)*** Official name:	
Postal Address:	
Town:	
Postcode:	
Country:	
Email:	
Telephone:	
Internet address: (URL)	