Thank you for the opportunity to give evidence to the Health Select Committee in connection with the Somerset Together programme and the introduction of Outcome Based Commissioning.

I felt that the session was well constructed and gave me sufficient opportunity to share our plans and experience alongside colleagues from Manchester.

You were specifically interested in the reasons for the different advice received by the CCG and County Council in respect of the Most Capable Provider process. I enclose for your information the advice that we received from our solicitors (Wragge Lawrence Graham & Co) in July as to the feasibility of the MCP process and the Council have kindly also provided a statement from the County Solicitor setting out the basis of their advice.

Although the matter was discussed with Monitor, the written advice was from our solicitors and not Monitor, as I incorrectly stated in my verbal evidence to the Committee.

You will note that both statements also refer to the change in regulations for the NHS which I understand to mean that other CCGs will not be able to follow us using the same process. From April 2016 the CCG and Council are both required to use the “Light Touch Regime” rather than the Most Capable Provider.

Both our solicitors and the County Council have consented to these statements of advice being shared with the Committee and being in the public domain.

Please do not hesitate to contact me if you require any further information.

Council View of MCP April 2016

Most Capable Provider Process

The legal basis for the procurement process

1. The rules for health commissioners and local government differ. Health commissioners currently follow the Public Contracts Regulations 2006 and the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013. Local government authorities now have to comply with the Public Contracts Regulations 2015 (‘PCR 2015’).

2. From 18 April 2016, the NHS will be subject to the PCR 2015. This is significant. Under the 2013 Regulations, NHS organisations must procure services from providers most capable of meeting the commissioner’s object to secure patients’ needs and improve the quality and efficiency of services (known as ‘Most Capable Provider’ or ‘MCP’), as well as best value for money. However, they are not constrained to follow a particular process provided they can demonstrate that they have achieved the quality, efficiency and value for money objectives in a way which is proportionate to the value, complexity and clinical risk.
3 For local authorities such as Somerset County Council, the PCR 2015 apply and the services to be commissioned must be procured through one of the procurement processes set out in those regulations. The MCP process, which has evolved under a combined application of the PCR 2006 (Part B) and NHS regulations, is not one of them. Social care services (a function of unitary/county local authorities) fall into the Light Touch Regime in the PCR 2015. Healthcare services for the purposes of the NHS do not fall within the LTR until 18 April 2016.

4 Historically in joint commissioning, the route to market has sometimes been chosen based upon the predominant value i.e. if the predominant value fell within Part B of Schedule 3 of the PCR 2006, there was significant flexibility in procurement of services. But because Somerset County Council is now operating under a different set of regulations without Part B, but instead, the Light Touch Regime, there is no longer any harmony of ‘flexibility’ – that harmony existed to a sufficient degree prior to the PCR 2015 and was useful for joint NHS/council commissioning in the past, including commissioning involving the MCP process.

The decision to proceed with the MCP process

5 The Somerset CCG commenced the MCP process in Autumn 2015. It was satisfied that the MCP process would deliver the outcomes-based commissioning it sought to achieve. At that time, the CCG believed that Somerset County Council would be able to participate lawfully in the MCP process. However, the Council’s solicitor identified the legal issues outlined above.

For these reasons, the Council concluded that it could not be a commissioner for the purposes of the MCP process.

6 The CCG wanted to proceed promptly with the MCP process, having identified that this was their preferred commissioning model. Further, the CCG did not want to wait until April 2016 for the procurement regimes to come together, knowing that at that time, the MCP process would cease to be available to the CCG. The Council has nevertheless continued to provide guidance and assistance to the CCG in line with its duties with regard to public health, including social care. The Council continues to work with the CCG to identify those areas in the MCP process and beyond in which the Council can lawfully participate.

Confidential legal advice from Wragge Lawrence Graham & Co in connection with outcome based commissioning of person-centred care for people with long-term conditions

This note considers the 5 questions raised in Stephen Foster's email dated 6 July 2015. The 5 questions and our responses are as follows:

A. On what grounds is the MCP process authorised under EU or NHS regulations and why can this be used instead of a full open procurement?

a. The procurement of healthcare services falls under Part B of Schedule 3 to the Public Contracts Regulations 2006, allowing the CCG significant flexibility for procuring the Services. The Regulations are set to change in April 2016 for procurements commenced after that time. In the meantime, the 2006 Regulations continue to apply to healthcare services.

b. The CCG is recommended to test and document any assumptions about the
existence of cross-border interest as part of its decision process about which procurement option to use.
c. Where there is unlikely to be any cross-border interest in the Services being commissioned, the CCG is not bound by EU procurement law to competitively tender the services contract, but it may still need to consider competitive tendering in order to comply with the NHS (Procurement, Patient Choice and Competition) (No 2) Regulations 2013.
d. Running a competitive tender for healthcare services is one option available to the CCG. Commissioners will need to make a balanced judgment about what is its best procurement option for service users, based upon the CCG's local knowledge. The CCG can use methods other than a competitive tender to identify the 'most capable' provider.
e. When procuring services, the CCG must procure them from one or more providers that are most capable of delivering services of improved quality and efficiency (and on an integrated basis) and that provide best value for money.

f. Should the CCG decide that there is an obvious most capable provider or providers for the Services, taking into account the health economy in the round, it must articulate a clear rationale for not engaging in a formal procurement and demonstrate how it has tested that a provider(s) is the most capable. We refer to this approach as a 'managed process'.
g. The CCG will need to assess the extent of each potential most capable provider's (each an 'MCP') capability by reference to specific criteria that address the aims and objectives of the procurement.
h. A potential MCP's service proposal will need to convince the commissioners of its understanding of and intention to adhere to the underpinning principles of Outcomes Based Commissioning ('OBC').
i. A positive outcome of the managed process for a MCP would enable the CCG to work with the identified provider to develop the contractual terms and move towards delivery of the new service model.
j. The alternative to using a managed process to identify the MCP is to run a competitive tender following a formal procurement process. For complex requirements or those requiring innovation, a dialogue process can be followed to enable discussion with bidders about possible solutions.
k. From a procurement law perspective running a competitive tender is the option which presents the lowest risk since it involves an objective assessment of a range of bids in which quality and value for money are assessed and in which all interested parties can take part.
l. Full details of the legislative background are set out in Appendix 1 to this advice note.

B. What are the key risks the CCG (and its fellow commissioners) face (with regard to procurement challenge) in following an MCP route?

a. The benefits of running a managed process to identify the most capable provider or providers include:
   • Reduced risk of destabilising existing service provision;
   • Existing providers are likely to have a better understanding of the local health economy than incoming ones;
• Existing providers are likely to have a better understanding of service users' needs;
• Can be a quicker and less resource-heavy process;
• Allows focus on service improvement and integration rather than the ability to win a bid;
• Less expensive than competitive procurement at scale;
• A more flexible approach is possible, borrowing from, but not constrained by, procurement processes;
• Reduced risk of issues arising from service transition/mobilisation.

b. The risks or challenges that could arise in using a managed process to procure services include:
• The process inherently lacks competitive tension; how can providers be made to go further faster?
• Entrenched views and positions may be hard to overcome;
• Requires a new mindset and cultural change;
• Harder to demonstrate value for money and that the CCG has indeed identified the most capable provider(s) rather than the easiest option;
• Risk of challenge from providers not involved in the process – how is their non-involvement justified?
• It could suggest that the CCG is 'playing it safe' and is in thrall to incumbent providers;
• It is an untested approach in the new environment of the 2013 Regulations.

c. Should a complaint be made about the direct award of health care contract, the question for determination by Monitor is likely to be whether the lack of a competitive process has led to the best possible provider not having been secured for the patient population rather than the lack of a procurement process itself. In our experience, commissioners need to consider and explain the decision for the direct award of a contract and to follow a robust process in forming that view. Provided the decision is based upon available evidence, sets out the various factors which have been taken into account, and is reasonable in light of those factors, any challenge to the award can be robustly defended, even if individual service users disagree with the outcome reached.

C. Can multiple MCPs be used for the same geographic area in order to create or test competition between providers?

a. It is possible for the CCG to run multiple managed processes to identify a range of 'most capable providers' for different elements of healthcare services. And so, it may, for example, seek to identify its most capable provider of community services under one process and its most capable provider of mental health services under another process. These providers could then be invited to work together as part of an integrated pathway.

b. Equally, we have seen various health and social care services 'packaged together' as part of a single managed process under which a most capable provider or, more likely, a group of providers is identified to assume responsibility for the provision of the Services.

c. Within a managed process our experience to date has been to run a 'desktop' exercise under which different providers capabilities are tested and evaluated. It would be possible as part of that process to invite competing proposals from potential providers. Having said that however, that moves ever closer to an open procurement and it may be difficult to explain or justify why some providers were invited to submit proposals and others were not.
D. How can County Council social care (as commissioners or providers) engage in the MCP process?

a. The County Council is not subject to the NHS 2013 Regulations but rather the Public Contracts Regulations 2015 (PCR2015) (introduced into UK law earlier this year).

b. Social care services are already subject to a new 'light touch regime' (LTR) under the PCR2015.

c. As noted above, healthcare services for the purposes of the NHS do not fall within the light touch regime until 18 April 2016.

d. For joint commissioning, involving commissioning of health care services by a CCG and social care by a local authority, the rules are silent - as is (disappointingly) the Crown Commercial Service guidance issued recently on the LTR.

e. Our view on the position is as follows: on a strict interpretation of Regulation 120 of the PCR2015 (below), the regime would not apply to a procurement involving joint commissioning until 18 April 2016. Regulation 120 says this:

Nothing in these Regulations affects—
(a) any contract award procedure that—
(i) relates to the procurement of health care services for the purposes of the NHS within the meaning and scope of the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013(b), and
(ii) is commenced before 18th April 2016; or
(b) any contract awarded as a result of such a procedure.

f. In our view, commissioning of healthcare services by a CCG together with some social care services is a “contract award procedure that… relates to the procurement of health care services” – despite also relating to social care.

g. That, by definition, is a pragmatic view. The other view (which we do not necessarily accept) is that one should apply the ordinary rules around classifying contracts with a mixed element (i.e. look at which element counts for the greater value, and take it from there).

E. Assuming a multiple provider route, what happens if one of these ‘coordinating providers’ drops out of the MCP process, can the process continue?

a. We have seen examples where a pool of most capable providers has been identified by commissioners and who initially appear willing to take on the collective risk/reward model of an outcomes based contract. It is perfectly possible that as negotiations and discussions progress, that one or more providers form the view that they should not be part of the lead provider group/consortia that is responsible for the delivery of the services and associated outcomes.

b. In those circumstances, it will be necessary for commissioners to consider whether the provider in question should remain part of the ‘supply chain’ – perhaps providing its services as a subcontractor to one of the lead providers or whether its contribution can be covered by another provider.

c. Ultimately, of course, if too many providers withdraw from the process then it may simply be impractical to proceed with the remaining providers. Each circumstance will be
different and factors will include such matters as the scope of services in question, the capability and capacity of the remaining providers and their willingness or ability to assume the contractual risks which are an inherent part of outcomes based contracting.

Appendix 1

1. Legislative Background

1.1 Both EU procurement law and the NHS (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 (the ‘2013 Regulations’) apply. This section of the advice sets out the legal framework which will inform the CCG’s choice of an appropriate procurement option.

EU Procurement Law

1.2 For healthcare services, the relevant EU public procurement Directives are transposed into UK law by the Public Contracts Regulations 2006 (the ‘2006 Regulations’). These remain in force for healthcare related services until April 2016.

1.3 The 2006 Regulations apply to contracts for services being let by contracting authorities, including NHS clinical commissioning groups. Services under the 2006 Regulations are categorised as either Part A or Part B services. Generally, the EU public procurement Directives and the 2006 Regulations apply to Part B services to a limited extent only; healthcare services and social care services are categorised as Part B services.

1.4 Under EU public procurement law, a contracting authority must advertise a Part B services contract if the contract in question would be of interest to a provider in another EU member state – i.e. of ‘cross-border interest’1. Further, if the value of a contract for services is above a specified threshold (currently £111,676) and of cross-border interest, the general EU procurement law obligations of transparency, equal treatment, non-discrimination and proportionality will apply to the procurement process used by the authority. Case law has confirmed that complying with these obligations means that the contracting authority must ensure that the opportunity is advertised to a “sufficient” degree so as to open up the opportunity to competition from the relevant provider market. In practice, once ‘cross-border interest’ is identified, most contracting authorities will follow a procedure which involves a competitive tender.

1.5 In practice, healthcare commissioners have often concluded that contracts for services do not have a cross-border interest and they have therefore considered themselves free to proceed to negotiate and award contracts outside of the public procurement regime.

1 The question of cross-border interest is a question for determination in each case but will involve a consideration of the sector involved (size and structure of the market, usual commercial practices etc.) and the geographic location of the place of performance. The consideration of the question by the authority, including the steps taken to establish the likelihood of any cross-border interest, should be recorded in writing so that it can be referred to in a robust evidential trail if challenged.

Nevertheless, if challenged, the CCG would need to be prepared to demonstrate that it
was satisfied that this was a safe conclusion to have reached, and one based on adequate evidence. The CCG is recommended to consider whether the contract for the Services is of cross border interest and hence whether EU procurement law applies, and hence whether there is a requirement to advertise the opportunity.

1.6 We anticipate that the CCG will have its own internal requirements such as standing financial instructions, which mean that it must follow a particular procurement protocol depending on expected contract value.

1.7 Where an authority determines that a contract is unlikely to be of cross-border interest, then it can be concluded that the proposed contract does not fall within the scope of the EU public procurement Directives or the 2006 Regulations. As such, contracting authorities are free as a matter of EU law to negotiate and award contracts without running a competitive tender. Note however, this freedom to negotiate and award is subject to any separate requirements – unconnected with EU public procurement law – to open up some level of competition, including the 2013 Regulations. The NHS-specific regime is discussed in paragraph 4.9 and following below.

1.8 It should be emphasised that should a contracting authority elect to run a competitive tender for the provision of health and social care services (notwithstanding the non-application of EU procurement law or the 2006 Regulations) then it is expected to comply with general principles of fairness (transparency, equal treatment etc.) and of good administration.

1.9 The CCG should note that a new EU Directive covering public procurement (2014/24) is likely to be brought into force in the UK within the next 12 months (possibly earlier). When implemented in UK law, the new Directive will render the 'cross-border interest' test inapplicable – at least in relation to contracts worth in excess of a financial value of €750,000. Instead, the new law will require automatic advertisement in any instance where the estimated contract value exceeds the €750,000 threshold. This may result in many more health care contracts having to be advertised (as a matter of EU law) than at present.

The 2013 Regulations
1.10 The 2013 Regulations apply to Clinical Commissioning Groups (CCGs) and to NHS England, and operate alongside the 2006 Regulations outlined above.

1.11 The 2013 Regulations provide a bespoke set of rules for healthcare commissioners (specifically CCGs and NHS England) and provide a mechanism for Monitor, as the sector regulator, to investigate complaints about the procurement of healthcare services. There is no financial threshold under the 2013 Regulations and they therefore apply to the procurement of all contracts for healthcare services.

1.12 The overriding objective in the 2013 Regulations is set out in Regulation 2. This confirms that, when procuring healthcare services, NHS commissioners (for the most part CCGs):

“must act with a view to
(a) securing the needs of the people who use the services,
(b) improving the quality of the services and
(c) 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).”

1.13 Regulation 3 of the 2013 Regulations sets out a number of general requirements which apply to CCGs when procuring healthcare services. Significantly, Regulation 3(3) provides that the CCG must:

“procure the services from one or more providers that
(a) are most capable of delivering the objective referred to in Regulation 2 in relation to the services, and
(b) provide best value for money in doing so”.

1.14 Regulation 3(4) is also important in this regard. This provides that “in acting with a view to improving quality and efficiency in the provision of the services,
the [CCG] must consider appropriate means of making such improvements, including through:

- the services being provided in a more integrated way (including with other health care services, health-related services, or social care services),
- enabling providers to compete to provide the services, and
- allowing patients a choice of provider of the services.”

1.15 Monitor has issued a publication entitled “Substantive Guidance on the Procurement, Patient Choice and Competition Regulations” dated December 2013 (‘the Monitor Guidance’).

1.16 The Guidance articulates the following principles for commissioners of healthcare and social care services:

- it is for commissioners to decide what services to procure and how best to secure them in the interests of patients;
- commissioners will need to consider what steps they have taken to identify providers that might be interested in providing the services, and in some circumstances, commissioners may be able to identify interested providers based on their knowledge of the market, whereas in other circumstances they may need to advertise their intention to procure services;
- commissioners must procure services from one or more providers that “are most capable of securing the needs of NHS healthcare service users and improving the quality of services and the efficiency with which they are provided; and provide best value for money for doing so”;
- commissioners must consider appropriate means of making improvements in quality and efficiency through services being provided in a more integrated way (including with other healthcare services, health-related services or other social care services);
- it is for commissioners to determine ways of improving the quality and efficiency of NHS healthcare services including the extent to which improvements can be achieved through providing services in a more integrated way, by allowing patients the choice of provider and/or by enabling providers to compete for contracts to provide services.

1.17 Clearly, commissioners have a range of options about how to procure healthcare services; competitive tendering for the opportunity is an important option, but is not the only option. The Monitor Guidance gives examples of when a competitive tender may not be appropriate. These include:

- where there is only one provider that is capable of providing the services in question. Regulation 5 (3) of the 2013 Regulations makes it clear that, in these circumstances, commissioners may award a contract to a provider without advertising the opportunity. Some examples of where this might apply are given on page 41 of Monitor’s Guidance.
- where the commissioner carries out a detailed review of service provision in a particular area to understand how those services can be improved and, as part of that review, identifies with reasonable certainty the most capable provider or

2 See Substantive Guidance on the Procurement, Patient Choice and Competition Regulations, Monitor, December 2013, paragraph 3.2.3;
3 Regulation 5 provides that ‘a relevant body may award a new contract …without advertising an intention to seek offers from providers …where the relevant body is satisfied that the services…are capable of being provided only by that provider.’
providers of those services, then it may be appropriate to negotiate directly with the
provider (or, by extension, the providers) in question.

1.18 The Guidance states that a commissioner may conclude that there is only one
capable provider where that provider has (or is able to develop) the necessary
infrastructure (facilities, equipment etc.) and/or capacity to provide the services in
question such as where there is only one provider capable of providing specialised
services.

1.19 The Monitor Guidance clearly states that a competitive tender process is not the
default mechanism to be used when purchasing healthcare services and the clear
message is that commissioners need to consider matters on a case by case basis. A
balanced judgment is required based upon local circumstances. The Guidance states
(page 37) that:

“Local circumstances vary, so the decision of how to go about procuring services
(including, for example, whether to publish a contract notice) is a matter for
commissioners, having due regard to the requirements of the [2013 Regulations] set out
above. Commissioners need to make an informed and balanced judgment on the mix of
factors relevant to their local circumstances. What is relevant will depend on the
circumstances, but may include, for example: existing provider performance; ensuring
service sustainability; delivering care in a more integrated way; whether there is likely to
be more than one capable provider; whether providers have expressed an interest in
providing the services or are likely to be interested in providing them; whether it would
be beneficial to enter into a contract with one provider, several providers or all providers
of the service; how much time has passed since services were last reviewed; and the
value of the contract and the costs associated with running the different procurement
processes being considered. Commissioners will need to balance the short-term and
long-term impact of their commissioning decisions (including the potential impact of any
procurement decision on the sustainability of services).”

1.20 The focus of the Monitor Guidance is upon stressing that local circumstances will
be different for each CCG and that it is for the local commissioners to determine what is
right for its local population in light of its understanding of the local requirements and
needs, and its knowledge of local service provision: for example, satisfaction with
existing provider performance, the need for facilities/investment, a desire to integrate
services across the health and social system. Recognising the mix of factors that come
into play, the Guidance states (page 38) that "commissioners should only introduce
competition where it is appropriate for local circumstances and in the best interests of
patients".

6 May 2016