New care models

Procurement and Assurance Approach

Accountable Care Organisation (ACO) Contract package - supporting document

Our values:
clinical engagement, patient involvement, local ownership, national support

August 2017

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Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Introduction

1 This paper has been produced to support the Accountable Care Organisation (ACO) Contract for accountable models, and provides information to commissioners around likely considerations for the procurement of an MCP. It is not intended to replace the need for local procurement or legal support, it does not set out an exhaustive list of requirements and it does not offer guidance on how individual processes should be run. However, it does set out latest thinking around the likely common issues and solutions facing commissioners. It sets out the regulatory landscape, updates on the development of the Integrated Support and Assurance Process by NHS England and NHS Improvement, and sets out a number of common principles and considerations in order to support local processes.

2 This document should be read in conjunction with the MCP Framework and the wider Contract package. Similar principles relate to the procurement of other accountable models such as PACS.

Current regulatory framework

3 The Public Contracts Regulations (PCR 2015) came into force on 18 April 2016 for CCGs and NHS England when procuring health and care services. These new rules apply to public bodies, including CCGs, NHS England and local authorities, and have implications for the procurement of ACO Contracts commenced after that date.

4 The PCR 2015 form part of the procurement landscape alongside the NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (PPCCR). Made under Section 75 of the Health and Social Care Act 2012, the PPCCR apply to NHS England and CCGs and are enforced by NHS Improvement. Whilst the two regimes overlap in terms of some of their requirements, they are not the same – compliance with one regime does not automatically mean compliance with the other. Commissioners should ensure that they comply with both regimes when procuring healthcare services.

Requirements under PCR 2015

5 This section summarises the requirements under PCR. Further information can be found in existing guidance at the following locations:

a) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/561778/PCR_2015_and_NHS_commissioners_A.pdf

b) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/560272/Guidance_on_Light_Touch_Regime_-_Oct_16.pdf

6 The procurement of healthcare services can be conducted under the Light Touch Regime (LTR), within regulations 74-76 of the PCR 2015. The rest of this paper addresses this approach. Under these requirements, all contracts for clinical services with a lifetime cost over the £589,148 threshold[1] must be advertised in the Official Journal of the European Union (OJEU) and in Contracts Finder. The commissioner should then run a procurement process that is compliant with the advert and the principles of transparency and equal treatment.

7 This does not mean that every clinical services contract will be subject to a full competitive tender exercise in the traditional procurement sense:

- If, having carried out a market engagement/assessment exercise, the commissioner can determine that competition is absent for technical reasons and there is therefore only one provider (or group of providers) capable of delivering the contract but only 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, then the commissioner can enter into negotiations with that provider and there is no need to advertise the contract opportunity;
- If there is only one expression of interest in response to the advert in OJEU and Contracts Finder, the commissioner can assess whether the provider is capable of delivering on its objectives, and negotiate the contract with that provider (the contract must reflect the requirements set out in the advert);
- If more than one provider expresses an interest in response to the advert, the commissioner should run a competitive process to award the contract, in accordance with criteria that must be open, transparent and fair to all providers.

8 It is worthwhile setting out that there are a number of ways to carry out market engagement, advertise a contract opportunity and start a procurement process in a transparent manner.

- This document describes using a **Prior Information Notice ("PIN")** to start a market engagement exercise. In this case, the PIN would, for example, describe the commissioner's intentions to develop a specification for a certain service and invite interested providers to engage with the commissioner to develop its ideas. It does not commit the commissioner to running a procurement process or awarding a contract.
- The contract opportunity can be advertised in either a **Contract Notice** or a **PIN as a Call for Competition**. The advert would start the procurement process. The Contract Notice is the most common document used to start a procurement process.

These documents would be published in OJEU and Contracts Finder.

1 The new rules do not normally require contracts below the threshold to be advertised in the OJEU. The EU Directive recognises that only services above the threshold would normally be likely to be of cross border interest. Therefore, services with a lifetime value below this threshold do not need to be advertised in the OJEU, unless there are concrete indications of cross-border interest. Please note this threshold has been converted to GBP from the Euro threshold amount. This threshold is applicable until 31 December 2017. Procurement thresholds are updated every 2 years and commissioners should ensure that they confirm the actual GBP amount applicable at the time of their procurement.

For competed contracts commissioners will need to develop detailed service specifications, award criteria, evaluation methodology and required outcomes, in advance of the competition phase commencing. This is to ensure transparency and also to enable the commissioner to determine its process. If competing the contract, the commissioner will have to publish all procurement documents (including any Pre-Qualification Questionnaire (if relevant) or other 'selection' document, Invitation to Tender or similar, the Specification, the Contract terms etc.) on the internet at the date the advert is published in OJEU.

9 The commissioner can design the award criteria to reflect the service being contracted, so could include, for example: ensuring quality, continuity of service, accessibility, affordability, availability, CQC assessment, needs of vulnerable patients, teaching accreditation, continuity, and comprehensiveness of the services etc. Neither the advert nor the criteria should specify the organisational form of the body that will be awarded the contract. It is important to ensure that the people involved in evaluating the tenders have been engaged with in order to develop the award criteria and evaluation/scoring methodology. The award criteria, evaluation/scoring methodology should be clearly set out in the procurement documents and the evaluators should understand how they are to apply it.

10 The Crown Commercial Service has published guidance on the LTR, which can be found here.

11 Once the process is complete, following the standstill process (for competed contracts) and the award of the contract, the commissioner must publish a Contract Award Notice in OJEU and Contracts Finder.

Requirements under PPCCR

12 The PPCCR follow a principles based approach leaving commissioners flexibility as to how best to procure and secure services in the best interests of service users. Commissioners need to comply with a number of requirements under the PPCCR to help them achieve the overall objective of securing the needs of patients and improving the quality and efficiency of services, including:

a) acting transparently and proportionately, and treating potential providers equally and in a non-discriminatory way;

b) procuring services from the providers that are most capable of delivering commissioners' overall objective and that provide the best value for money;

c) considering ways of improving services; and

d) having arrangements in place that allow providers to express an interest in a contract.

13 Further details on the expectations of commissioners under these regulations can be found in NHS Improvement's substantive guidance on the Procurement, Patient Choice and Competition Regulations which can be found here.

The Integrated Support and Assurance Process

14 The commissioner is solely responsible for carrying out the procurement, including the agreement of the award criteria, selection process and evaluation, and award of the contract. In November 2016 NHS England and NHS Improvement published details of a new Integrated Support and Assurance Process (ISAP) here. The dual purpose of the ISAP is to guide the work of local commissioners and providers in creating successful and safe schemes and to provide a means of assurance that this has happened.

15 The ISAP is aligned with:

- NHS England's processes, including those for major service redesign and the CCG Improvement and Assessment Framework;[2] and
- NHS Improvement's processes for evaluating the risk impact of transactions. NHS Improvement is not implementing a new process and therefore will apply the thresholds set out in its guidance on transactions.[3]

16 NHS Improvement will not be assessing compliance with the PPCCRs or other procurement rules, although can provide informal advice to commissioners if needed as it does currently where issues related to the PPCCR arise.

17 The ISAP principles are intended to support all novel or complex procurements by commissioners. To do this, the ISAP will consider Key Lines of Enquiry (KLOEs), which is the collective term for the areas of focus for NHS England and NHS Improvement's assurance regimes. KLOEs are structured as questions, which will establish the risk profile and other parameters of the complex contract. The ISAP will be testing whether commissioners have adequately assessed as part of the procurement the ability of the preferred provider to take on the risks associated with the proposed contract. It will do this by applying the ISAP Guidance, setting out the process that will be followed during an Early Engagement period, and then over three checkpoints, taking place before, during and after the procurement. Commissioners will want to familiarise themselves with the ISAP's requirements, as it is expected that they design their procurement process to collect sufficient information from bidders to satisfy any considerations relating to potential providers.

18 At Checkpoint 2 - where an NHS Trust or FT is appointed as the preferred bidder (or is part of the preferred provider), NHS Improvement will ask the preferred bidder questions aligned with the NHS Improvement transaction guidance. It will do so in the exercise of its existing functions, as it does now, and would not in any way be assisting the CCG in running its procurement. Where possible, NHS Improvement will align information requests with those required for the commissioner's procurement process in order to minimise regulatory burden.

2 CCG improvement and assessment framework 2016/17 (31 March 2016) is available at: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/03/ccg-iafmar16.pdf

3 Supporting NHS providers: guidance on transactions for NHS foundation trusts updated March 2015 at www.gov.uk/government/publications/supporting-nhs-providers-considering-transactions-andmergers

19 NHS Improvement and NHS England will work together to review the information submitted by the commissioner as it progresses through the ISAP, although each organisation will be responsible for exercising its own functions. Feedback and outcomes will be provided at the end of each checkpoint. This will include recommended next steps and will rate the proposals against a three-point colour rating (Red/Amber/Green).

20 The decision about whether to procure and award a contract, and then to allow service delivery to begin, must be one for local commissioners, and the ISAP will not transfer this decision to the national bodies. However, the view of the national bodies should be a key consideration for local commissioners. NHS England will expect commissioners to carry out any extra activities indicated in the checkpoint outcome before they move onto the next stage. In addition, NHS Improvement will expect NHS Foundation Trusts and NHS Trusts to pause and adapt their involvement in a transaction if its Provider Regulation Committee issues a red transaction risk rating, in accordance with NHS Improvement's transaction guidance.

21 To minimise the risks associated with changes to a procurement process/contract that the commissioner may decide to make as a result of a recommendation from the ISAP, it is important that commissioners incorporate sufficient and appropriate flexibility into their procurement processes to make changes to the process itself and to the scope/value/risk-share (for example) of the contract. The potential for these eventualities will need to be made clear to bidders at the outset in the procurement documentation. It is also important that the ISAP itself robustly tests the adequacy of the procurement plans (including the procurement documents) to ensure that Commissioners are ready to start a procurement process and have addressed the requirements of the ISAP sufficiently to avoid the need for future changes, which will inevitably involve risk.

22 Discussions at the Early Engagement meeting between NHS England and NHS Improvement and the commissioner (pre CP1) will include a check that the commissioner understands what the ISAP involves and has factored this into the design of its procurement process.

Implications for social care services

23 NHS England and NHS Improvement have established the ISAP to assure and support CCGs, NHS providers and the effective operation of the health system. Some of the new care model contracts that will be subject to the ISAP will include social care and public health services for which local authorities are responsible. The ISAP is not designed to consider the decisions of local authorities or assure the providers of local authority services. However, the ISAP applies to the procurement in its entirety, and where local authority services are in scope it will seek assurances that any additional risks arising are properly assessed and managed. Inevitably the steps commissioners are required to take and any recommendations made by NHS England and NHS Improvement in the ISAP will impact on the decisions of local authorities as joint commissioners and potentially as providers. There will be discretion for local authorities to be involved in the submission of evidence and discussions with the panel as part of the ISAP.

24 Each local authority is accountable for the decisions it takes in carrying out its statutory functions, and the ISAP is not a substitute for its own governance and assurance processes, although it is anticipated that local authorities will find the ISAP supportive in jointly commissioning a complex new care model spanning health and care.

General principles for MCP procurements

25 Two of the three contracting options for an MCP – the partially integrated and fully integrated models - require a new contract to be procured. In both these cases the starting point for calculation of the MCP's registered list will be the combined lists of the practices which are either fully or partially integrated. No new procurement is likely to be needed for a virtual MCP, where an Alliance Agreement is required, if the existing arrangements remain otherwise unchanged.

26 For fully and partially-integrated MCPs the Contract will need to be advertised in OJEU and Contracts Finder, unless a contract award procedure was commenced before 18 April 2016 (in which case they would just have to be advertised in Contracts Finder to have complied with the PPCCR).

27 Through the process commissioners will need to be careful to avoid implicitly (or explicitly) discriminating in favour of any potential provider. This is particularly important where there is already a prospective provider in the local area. Further, the selection criteria must not inappropriately restrict the range of organisations eligible to compete for the contract in terms of capability, capacity or organisational form. The criteria should be objectively justifiable.

28 GP involvement needs to be carefully considered. The partially and fully integrated models require local GP signup in order to be successful. In the partially integrated model the GPs will need to sign up to an Integration Agreement in order to deliver on the care model set out in the contract. It is expected that commissioners will have engaged with the market (including GPs) and patients to determine the most appropriate model.

29 For any of the options under development, bidders for the new ACO Contract will have to demonstrate through the procurement how they will work with local practices, with agreement on how GPs will relate to the MCP required before any contract is signed. What will be appropriate will depend on the circumstances, including the type of ACO Contract commissioned, the bidders to the procurement and how they choose to organise themselves, as well as the chosen procurement process. The commissioner's procurement documentation should set out the evidence required from the bidders in order to demonstrate participation by, or cooperation with, GPs. This might, for example, be in the form of a memorandum of understanding, a consortium arrangement or bidding agreement. Commissioners may want to assess this as part of any shortlisting process (for example, by requiring bidders to confirm the structure of the bidding entity(ies) but it is likely that this would be addressed in more detail within tenders/dialogue.

30 The ACO Contract will, among other things, require the MCP:

- To ensure that its services and GMS/PMS are operationally integrated, to deliver seamless care for patients
- To secure the sign-up to an Integration Agreement of those practices who wish to be part of a partially integrated model. The Agreement will govern the relationship between partially integrated practices and the MCP
- To progress and perform against KPIs to measure MCP-practice integration
- To achieve against certain metrics to receive certain payments (Improvement Payment Scheme)

31 The commissioner, in order to strengthen this integration, may further choose:

- To include current LES (and other discretionary spend with practices) within the MCP's integrated budget, which the MCP may choose to sub-contract to practices choosing to be semi-integrated
- To offer practices in a partially integrated MCP an alternative to QOF that aligns those payments with the MCP's Improvement Payment Scheme.

Common steps in procuring an MCP

32 It is likely that the first step in the process will be engagement on the case for change, MCP care model and strategy with providers and other stakeholders, including patient and public engagement and/or consultation. This engagement could be started by publishing a PIN, which could be used to advertise an engagement process but would not commit the commissioner to actually award a contract/ start a procurement. This engagement exercise should assist the commissioner in considering the objectives under the PPCCR and also determining the most appropriate procurement method. Other responsibilities and duties that need to be considered at this stage in order to inform the scope of the MCP and the procurement method include those in the Public Services (Social Value) Act 2012 and the Equality Act 2010.

33 Based on engagement, identify the scope of the MCP and consider the most appropriate procurement method.

34 As these contracts are innovative, it is likely to be the case that the commissioner will need to have dialogue with the bidders in terms of seeking solutions that meet any core requirements prescribed by the commissioner in the procurement documents and in relation to the contract terms. In this case the procurement process may reflect aspects of the competitive dialogue procedure under the PCR 2015 (although note that the commissioner is free to determine its procedure as long as it is transparent and bidders are treated equally and the commissioner complies with its other obligations under procurement law).

35 Once the procurement method has been determined, draw up the advert for publishing in OJEU and Contracts Finder, design the process and develop the procurement documents including the award criteria and evaluation/scoring methodology which must be open, transparent and fair to all providers.

36 The advert should, as a minimum:

a) set out the conditions for participation and the timescales for contacting the commissioner;

b) describe the award process to be followed and direct interested organisations to the website from which they can download the procurement documents

c) describe the scope of the MCP and description of the model (unless inviting solutions from the bidders to determine the appropriate model). The advert should include (but is not necessarily limited to):

- how the budget will be calculated (dependent on the extent of core primary care provided by the MCP and the population served etc)
- duration of contract, and review arrangements
- future intentions and arrangements for extending or varying the contract over time (e.g. bring in new services or extending the population served)
- any other parallel contracts that are necessary for the operation of the relevant model

37 If only one provider expresses an interest in response to the advert, the commissioner can assess whether the provider is suitable and negotiate the contract (which must reflect the original advert and published contract documents). If more than one provider expresses an interest, the commissioner must run a competitive process to award the contract in accordance with the criteria.

38 The commissioner will require, as part of the evaluation process for potential MCPs, any potential MCP to demonstrate (among other things):

- Its ability to provide all MCP services to the standard required by the Contract
- Its ability to perform the integrator functions and deliver the integration outcomes

39 The commissioner will need to agree with the preferred bidder the terms of the Integration Agreement(s) if conducting dialogue.

40 The second test within the Integrated Support and Assurance Process will take place prior to award of the contract (see section 3).

41 Following a standstill process, award contract (ensuring clarity on variations and extensions over time – reflecting what was said in the procurement documents). CCGs would be expected to require both any applicable sub-contracts and an Integration Agreement to be signed by all parties as a condition of final Contract award.

42 Publish Contract Award Notice in OJEU and Contracts Finder.

GP involvement in the procurement

43 Given the critical nature of GP participation in the MCP, a successful procurement will be contingent on full engagement with local practices.

44 Commissioners will need to have regard to any feedback from patients, providers and other relevant stakeholders about the type of MCP that is best suited for the local area when designing the model of care and procurement process. A commissioner may for example want to set out a scope and selection criteria for a fully integrated MCP, or for a partially integrated MCP. It is also possible that GPs within the patch will not all wish to relate to the MCP in the same way, therefore consideration could be given as to how decisions regarding the nature of GP participation could be taken during the procurement process.

Case Study - NHS Dudley CCG

Since 2015, Dudley CCG has led work with local stakeholders to develop a MCP model for integrated primary, community and mental health Services. This will serve a total population of around 318,000.

The involvement of patients and the public in both the development of the model of care and the procurement process has been key. Dudley people highlighted early in the process their ambition for improved access to care, continuity of care and care co-ordination – key features of the model to be procured.

The outcome of a public consultation in the summer of 2016 informed the key documentation which forms the foundation of the procurement exercise, including: outcomes- reflecting the CCG's assessment of local health need and key system effectiveness priorities, characteristics of the MCP organisation, and the scope of services.

The CCG intends to commission a fully or partially integrated MCP through a competitive dialogue process. A market engagement event in January 2017 was attended by over 240 people representing 60 providers.. This provided an opportunity for providers to engage with each other and practices across the footprint in advance of a formal contract notice.

All relevant documents are available at www.dudleyccg.nhs.uk/mcp-procurement

45 Through the procurement process, it is likely that the CCG will need to determine:

- Whether any interested provider has obtained agreement from GPs to form an integrated organisation, and therefore to suspend (or terminate) existing primary care contracts
- Whether any interested provider has obtained agreement from GPs to sign up to an Integration Agreement
- Sign up to the shared vision for integrated care set out by the CCG

46 The suggested terms of the Integration Agreement should be defined by the CCG at the commencement of the procurement process, however may develop during discussions between the MCP and practices. The level of integration set out in the Integration Agreement will also be tested during the ISAP.

GPs joining during the life of the contract

47 There may be the option for GPs to join the MCP (either through an integration agreement or in a fully integrated organisation) after the initial procurement. This type of change to the scope of the Contract will be subject to the rules set out in the PCR 2015 around contractual variations (see section 7 below), and where possible, commissioners should anticipate at the outset of the procurement process where likely changes of this nature are foreseen, and develop the procurement documents (including the advert) and contract which set out these changes in advance unless the procurement involves dialogue on those terms.

48 A likely example of this could be where a MCP area encompasses 10 practices, however one practice in the middle of the area wishes to remain outside the MCP initially. The Contract may initially state that the scope of the community services element of the Contract will be to cover all 10 practices, however the Integration Agreement / primary care scope will only cover 9 practices. The Contract would then state that at year X the scope may expand to include the 10th practice.

A mixed economy

49 It is possible, as highlighted above, that an MCP could encompass simultaneously some practices who wished to participate on a partially integrated basis, and some who would be fully integrated, having suspended their primary care contracts. The Contract will be able to be used for this purpose.

Conflicts of interest

50 Commissioners should be aware of the possibility for conflicts of interest to arise when procuring primary care services through an ACO Contract, particularly where members of a CCG are bidding for the contract, and take appropriate steps to identify and mitigate any conflicts. On 16 June 2017, NHS England published revised statutory guidance on managing conflicts of interest for CCGs. This replaces the 2016 version of the guidance. We have included a new annex to provide further advice on identifying, declaring and managing conflicts of interest in the commissioning of new care models: Annex K: Conflicts of interest and New Models of Care.

Involvement of other providers in the procurement

51 In many ways, the involvement of other acute, community, social care, mental health or voluntary sector providers in the procurement will be similar to general procurements of NHS services. Providers will need to consider, based on the scope of the Contract, whether they have an interest in being party to a bid. This may be the case for example where they already provide elements of the proposed service scope. All bids, whether launched together by a consortium of providers or by individual organisations, will be evaluated against the award criteria, and will therefore be expected to demonstrate how they will be able to deliver the services required by commissioners. In order to meet the requirements in the Contract for integration with general practice, providers will also be expected to demonstrate how, as described in section 6, they have reached agreement with local practices on future working arrangements, either as partially or fully-integrated organisations.

52 The implication of commissioning a larger contract which brings together services currently commissioned separately is that some providers, particularly those who provide a narrower range of services currently, may move to a subcontracting relationship with the MCP, rather than holding a direct contract with the CCG, Local Authority or NHS England. This may apply for example to voluntary sector providers, or separately to acute trusts, where they currently deliver hospital based services that are within the scope of the ACO Contract. The commissioner(s) will require the details of any subcontracting arrangements to be developed over the course of the procurement, so that they have assurance on award of the Contract that all services

will be mobilised to the required standard from the agreed commencement date. All significant relevant subcontracts and associated agreements will need to be signed together with the ACO Contract prior to mobilisation.

Changes to scope or scale of the MCP post contract award

53 Given the duration of the ACO Contract, it is expected that local discussions may be taking place around how the scope, scale or funding of the Contract will change over its life. This may for example include building in new service scope as other local contracts end, or inclusion of additional GP practices, increasing the population served. There are a number of principles around how these changes can be achieved within existing procurement law. This paper does not set out an exhaustive list of how changes can be achieved within existing procurement law and commissioners should take their own legal advice in relation to this issue.

Using a variation clause in the Contract

54 This could be done where the changes (irrespective of monetary value) have been provided for in the initial procurement documents in clear, precise and unequivocal review clauses, which may include price revision clauses, provided that such clauses:

a) State the scope and nature of the possible changes or options as well as the conditions under which they may take place or be used; and

b) Do not provide for changes or options that would alter the overall nature of the Contract.

55 Therefore, the initial procurement/contracting documentation could be written to allow for a variation allowing new practices to join the MCP for the provision of services beyond core primary care or upgrade the depth of their involvement to the 'full' model, including when and how the variation could be triggered (eg by the commissioner serving notice, to take effect at the start of year 3) and the detailed terms and conditions of expansion (eg how the budget would be amended to reflect the change).

56 The complexity and risk should not be underestimated. The procurement/contracting documentation would have to be clear from the outset (including setting it out in the advert) about the population served by different services, how the related budget for those services is calculated, and how the budget is adjusted for incoming registered patients (or departing GPs returning to GMS) and the mechanism for making these changes. The bidders for the Contract would have to explicitly agree at the outset to the potential for future extension, and explain how they would manage it.

Variations not included in initial procurement and contract but which need to be provided by the same contractor

57 The PCR 2015 allow for changes to contracts without advertising a new contract where additional requirements become necessary and were not included in the

initial procurement in the situation where a change of contractor to provide those additional requirements:

- cannot be made for economic or technical reasons such as requirements of interchangeability or interoperability with existing services provided under the initial procurement; and
- would cause significant inconvenience or substantial duplication of costs for the contracting authority.

provided that the increase in price does not exceed 50% of the value of the original contract (changes that are specifically envisaged in the original procurement documents, and in a review clause in the Contract, as described above, do not count towards the 50%).

58 This might allow for additional GP practices to be brought into the MCP or to upgrade their involvement (agreeing to suspend their GMS/PMS contracts, so enabling all services to be commissioned via the ACO Contract) without further advertising, provided the change is not over the 50% value threshold set out in the regulations. However, a case would need to be made that those additional services could not be delivered by a provider other than the MCP and that the requirements of the PCR 2015 had been satisfied.

59 It should be noted that the 50% limit is cumulative for the lifetime of the Contract; so applies to any changes made to the ACO Contract, not just changes to include GPs.

60 Any changes to the initial contract using this provision would require a convincing rationale for the services being provided by the same contractor, and must be publicly recorded by the Commissioner issuing a Contract Award Notice in respect of the change.

61 In terms of practicality and legal and other risk, it would be far preferable to anticipate and plan for foreseeable and anticipated changes, like additional GP practices joining the MCP, through the procurement and contract, rather than attempting to rely on this provision.

Other abilities to make changes

62 The PCR 2015 also provide for other changes:

a) Unforeseen circumstances – the contracting authority acting diligently could not have foreseen where the change does not alter the overall nature of the Contract and the value of each change does not exceed 50% of the original contract value (again cumulatively with all other changes);

b) New contractor – where allowed for in the Contract or as a result of corporate restructuring;

c) Changes that are not substantial – ie that don't render the Contract materially different, would not have allowed for admission of, or attracted, other candidates, do not change the economic balance in favour of the economic operator, does not extend the contract scope considerably or change the contractor other than as allowed above; and

d) Low value changes – are below the relevant EU financial threshold (currently £589,148 for health services as at the date of this paper) and are less than 10% of the initial contract value (again cumulative) and do not alter the overall nature of the Contract.

63 The provisions allowing changes that are not substantial and low value changes may provide some latitude for change to include additional practices, but probably only on a very small scale. It would be far preferable, in terms of practicalities and legal and other risk, to build such changes into the procurement process and contract (particularly given the risk of cumulative changes).

64 We have included as annexes to this paper some potential considerations in relation to Workforce and Estates issues. However, it is for commissioners to develop their own procurement processes for MCPs and there will clearly be a number of other issues concerning additional topics/matters to take account of.

ANNEX 1
Workforce considerations for commissioners procuring an MCP

1. The aim of this document

This document sets out a number of factors relating to workforce planning that commissioners might wish to consider within their procurement processes for ACO Contracts, for example when determining the award criteria, or to assure themselves that bids are fit for purpose both in the immediate and longer term. The information and checklists contained in this document can be adapted for use in any, or all, phases of the procurement process and are not meant to represent a process in themselves. Whilst this document refers primarily to MCPs similar principles apply to other accountable models such as PACS.

2. Summary overview

The current workforce providing services will be employed in a range of organisations including NHS Trusts and Foundation Trusts, GP Practices, Local Authorities, independent providers and may include charities and the voluntary sector. Creating the right workforce, in the right place to deliver services at the right time is essential if the MCP is to achieve the health outcomes set out in the Contract. Commissioners might therefore want to assure themselves that bidders have clearly understood and taken into account the following workforce elements in their workforce planning and bids. (It is also worth identifying whether the data provided by bidders clearly differentiates between assumed and actual data, dependent on whether the workforce changes are proposed as a 'big bang' or to be phased over a period of time). The ISAP should be followed as required.

Elements to consider include:

- A workforce baseline and an impact analysis of the proposed changes in service delivery on the current workforce, and clearly identified risks (including financial risks) and mitigations
- The workforce strategy including:
  - The transition and transformation plans for the workforce including changes to organisation form and employment models, with associated engagement and consultation plans.
  - Implications for STP alignment
- The ability of the bidder to maintain a safe well-led service during mobilisation and beyond

A number of checklists have been developed against each of these elements, which can be found below.

Commissioners' requirements of bidders to submit future workforce transformation and employment model(s) and plans will vary. This will depend on the scale and complexity of the Contract and the organisational form of the MCP, subcontracting arrangements and how far the setup will differ from current arrangements. Commissioners in assuring themselves of a safe well led service may wish to consider the scale and complexity of the bidders workforce proposals.

Commissioners should note that this document does not replace the need for them to take their own legal advice on the detail of their local procurement.

3. Workforce and the MCP model

The success of an MCP will depend on how it grows and deploys its assets. The transformation of care involves major shifts in the boundary between formal and informal care and in the use of the workforce. It empowers and engages staff to work in different ways by creating new multidisciplinary teams; by redesigning jobs so that they are more rewarding, sustainable and efficient; and by implementing newer professional roles.

The workforce component is critical to the delivery of the MCP model in each local system. It takes time and effort to develop a new workforce culture, build skills and develop roles to support multi-professional working between health and social care teams.

An MCP cannot simply be willed into being through a transactional contracting process. Merely rewiring organisational forms, contracts and financial flows changes nothing. By far the most critical task in developing an MCP is to get going on care redesign. However, to be sustainable and fulfil their potential, all MCPs ultimately need to be commissioned rather than rely on a shared vision and goodwill. In this way money flows and contracts and organisational structures all actively help rather than hinder staff to do the right thing.

4. Workforce checklists

The following checklists are intended to be suggested, non-exhaustive lists of workforce considerations for those engaged in commissioning an ACO Contract.

1 Workforce baseline and an impact analysis of the proposed changes in service delivery on the current workforce (immediate or phased), with identified risks (including financial risks) and mitigating actions.

Proposed checklists to test bidders submissions	
Current workforce	Baseline current state workforce by: • Employing organisations • Terms and conditions • Current organisation structures, roles (numbers and type) • Establishment versus actual workforce numbers, grade mix (and cost) • Vacancies • Interims / contractors costs and profile • Skills/competence mix • Work pattern profile (e.g. part/full time; flexible working, home working) • Diversity profile • Turnover/Sickness Absence/Vacancy rates • Behavioural and cultural analysis / staff engagement, e.g. staff survey scores • Leadership capability and capacity assessment • HR capability and capacity assessment • Staff engagement and partnership working arrangements / trade union recognition
Organisation design	**Future state** Identification of the future required skills/competence mix and team based approach by: • Employing organisation(s) / governance and assurance (e.g. boards) • Terms and conditions • Target structures (reporting lines), roles (numbers, grades and type) – new, extended and as-is • Business critical roles – expect focus on clinical front-line roles • Workforce numbers, grade mix (and cost) • Partnership working arrangements / trade union recognition • Skills/competence mix (new and existing) • Behavioural, leadership and cultural changes to enable integrated working • Education and training plans

Proposed checklists to test bidders submissions	
Organisation design	**Feasibility study/gap analysis** The gap between current and future state workforce by: • Workforce numbers, grade mix (cost) • Skills/competency gaps (new and existing) – particular focus on business critical skills • Resource gaps v planned redundancies – particular focus on business critical roles and people • Staff engagement / partnership working arrangements • Behaviours and culture (new ways of working) • Diversity impact • Governance and assurance structures • Identified key risks, issues and mitigation • Available funds to effect change and deliver reconfigured services
Workforce impact analysis, risks and mitigations	• Technical and legal e.g. the legal basis for a transfer of functions TUPE/COSOP, transfer schemes / orders • Barriers and enablers – national, regional and / or local, including regulation, estates, technology, availability of workforce data • Potential redundancy costs • Identified costs associated with new skills or additional capacity requirements • Terms and conditions e.g. the possibility, or otherwise, of harmonisation / Pensions • Identified conflicting employment policies and plans to co-design any required overarching policies to enable transition • Implications of creating any new employing body e.g. whole system nurse bank • Equality impact assessment • Existing regulations, e.g. associated with changing current job roles • Implications of workforce changes to existing facilities, estates, technology, etc.

2 Workforce strategy including

a. The transition and transformation plans for the workforce including changes to organisation form and employment models, with associated engagement and consultation plans should be considered

b. STP alignment

Proposed checklists to test bidders submissions	
Organisation design/ development and workforce strategy	A clearly defined organisation development plan and workforce strategy to support the agreed organisational form and a compelling narrative describing the future state MCP, including (but not limited to): • 'Target' organisation defined (future state) with supporting case for change, including financial and other resourcing requirements • Detailed 'target' organisation structures – overarching governance and assurance structure(s), reporting structures, numbers of existing / new roles and role definitions, establishment and associated employment costs • Clarity about the current position – number of current employers, existing structures, roles, terms and conditions, working patterns, employees, diversity, establishment and associated employment costs, current staff engagement and partnership working arrangements • Feasibility study / gap analysis to test practicability and sustainability of 'target' organisation design, including number of any redundant posts and affected staff, capability and capacity of existing workforce and identified resourcing 'pools' to plug any gaps through a labour market analysis, impact on diversity and inclusion, available funds to effect the changes and deliver reconfigured services, barriers and enablers (national, regional or local) – e.g. legislation, regulation, estates, technology, data, etc • Transition plan to support move from current to target state (people migration plan) – timetable / phasing, information sharing agreements for sharing of workforce data, due diligence process and timetable, staff engagement, partnership working and consultation plans, redundancies, recruitment, re-training of existing workforce, affecting immediate changes to leadership capability and capacity to affect initial change • A longer term plan to show how they intend to ensure sustainable organisation and service delivery change, including training, education and learning and development • Throughout the change process, delivery of the workforce strategy and plan will be dependent on the providers ability to engage effectively with all workforce stakeholders

Proposed checklists to test bidders submissions	
Transition plan	• Transition approach (e.g. dual running / 'lift and shift') and associated timetable and costs • Transition team - HR capability and capacity; programme and change management structures / resources, including: - Governance and assurance structures - Risks, issues and mitigation plans/actions - Costs (see below) • Demonstrable evidence that appropriate advice has been taken, shared and agreed with all affected employing organisations on the legal basis of any staff transfers • Staff engagement, partnership working and consultation plans (see below 'transition principles') • Information sharing agreements for sharing of workforce data • Due diligence process and timetable • Any Redundancies / redeployment / re-training of existing workforce • Recruitment plans • Affecting immediate changes to leadership capability and capacity to affect initial change (might include interim resourcing solutions) • OD plan
Transition principles	Employers should be expected to apply good practice transition principles that have been consulted on and agreed through appropriate partnership working structures and processes and include the following: • Ensure the long term sustainability of service delivery by (the following list provides examples and is not exhaustive): - retaining valuable skills and experience required for the future, in particular those for care roles. - Clearly defining and developing the necessary leadership capability and capacity - Ensuring affordable structures by integrating, for example, back office and senior leadership functions wherever practicable and appropriate to minimise avoidable duplication of roles. • Ensure staff are consulted with and kept informed of progress and of available transfers and redeployment opportunities. • Minimise redundancies. • Minimise disruption to business critical 'clinical' and 'care' roles. • Ensure the approach to change is transparent, equitable, fair and simple.

Proposed checklists to test bidders submissions	
Transition principles	• Ensure compliance with relevant employment legislation and COSOP. • Effect transfers in accordance with the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE) where it applies. In circumstances where TUPE does not apply in strict legal terms, the Cabinet Office Statement of Practice, January 2000 (Revised December 2013) ('COSOP') will be followed. In COSOP the employees involved in such transfers will be treated no less favourably than if TUPE applied in relation to protecting statutory continuity of employment and transferring on current terms and conditions including any contractual redundancy or severance entitlements. Further, principles contained within the Fair Deal Annex of COSOP relating to occupational pensions will be adhered to. • Enable new organisations to be effective in the operation of their business by pre transfer selection of staff, where appropriate. Prior to transfer, it is expected that transferors ('sender' employers) will comply fully with appropriate legislation.
Stakeholder engagement	Plans should include the following stakeholder groups as a minimum: • Clinical leaders • Workforce (existing and new) • Workforce representation including trade unions, across organisational boundaries • Arms-length bodies (ALBs) – key ALBs include HEE, NHS England, NHS Improvement and CQC • Business Services Authority • Third sector including voluntary and charity organisations • Local Authority • Patient representatives
Contribution to Sustainability and Transformation Plans	The proposed service redesign sits within the context of the STP and therefore it is expected that bidder proposals would identify their contribution to the workforce change priorities required to enable the STP vision: • Delivery of key national priorities (to include national clinical standards and seven day services) • New models of care • Delivering services at scale • Strategies for prevention

3 Consider whether bidders have the ability to maintain a safe well led service during mobilisation and beyond.

Proposed checklists to test bidders submissions	
Governance arrangements to support mobilisation and beyond	Bidders should demonstrate plans to ensure that appropriate governance arrangements will be established including: • New governance structure for the MCP including: - Board - MCP integrated PMO to ensure success of mobilisation and new integrated organisation - Appropriate leadership in place in time for mobilisation. • Mobilisation plans and process for reporting/ monitoring including milestones for: - Public and staff consultation executed - Clinical governance/ professional registration/ revalidation of clinical staff complete - Patient complaints process in place - Safe staffing levels in place for go live
Organisation development / sustainability plans To ensure that the long term plans are in place to embed and maintain required changes	• Plans to develop and embed new ways of working • Plans to build 'new' leadership capability and capacity • Strategic resourcing plans to ensure continued access to core / key skills and resources, including education and training, skills development, talent management • Continuous improvement plans to assess the ongoing effectiveness of the original 'target' organisation design
Workforce education, training and resourcing plan To identify the new training and education needs that will emerge as a consequence of new ways of working.	• Detailed training needs analysis skills/competence/behaviours • Commissioning plans for education and skills development, including leadership development • Ongoing resource plan, including identified pools / markets and talent management strategies and approaches

ANNEX 2
Estates considerations for commissioners procuring an MCP

Introduction

The aim of this document

1 This document sets out a number of considerations for commissioners wishing to procure an ACO Contract with respect to the estate from which the MCP care model and services would be delivered. Whilst this document refers primarily to MCPs similar principles apply to other accountable models such as PACS.

2 Commissioners should note that this document does not replace the need for them to take their own legal advice on the detail of their local procurement.

The importance of estates in delivering the MCP care model

3 Estates can act as a key enabler as well as a barrier to achieving local ambitions for redesigning services. Whilst local configuration, context and requirements will vary, the estate from which services are delivered will be an important consideration for commissioners and potential MCP providers.

4 The table below suggests how estate could help deliver the MCP care model:

Feature	Detail	How this supports MCP care model delivery
Rationalisation and utilisation	Working with partners across the whole public sector to: • make efficient use of existing estate • co-ordinate estates planning, design, disposal and investment • standardise clinical and back office functions	• Cost effective and sustainable estate from which to provide services
Location	Accessible and consolidated estate to support co-location of services (where this makes sense locally) including out of hours; primary care, community and specialist services	• Enables joined up care closer to home and in the community • Supports community multidisciplinary working • An extensivist care model including enhanced primary and community services

Feature	Detail	How this supports MCP care model delivery
Flexibility	Able to meet current and future demand pressures as well as respond to an evolving MCP service scope	• Flexible use of the multipurpose community bed base • Accommodate mix of services including preventative services and specialists working in the community • Single point of access to broad range of services
Capability	Offers the space, infrastructure, IT and facilities to deliver the MCP care model	• Supports the equipment and teams needed to deliver a broader range of services such as diagnostics, outpatient care and alternatives to face to face appointments such as digital consultations
Scale	Primary and community care premises configured with additional capacity to be able to provide enhanced primary care at scale	• Delivers whole population health model

Key considerations

MCP estates strategy

5 Prospective bidders for an ACO Contract should be able to describe the estate from which they will deliver their care model and services. Commissioners should ask prospective providers to submit an estates strategy as part of their bid. This will help the CCG understand the providers' plans to:

- Maximise use of existing estate and the locations from which they intend to deliver services including optimising occupancy costs and the value derived from that estate;
- develop premises and target investments that support local service and capacity requirements;
- facilitate the disposal of surplus and/or poorly-used assets for the benefit of the wider NHS;
- deliver services from safe, secure and appropriate buildings;
- use high-quality healthcare environments, which may aid staff retention and morale and patient outcomes and satisfaction levels; and
- comply with sustainable development and environmental requirements and initiatives.

6 The commissioner will need to articulate how it will assess the estates strategy in award criteria. The commissioner should also consider what information can be made available or signposted to for all potential bidders in order for them to develop their strategies. This may include details about the current estate landscape including details on premises, use and ownership and relevant information from Sustainability and Transformation Plans (STPs).

Strategic fit

7 A bidding MCP should be able to demonstrate how their estates strategy is consistent with, and reflected in, the local estates strategies of each relevant CCG and local authorities. Local estates strategies will naturally inform the consolidation, validation and recognition of local priorities in STPs. An MCP estates strategy should reflect and demonstrate alignment with STP planning.

Reflecting change

8 An MCP estates strategy should demonstrate how their use of estate will change (including future estate requirements) as their care model matures over the length of the contract. A credible and robust estates strategy would seek to articulate the following:

Part A	The day one position – MCP describes delivery of their care model from the existing available estate
Part B	Optimal configuration - sets outs, if relevant, a phased and affordable (in capital and revenue impact terms) plan to get from the day one position to an optimised delivery infrastructure to maximise the care model benefits

9 Further detail on the key considerations within both parts is set out below.

PART A - The day one position

10 This part would set out the 'where we are now' in terms of the current and pre-existing estate from which the MCP would serve the population covered by the ACO Contract.

11 A prospective MCP should undertake an estates appraisal to show the existing service delivery infrastructure that they would use including its efficiency, sustainability and general fitness for purpose for contract delivery. Commissioners should assure themselves that any relevant occupancy agreements, where they exist, are in place.

PART B - Optimal configuration

16 This part would set out the 'where we want to be' and why, providing the bidding MCP an opportunity to articulate the optimal estate configuration to realise the full benefits of their care model. Proposed estates solutions should be affordable and sustainable. For any proposed solutions, the benefits should be clearly articulated and demonstrate how care model delivery can be improved; the clinical and environmental benefits to patients, staff and other users of that estate and facilities; and how it would lead to improved performance and utilisation of their estate.

17 Commissioners should be able to consider options from prospective MCPs for getting from 'part one' to 'part two' that demonstrate:

- the opportunities for improving value for money, efficiency and productivity by identifying the sites that need to be retained, used more intensively and used differently;
- the opportunities for rationalisation and disposal of unfit, under-used or redundant assets;
- the new estate requirements including where and why;
- consistency with existing locality plans for service change and reconfiguration including STP priorities and local authority development strategies;
- the capital investment plan that includes prioritisation and a phased approach, for example, to address high risk areas that need urgent attention or develop new or re-purposed accommodation; and
- how associated risk will be managed and how estates relates to wider risk management.

18 The MCP should also identify existing estate that is subject to planned or committed improvement over the next few years along with the identified funding source, for example, funding approved through the Estate and Technology Transformation Fund.

Other considerations

19 Prospective MCPs should demonstrate how they do, or will, participates in the arrangements each relevant CCG has established, such as a local estates forum, to engage regularly with key stakeholders including NHS and independent provider organisations, mental health trusts, other vanguards, Local Authorities, Community Health Partnerships Limited (CHP), Local Improvement Finance Trust companies, NHS Property Services Limited (NHSPS) and the local voluntary sector. Where multiple organisations are involved in the MCP, commissioners may wish to see evidence of how they will work together on estates issues such as a Memorandum of Understanding (MoU). The estates strategy may also need to consider the wider geographical location than that of the MCP, for example, taking into account neighbouring services where this is relevant.

20 Any potential MCP estate strategy would need to demonstrate alignment with and take account of other national estates priorities and developments, including the Carter efficiency measures, and the DH goal to generate £2bn from the sale of surplus land and buildings, and to release enough land to support the development of 26,000 homes.

21 In instances where a prospective MCP suggests changes to the location from which services are provided from (whether the change will be immediate or later in the life of the contract), commissioners will need to be mindful of their legal duties to involve patients under section 14(Z2) of the NHS Act 2006 if a contract was to be awarded. Commissioners should seek their own legal advice on whether or not a change of location is significant enough to require full public consultation.

22 There are provisions within the ACO Contract which require the MCP to support the CCG in respect of its consultation duties.

23 There is also flexibility in the ACO Contract to specify the location from which a particular service is provided. This would need to be specified as part of the procurement and reflected in award criteria.

Useful links

24 There is a broad range of information sources available to help with the development of MCP estates strategies. These include:

- Published CCG Local Estate Strategies;
- Publically available ERIC data http://hefs.hscic.gov.uk/Eric.asp;
- Published local government authority plans;
- Published output from local estates forums;
- DH guidance on 'The efficient management of healthcare estates and facilities' and 'Developing an estates strategy' both available at https://www.gov.uk/government/publications/
- Information and advice made available locally on current planning and engagement on service change and reconfiguration – this includes published STP priorities and planning.

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England
- Care Quality Commission
- Health Education England
- The National Institute for Health and Care Excellence
- NHS Improvement
- Public Health England

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