NHS North Central London Clinical Commissioning Group Clinical Procurement Policy

Version 1
Date: 11th March 2021

1.	**SUMMARY:**	This policy sets out North Central London Clinical Commissioning Group's policy and procedures for the procurement of healthcare goods and services.			
2.	**RESPONSIBLE OFFICER:**	Chief Finance Officer.			
3.	**ACCOUNTABLE OFFICER:**	Accountable Officer.			
4.	**AUTHOR:**	Ros Clarke, Head of Procurement- NEL Commissioning Support Unit. Shaju Jose, Head of Procurement- NEL Procurement- NEL Commissioning Support Unit. Chris Hanson, Governance and Risk Lead, NCL CCG.			
5.	**APPLIES TO:**	All CCG members, employees, self-employed consultants, contractors, officers and office holders, Governing Board (including committee) members.			
6.	**GROUPS/ INDIVIDUALS WHO HAVE OVERSEEN THE DEVELOPMENT OF THIS POLICY:**	CSU Procurement Team. CCG Governance and Risk Team. Kate Harrington-Stillwell, Local Counter Fraud Specialist. Simon Goodwin, Chief Finance Officer. Sarah Mansuralli, Executive Director of Strategic Commissioning.			
7.	**GROUPS WHICH WERE CONSULTED AND HAVE GIVEN APPROVAL:**	Procurement Committee reviewed the Policy on 25th February 2021 and recommended it for approval.			
8.	**EQUALITY IMPACT ANALYSIS COMPLETED:**	**Policy Screened** ✓		**Template Completed**	
9.	**RATIFYING COMMITTEE(S) & DATE OF FINAL APPROVAL:**	Strategy and Commissioning Committee approved this policy on 11th March 2021			
10.	**VERSION**	NCL CCG Version 1			
11.	**AVAILABLE ON:**	CCG website and staff intranet.			
12.	**RELATED DOCUMENTS:**	CCG Constitution; Standing Financial Instructions; Conflicts of Interest Policy; Standards of Business Conduct Policy; Counter Fraud, Bribery and Corruption Policy; Disciplinary Policy;			

		Speaking Up (Whistleblowing) Policy; Sponsorship and Joint Working With The Pharmaceutical Industry Policy; Any Qualified Provider Policy; Patient and Public Engagement Strategy; Equalities Strategy.
13.	**DISSEMINATED TO:**	Governing Body and all Staff
14.	**DATE OF IMPLEMENTATION:**	12th March 2021
15.	**DATE OF NEXT FORMAL REVIEW:**	11th March 2022

Document Control

Date	Version	Action	Author
11th March 2021	1	Policy drafted to reflect best practice in Procurement of healthcare services	Ros Clarke, Head of Procurement- NEL Commissioning Support Unit. Shaju Jose, Head of Procurement- NEL Procurement- NEL Commissioning Support Unit. Chris Hanson, Governance and Risk Lead, NCL CCG.

Clinical Procurement Policy

1. Purpose

1.1 This is the Clinical Procurement Policy ('Policy') of NHS North Central London Clinical Commissioning Group ('CCG'). The purpose of the Policy is to ensure the CCG has and follows fair, transparent and consistent standards when procuring healthcare goods and services. The Policy reflects NHS guidance and English law.

1.2 This policy does not include non-healthcare goods and services which are procured in accordance with the CCG's Standing Financial Instructions.

2. Introduction

2.1 Robust procurement policy and practice are key to ensuring the commissioning of high quality healthcare goods and services that are appropriate and safe for service users, and that offer value for money. The Policy aims to ensure that the CCG has robust procedures and processes in place to deliver its statutory and regulatory obligations and effectively manage the significant public resources entrusted to it, whilst remaining flexible enough to encourage innovation to best meet the healthcare requirements of the local population.

2.2 Procurement is central to driving quality and value, and encompasses the whole process-cycle of acquisition of goods, works and services. It starts with the identification of need, includes performance management, and finishes with the end of a contract or the end of an asset's useful lifespan. Procurement encompasses everything from repeat, low-value orders through to complex healthcare service solutions developed through partnership arrangements. There are a range of procurement approaches available which include, but are not limited to, working with existing providers, competitive and non-competitive tenders, and multi-provider models such as the Any Qualified Provider ('AQP') model and Framework Agreements.

2.3 This Policy has been developed to ensure that all procurements of healthcare goods and services agreed to be undertaken by, or on behalf of, the CCG are consistent with the CCG's principles and policies and to ensure:

- 2.3.1 Compliance with laws, regulations and guidance;
- 2.3.2 Probity in spending public funds;
- 2.3.3 Professional and ethical conduct;
- 2.3.4 Quality and meeting the needs of the services users;
- 2.3.5 Best value for money; and,
- 2.3.6 Efficiency, effectiveness and environmental and socio-economic sustainability.

2.4 This policy will be published on the CCG's website and staff intranet.

3. Scope

3.1 This Policy must be followed by all CCG's Governing Body members, Clinical Leads, employees and any other staff, representatives acting on behalf of the CCG including staff from member

practices, and any external organisations or agencies acting on behalf of the CCG. All revenue or capital expenditure by the CCG on healthcare goods and services procurements are subject to this Policy. Some parts of the Policy may only relate to the procurement of certain healthcare services and these are clearly indicated in the policy.

4. Statutory Framework and Guidance

4.1 The legislation and guidance affecting procurement in the NHS, has been summarised in the General Procurement Guidance. A copy of the General Procurement Guidance is provided at Appendix 1.

4.2 This Policy is informed by and/or is in compliance with:

- 4.2.1 The National Health Act 2006 (as amended);
- 4.2.2 Equality Act (2010);
- 4.2.3 Bribery Act (2012);
- 4.2.4 Modern Slavery Act (2016);
- 4.2.5 Public Services (Social Value) Act 2012;
- 4.2.6 Freedom of Information Act (2000) (UK);
- 4.2.7 Data Protection Act (2018):
- 4.2.8 The National Health Service (Procurement, Patient Choice and Competition) Regulations (2013) (No. 2) ('PPCCR 2013');
- 4.2.9 Public Contracts Regulations (2015) ('PCR 2015')
- 4.2.10 EU Procurement Directives (2014);
- 4.2.11 Substantive guidance on the Procurement, Patient Choice and Competition Regulations (Monitor, December 2013);
- 4.2.12 Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2017
- 4.2.13 Cabinet Office Public-sector Procurement guidance from 1 January 2021 (in relation to Brexit);
- 4.2.14 NHS Principles and Rules for Cooperation and Competition (2010);
- 4.2.15 Procurement Guide for commissioners of NHS-funded services (DH, 30 July 2010);
- 4.2.16 NHS Long Term Plan (2019);
- 4.2.17 NHS England Standing Financial Instructions v.12 (January 2020); and,
- 4.2.18 A fair playing field for the benefit of NHS patients: Monitor's independent review for the Secretary of State for Health (March 2013).

4.3 This policy operates alongside and should be read in accordance with the CCG's:

- 4.3.1 Constitution, Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation and Prime Financial Policies;
- 4.3.2 Conflicts of Interest Policy;
- 4.3.3 Counter Fraud, Bribery and Corruption Policy;
- 4.3.4 Standards of Business Conduct Policy;
- 4.3.5 Sponsorship and Joint Working with the Pharmaceutical Industry Policy;
- 5.3.6 Raising Concerns (Whistle Blowing) Policy;
- 5.3.7 Communication and Engagement Strategy;
- 5.3.8 Disciplinary Policy;

5.3.9 Any Qualified Provider Policy;

5.3.10 NHS England Standing Financial Instructions (SFIs) including but not limited to the impact on the procurement of GP services commissioned by the CCG under delegated authority from NHS England.

5. Roles, Responsibilities and Governance

5.1 The CCG is legally accountable for commissioning health services for its local population. This Policy applies to all healthcare contracts held by the CCG, for and on behalf of the CCG, and for and on behalf of NHS England. The CCG is responsible for not only the outcome of the procurement process but also ensuring it is carried out fairly and according to the law, whilst ensuring improved health outcomes and value for money.

5.2 The Governing Body has delegated the responsibility for ensuring oversight of compliance with this Policy, and that the CCG's procurement responsibilities are conducted in a timely and planned manner, to the Procurement Committee, a sub-committee of the Strategy and Commissioning Committee. A copy of the Governing Body committee structure is provided at Appendix 2.

6. Governance Structures for Procurement Processes

Level	Responsibilities

Governing Body
 	
(excluding any member who has a conflict of interest)
	The Governing Body will, subject to its Scheme of Reservation and Delegation:
	
	• Establish the strategic direction for service development
	• Agree business cases for the development (where required, and not delegated to its committees) which will include:
	  ○ case of need;
	  ○ priority outcomes and objectives for the scheme;
	  ○ budget
	• Receive recommendations on the preferred bidder and review the justification and evidence for that decision
	• Award the contract

Strategy and Commissioning Committee (excluding any member who has a conflict of interest)	The Strategy and Commissioning Committee will: • Oversee the development and delivery of the CCG's commissioning strategy and plans; • Oversee system-wide strategy, commissioning and implementation; • Approve the commissioning of services including acute, mental health, community (where required), specialist services delegated to the CCG by NHS England and services not commissioned by the borough based decision making structures or by the Primary Care Commissioning Committee; • Provide assurance to the Governing Body that the CCG is discharging its statutory commissioning functions effectively; • Ensure that all of the CCG's strategic commissioning priorities and plans are congruent and aligned across NCL and at borough level; • Provide oversight of procurement on behalf of the Governing Body.
Audit Committee (excluding any member who has a conflict of interest)	The Audit Committee will take assurance from the Strategy and Commissioning Committee as to the principal and material risks facing the CCG as a result of their procurement responsibilities and will request such papers or discussions as it sees fit to discharge its responsibilities, in respect of procurement.
Procurement Committee	The Procurement Committee will:

Level	Responsibilities
(excluding any member who has a conflict of interest)	• Have oversight of any procurement where the contract value is £500,000 (five hundred thousand pounds) or greater across the life of the contract and/or any other procurement where the Governing Body and/or any of its commissioning committees request oversight by the Procurement Committee; • Provide oversight and scrutiny of procurements and ensure conflicts of interest are managed appropriately throughout the development of business cases, business case approvals and through the procurement process; • Provide assurance to the Governing Body, Strategy and Commissioning Committee and/or any other Governing Body commissioning committee where appropriate that conflicts of interest are properly managed and that the procurement routes for services are appropriate; • Ensure that procurement processes are proportionate to the cost and complexity of the services to be procured; • Review and approve Single Tender Waivers on the Governing Body's behalf where the financial value is in excess of that delegated to the Accountable Officer and Chief Finance Officer under the Standing Financial Instructions. • Oversee the Register of Procurement Decisions, populated in accordance with NHSE revised Statutory Guidance (2017): Managing Conflicts of Interest and the CCG's Conflict of Interest Policy.

7. Guiding Principles

7.1 In order to effectively procure healthcare goods and services, the CCG will:

7.1.1 engage with and listen carefully to, the views and comments of individual (and representative groups of) service users, and carers, to ensure that their needs and feedback are fully and prominently taken into account;

7.1.2 engage with relevant commissioners, stakeholders and other relevant parties when a procurement is undertaken, including seeking collaborative commissioning and service integration wherever this opportunity arises and is in the best interests of local patients. Best interests of local patients will be determined by the CCG having considered relevant factors;

7.1.3 act in compliance with relevant policy and guidance regarding procurement type, (e.g. AQP or full competitive tender);

7.1.4 ensure safe, high quality and equitable goods and/or services are commissioned and managed by the CCG;

7.1.5 achieve value for money in its procurements by considering the quantity, quality, performance and price of the goods and/or services;

7.1.6 ensure that it makes clear and transparent procurement decisions, including whether a procurement is necessary, and which route to market to take;

7.1.7 ensure it avoids conflicts of interest by ensuring transparency of decision making and, where they are unavoidable, effectively manages any conflicts of interest;

7.1.8 comply with and/or pay heed to all relevant procurement legislation, regulations and guidance (see Appendix 1 of this Policy for further detail);

7.1.9 meet its statutory duty to engage with the local community and stakeholders, and will adhere to its Patient and Public Engagement Strategy, and,

7.1.10 ensure it carries out all Procurements in accordance with this Policy and best practice.

7.2 In relation to each procurement decision the CCG will consider all relevant factors including:

7.2.1 Ensuring clinical needs, clinical quality and measurable improvement in outcomes are taken into account. This will include demonstrable inclusion of any evaluative criteria supported by clear clinical advice informed by gathering patient needs from the outset.

7.2.2 the CCG's approach for facilitating fair, robust and enforceable contracts that provide value for money and deliver required quality standards and outcomes, with effective performance measures and contractual levers;

7.2.3 the transparent and proportional process by which the CCG will determine whether health services are to be commissioned via competitive tender, AQP or framework approach, or through a non-competitive process;

7.2.4 the process for early determination of whether, and how, services are to be opened to the market to facilitate open and fair discussion with existing and potential providers, and thereby to facilitate good working relationships;

7.2.5 how the CCG will meet statutory procurement requirements;

7.2.6 how the CCG will ensure it does not engage in anti-competitive behaviour, and protect and promote the right of patients to make choices about their healthcare;

7.2.7 how the CCG's shared statutory duty to support integration is best met;

7.2.8 how the CCG will demonstrate compliance with the principles of good procurement practice which are:

- Transparency;
- Proportionality;
- Non-discrimination;
- Equality of treatment;
- Fair and open competition.

7.3 When considering whether or not a service should be competitively tendered the CCG in partnership with NEL Commissioning Support Unit ('CSU') will follow the Department of Health Procurement Guide or any successor document, the financial control limits (see Appendix 1) as well as other Standing Financial Instructions ('SFIs') and Standing Orders ('SOs') adopted and agreed by the CCG taking into account the scale of the procurement, the degree to which the service specification and funding model have been developed, and the number of potential providers for the service, and any other National or Regional Guidance issued by NHSE/I.

7.4 The CCG must balance the requirements of complying with procurement law and reducing legal challenge with the need to make effective and integrated commissioning decisions that are right for their local population. Commissioners will ultimately need to make a decision on the appropriate procurement route for a contract. In some instances, particularly related to out of hospital services, there may only be a single provider capable of delivering the contract and in these instances it is likely that the direct award of a single contract may be appropriate. In other circumstances there may be several potential providers of the services in question and commissioners will need to determine whether some form of competitive procurement exercise is run.

7.5 Where it is agreed that a competitive tender should be undertaken, it is imperative that due process is followed and in line with the law and the CCG's governance procedures. This is in order to minimise the risk of challenge to the process by unsuccessful bidders, and avoid associated costs and delays in service mobilisation. This Policy sets out the responsibilities of the CCG, and CSU in terms of the support it provides, to undertake clinical procurements. Where the CCG decides to procure a clinical service collaboratively with another CCG(s), a lead CCG will need to be identified under whose governance arrangements the process will be managed.

8. Procurement – Initial considerations.

8.1 Procurement options should be considered as part of the planning of any potential procurement process, including consideration as to whether a competitive procurement process is required. The CCG should engage with procurement professionals (within the CCG/ CSU) to scope the options. Procurement activity should be fair, transparent and proportionate to the size and complexity of the service(s) in question, and should be allocated resources accordingly.

8.2 Procurement should never be seen as a 'one size fits all' activity, and every individual service/pathway may require a specific option(s) appraisal before any decision for a formal market testing is undertaken. Where pooled budget arrangements are in place, the 'Contracting Authorities' will jointly consider opportunities to align procurement requirements to maximise outcomes and benefits.

8.2.1 For the purposes of the Policy, 'Contracting Authorities' means the State, regional or local authorities, bodies governed by public law or associations formed by one or more such authorities or one or more such bodies governed by public law, and includes central government authorities, not including Her Majesty acting in her private capacity.

8.3 At the outset, considering what should be procured may seem a straightforward question. However, not considering this question may lead to issues related to regulation or guidance compliance and/or the provision of the service(s). As the CCG transitions towards the role of a strategic commissioner, the focus on outcomes may lead to a more straightforward service specification, but a much more complex procurement, evaluation and delivery environment. If the CCG cannot identify what it wants and needs, then open market procurement may likely result in a sub-optimal response. In these cases therefore, it may be more prudent to adopt an Early Supplier Involvement ('ESI') approach to work with one or more partner organisation(s) to co-design and test via a pilot scheme or through a dialogue approach (provided that such involvement does not have the effect of distorting competition and does not result in a violation of the principles of non-discrimination and transparency) using the Plan, Do, Study, Act ('PDSA') discipline. PDSA allows Contracting Authorities to test an idea by trialling a change on a small scale and asses its impact, building upon the learning from previous cycles in a structured way before wholesale implementation.

8.3.1. ESI means before commencing a procurement procedure, contracting authorities may conduct early market consultations. The purpose is to seek or accept advice from independent experts or authorities or from market participants with a view to preparing the procurement and informing economic operators of their procurement plans and requirements. Such advice may be used in the planning and conduct of the procurement procedure, provided that it does not have the effect of distorting competition and does not result in a violation of the principles of non-discrimination and transparency.

8.4 Likewise, the question of why is also critical. It may be that there are clear performance and quality issues or that the financial arrangements are unsatisfactory, but it may be less clear cut. It may simply be that a contract is coming to a natural end and procurement activity is expected. However, if the question is not asked and answered appropriately, any decisions could result in short term solutions but problems in the longer term.

8.5 The question of whether the service is new or simply a change to an existing service is critical to deciding on options relating to the procurement approach. Depending upon the circumstances, a new service may be tested on the open market to encourage early supplier involvement and identify the best provider/model of provision to meet the needs of the CCG. However, if the service is existing and changes are required/desired, then the opportunity to work with the existing provider to shape this should be considered, ensuring quality standards and Value for Money ('VfM') are maintained. It should not be automatically assumed that a market exercise would result in this, not least since the procurement exercise and the transfer of services are not cost and/or risk-free options, and the impact of such changes/additions and/or variations to the contract and mitigation options should be considered carefully when deciding the strategy. The critical decision points would therefore need to be reached by a clear options appraisal taking all options and other key parameters into consideration.

8.6 The use of Prior Information Notices ('PINs'), Expressions of Interest ('EOI') and Marketplace Engagement events ('MPE') are guideline measures of market interest or capacity as an interested economic operator may choose not to engage in any of these engagements and subsequently submit a tender under a Selection Questionnaire ('SQ') or an Invitation to Tender ('ITT') exercise or vice versa, but the exploration of the market dynamism, early supplier involvement and gauging interest and capacity within the market is critical when deciding upon procurement options and activities.

9. Principles of Confidentiality and Conflicts of Interest

9.1 The CCG's Conflicts of Interest policy and Standards of Business Conduct Policy applies at all stages of the procurement process.

9.2 All tenders must comply with the SFIs and SO of the CCG. To protect the integrity of the process, all stages of the procurement process will be treated as commercially sensitive/confidential, unless required by statute to disclose at any stage of the process;

9.3 It is also essential that all members of the Governing Body, Strategy and Commissioning Committee, Procurement Committee, and project teams, who will be part of the procurement process will be asked to confirm that they have no conflict of interest and confirm that any information they are party to will be treated as confidential and not discussed or disclosed outside of the forum it is disclosed within;

9.4 The CCG will establish relevant processes for all procurements to ensure that there are no breaches of confidentiality.

9.5 The CCG will ensure that details of all healthcare contracts are published on the CCG's Register of Procurement Decisions in a timely fashion after contracts are agreed in line with PPCCR 2013 Regulation 9. Other requirements for publication may apply in addition.

9.6 Where the CCG decides to commission services through AQP, it will publish details of the categories of services that they have commissioned and the agreed price for each service. These details will also be detailed in the CGG's Annual Report. Where services are commissioned through

an AQP approach, the CCG will ensure that there is information publicly available about those providers who qualify to provide the service.

9.7 Throughout the procurement cycle the CCG will comply with NHS England's "Managing Conflicts of Interest: Revised Statutory Guidance for CCGs – 2017", as well as the provisions of PCR 2015 and PPCCR 2013, in order to manage conflicts of interest.

9.8 The most obvious area in which conflicts could arise is where the CCG commission (or continue to commission by contract extension) healthcare services, including GP services, in which a member of the CCGs has an interest. This may most often arise in the context of delegated Primary Care Commissioning.

10. Approach to Market

10.1 As part of the procurement process, all potential procurement routes should be considered to ensure that the route chosen is the most appropriate for the scale of the service being procured and the outcomes the procurement is intending to deliver. AQP and Competitive Tendering are set out below as routes that can be considered for above threshold of healthcare and non-healthcare procurements.

10.2 Under the Light Touch Regime ('LTR') (see Appendix 1 for details), the CCG in consultation with the CSU, can design a bespoke process taking different characteristics of the traditional routes as needed. On designing a bespoke process, the process must maintain compliance with the general principles of equal treatment, proportionality, transparency and non-discrimination. At times the CCG may consider it appropriate to adopt one of the traditional procedures (as set out below). However, whether the CCG designs a bespoke process or uses one of the traditional procurement procedures as a template, the CCGs are not beholden to follow the detailed rules set out for each in the PCR 2015 (including the timescales as set out within). The CCGs may tailor and adapt them where necessary, as long as the process adheres to the main rules governing the LTR as described elsewhere in this document.

10.3 The CCG's Procurement Committee will review procurements set out in business cases within the scope of their remit. All procurements will be included in the pipeline held by the Strategy and Commissioning Directorate. Procurements on the pipeline that fall below the Procurement Committee's threshold will be reviewed by the Strategy and Commissioning Directorate. Those procurements that are novel, contentious, repercussive or that have notable risk attached will be referred to the Executive Management Team. The Executive Management Team shall decide whether those procurements are presented to the Procurement Committee. All other Procurements will be overseen by the appropriate Executive Director.

10.4 Procurement of Primary Care services undertaken under delegated authority from NHS England is overseen by the Primary Care Commissioning Committee.

10.5 It should be noted that the procurement of contracts funded jointly between the CCG and Local Authority(s) across the sector for health and social care services will be subject to locally agreed procedures and the Standing Financial Instructions (SFIs) of the organisation leading the tender.

11. Any Qualified Provider

11.1 With the AQP model, for a prescribed range of services, any provider that meets criteria for entering a market can compete for business within that market without constraint by a commissioner organisation. Under AQP there are no guarantees of volume or payment, and competition is encouraged within a range of services rather than for sole provision of them.

11.2 The AQP model will not always be appropriate, for example where:

- 11.2.1 the number of providers needs to be constrained, e.g. the level of activity can only support one provider;
- 11.2.2 clinical pathways dictate a restricted number of providers;
- 11.2.3 Value for money cannot be demonstrated without formal market testing (e.g. to determine the price the CCG will offer for provision of the services);
- 11.2.4 Innovation is required from the market and cannot be achieved collaboratively;
- 11.2.5 There is no effective method of selecting from amongst qualified providers for delivery of specific units of activity;
- 11.2.6 Overall costs would be increased through multiple provider provision avoidable duplication of resources.

11.3 The AQP model promotes choice and contestability, and sustained competition on the basis of quality rather than cost. Any service that is contracted through the AQP model does not need to be tendered, although it will be advertised where appropriate (using the appropriate dedicated website and/or OJEU as required) and potential service providers will need to be qualified.

11.4 The NHS Standard Contract will be awarded to all providers that meet:

- 11.4.1 Minimum standards of clinical care (implying qualification/accreditation requirement);
- 11.4.2 The price the CCG will pay;
- 11.4.3 Relevant regulatory standards.

11.5 The CCG will have regard at all times to the PCR 2015 Principles of Procurement which are non-discrimination, equal treatment of all economic operators and act in a, transparent, mutual recognition and proportionate manner when applying the AQP and any Procurement procedure.

11.6 For further guidance see the CCG's Any Qualified Provider Policy.

12. Competitive Tendering

12.1 Where there is more than one single capable supplier, the CCG will elect to run a competitive tender process in order to award a contract to demonstrate the application of the principles of transparency, openness, equitability and obtaining and delivering value for money unless one or of the exemptions apply. The CCG should seek further guidance from their procurement support provider before making any procurement decisions.

12.2 There are several types of competitive tendering processes including, but not limited to, the following:

12.2.1 Reg 27 Open Procedure (Single stage process) -This allows an unlimited number of interested providers to tender against defined parameters. This procedure is open and transparent and is the recommended procedure if low numbers of interested providers are known.

12.2.2 Reg 28 Restricted Procedure (Two stage process) - This is a two-stage procedure. The first stage allows an unlimited number of interested providers to tender but allows the contracting authority to set the minimum criteria relating to technical, economic and financial capabilities that the suppliers have to satisfy. Following evaluation and short-listing, a minimum of five suppliers (unless fewer qualify) are invited to tender in the second stage.

12.2.3 Reg 29 Competitive Procedure with Negotiation - This procedure is appropriate for complex contracts where contracting authorities are able to define some of the technical means capable of satisfying their needs or objectives but which could be negotiated following receipt of tenders. The contracting authority may enter into negotiation with bidders following assessment of their initial tender to identify and define the means best suited to satisfying their needs but must ensure that the minimum requirements for service delivery are not amended and that all bidders are treated equally.

12.2.4 Reg 30 Competitive Dialogue - This procedure is appropriate for complex contracts where contracting authorities are not objectively able to define the technical means capable of satisfying their needs or objectives, and/or are not objectively able to specify the legal and/or financial make-up of a project. The contracting authority enters into a dialogue with bidders to identify and define the means best suited to satisfying their needs. The dialogue may be conducted in successive stages with the option of reducing the number of bidders at each stage with the remaining bidders being invited to tender. Bidders must be eliminated on the basis of applying the stated award criteria.

12.2.5 Reg 31 Innovation Partnership - This procedure is appropriate for the requirement of an innovative product, service or works that cannot be met by purchasing products, services or works already available on the market. This will not be appropriate for the procurement of clinical healthcare services.

12.2.6 Reg 32 Use of the negotiated procedure without prior publication - A single tender action is the process where a contract is awarded to a provider without competition. Although it is not a term that is defined in the EU Directives (2014) or UK Regulations, Regulation (32) of PCR 2015 refers to the “negotiated procedure without prior publication of a contract notice”. This allows a contracting authority to depart from the Regulations’ usual obligations on open competition and transparency and negotiate a contract directly with one or more providers. Its use is limited to a few defined circumstances in which it is considered strictly necessary. If

the negotiation is being conducted with one provider then this is in effect a single tender action. Evidence is critical for audit purposes and to overcome challenges that there are no other providers within the market with capability and capacity to provide the required service. Market engagement and analysis can provide the required evidence.

12.2.7 Bespoke procedure under the LTR (e.g. for health care services) - In appropriate circumstances where providers are willing and able to work collaboratively under collaborative contracting models a fair and transparent negotiation procedure that is compliant with advertising rules and mirrors the competition principles of awarding contracts in Section 7, Regulation 76, of PCR 2015 and PPCCR 2013 regulations should be considered. As the CCG moves towards more integrated care provider models (service transformation) as they develop their Integrated Care System ('ICS'), the CCG may consider using more bespoke procedures. Advice from Procurement colleagues within the CCG or CSU should be sought for appropriateness of adopting a bespoke procedure(s).

- This procedure should be accompanied with best value testing against benchmarking or formal financial model testing to ensure that the CCGs can be held accountable for public money and evidence VfM.
- The CCG should consider the risks and benefits of using this approach; seeking advice from procurement professionals.

13. Framework Agreements

13.1 Framework Agreements are pre-tendered agreements which are established in compliance with the EU Procurement Rules and which, once established, can be used by the CCG to purchase certain products and/or services without the need to carry out a full procurement process. The advantages of using a framework agreement is that, once established, it can be used to save both time and cost.

13.2 A framework can be established:

13.2.1 By the CCG for its own use; or

13.2.2 By another clinical commissioning group, contracting authority or a central purchasing body such as the Crown Commercial Service ('CCS').

13.3 The CCG may be entitled to use a framework agreement established by another organisation. It shall only do so where the framework agreement has been established correctly, in accordance with any applicable obligations under the EU Procurement Rules and where the CCG is named on the framework's OJEU notice and where the framework is fit for the CCG's purpose. In particular, the CCG shall check:

13.3.1 that they have been identified as a body which is entitled to use the framework agreement;

13.3.2 that their requirements fall within the specification of goods / services covered by the framework agreement;

13.3.3 that the term of the framework agreement has not expired;

13.3.4 that the terms and conditions applicable to call-offs made under the framework agreement are acceptable (as the CCG will be unable to make substantial modifications to these); and

13.3.5 that the pricing under the framework agreement is acceptable.

13.4 The terms and conditions set out in the Framework Agreement cannot be re-negotiated for individual purchasing purposes. The risks and benefits of using the terms and conditions of a Framework Agreement should be assessed with procurement consultation.

13.5 There are 2 Framework Agreement options:

13.5.1 Direct Award (Call Off) - Apply the terms and conditions of the Framework Agreement and Direct Award the contract to a supplier of choice (who meets all the requirements of the CCG) who has a place on the Framework Agreement. A note on the due diligence and decision making process must be kept to meet the requirements PCR 2015 Regulation 84.

13.5.2 Mini Competition - A smaller scale competitive process is undertaken with the approved suppliers on the Framework Agreement to establish the Most Economic Advantageous Tender (MEAT) to ensure, Quality, affordability, accountability and Value for Money.

13.6 Framework Agreements will stipulate in their terms and conditions if Mini Competition and Direct Award apply, some Agreements will also stipulate the weightings that must apply in each Mini Competition. In both options, the Contract Award can be no longer than 7 years.

13.7 Useful Framework Agreements can be found at:

13.7.1 Crown Commercial Services (CCS) http://ccs.cabinetoffice.gov.uk

13.7.2 NHS Shared Business Services (SBS) http://www.sbs.nhs.uk/procurement/immediate-contact-access

13.7.3 NHS Supply Chain http://www.supplychain.nhs.uk/

14. Dynamic Purchasing Systems (DPS)

14.1 The Dynamic Purchasing System (DPS) was established under PCR 2015 Regulation 34 as a procedure available to contracting authorities for contracts for works, services and goods which, as generally available on the market, meet their requirements.

14.2 Contracting authorities, including central purchasing bodies ('CPBs'), may set up a DPS. The DPS should be set up for identified types of requirement, which may be divided into categories of products, works or services.

14.3 As a procurement tool, it has some aspects that are similar to the AQP and an electronic framework agreement, but where new suppliers can join at any time. It is to be run as a completely electronic process, and should be set up using the restricted procedure and other conditions (as per Regulation 34).

14.4 The DPS is a two-stage process, much like the restricted process:

14.4.1 Step 1 - In the initial setup stage, all suppliers who meet the selection criteria and are not excluded must be admitted to the DPS. There is no limit on the number of suppliers that may join a DPS. Suppliers can also apply to join the DPS at any point during its lifetime; and,

14.4.2 Step 2 - In the second stage, the contracting authority invites all suppliers on the DPS (or the relevant category within the DPS) to bid for the specific contract. Individual contracts are awarded in this stage. There is no obligation to undertake a "standstill" period, although there may be some benefits in doing so.

14.5 Regulation 34(5) states that in order to procure under a DPS, contracting authorities should follow the rules of the restricted procedure, and subject to the provisions of clause 34. Therefore, Regulations that apply to the Restricted Procedure, and to procedures generally, apply to the DPS, except where regulation 34 specifically alters or dis-applies them.

15. Single Tender Waivers and Voluntary Ex-Ante Transparency (VEAT) Notices

Single Tender Waivers

15.1 There are limited situations under which the CCG may award contracts without competition. See Appendix 1 for the PCR 2015 and PPCCR 2013 relevant provisions.

15.2 Should one of the statutory provisions apply then the CCGs may consider it appropriate to proceed with a Single Tender Waiver ('STW'); that is to say where a contract is awarded to a single supplier, or a limited group of suppliers, without competition.

15.3 Decisions to proceed with a STW must be approved in line with the CCG's SFIs and Scheme of Delegation) and the CCG will record and evidence the rationale for the decision to proceed with the STW.

15.4 Where a service is put in place for reasons of urgency or safety, it will consider this as an interim step and plan to undertake a competitive process as soon as possible.

15.5 The use of STWs and urgency exemptions will be avoided except where robust reasons can be given. In any case the Audit Committee shall be at least quarterly informed in writing of the numbers and values of all such waivers.

15.6 In the case of health care services there may be situations where the circumstances may allow for an STW under PPCCR 2013 but not under PCR 2015 as the Regulations do not fully align. In such scenarios, advice should be sought from the CCG's procurement support provider and the CCG will make a decision on a case by case basis following an assessment of the advantages, disadvantages and potential procurement risk associated with the proposed approach.

15.7 Where there is judged to be tension between the PPCCR 2013 and the PCR 2015, guidance should sought from the General Procurement Guidance at Appendix 1 or from the CCG's procurement support service provider.

15.8 The use of STWs should not be used to split purchases (contract splitting) simply to circumnavigate the application of a more stringent procurement process.

15.9 All STWs are to be reported to an appropriate committee for review, scrutiny and challenge, in accordance with 15.9.1 to 15.9.3 below;

15.9.1 All STWs, irrespective of value are reported to the Audit Committee;
15.9.2 STWs for services valued in excess of £50,000 but less than Accountable Officer and Chief Finance Officer's approval limits, as set out in the SFIs, are to go to the Audit Committee for scrutiny;
15.9.3 STWs in excess of the Accountable Officer and Chief Finance Officer's approval limits are to go to the Procurement Committee for approval.

Voluntary Ex-Ante Transparency ('VEAT') Notices

15.10 If the CCG believes that it has sufficient grounds to award a contract without prior publication of a Contract Notice in compliance with the existing Regulations, it should publish a VEAT Notice on 'Find a Tender' Service with the following information:

15.10.1 the name and contact details of the CCG;
15.10.2 a description of the object of the contract;
15.10.3 a justification of the decision of the CCG to award the contract without prior publication of a Contract Notice;
15.10.4 the name and contact details of the supplier to be awarded the contract; and
15.10.5 where appropriate, any other information which the CCG considers it useful to include.

15.11 The CCG must follow a minimum of 10 calendar day standstill period from the date of publication of the VEAT notice before entering into a contract with the supplier. There is a 'Limitation Period' of 30 calendar days (Regulation 92 (2)) from the point a provider or supplier, who was not awarded the contract, knew or ought to have known of any infringement or breach to bring in a challenge. A 30 calendar day standstill period should be considered wherever possible.

15.12 If the above conditions are satisfied, a claimant may not be able to claim a declaration of ineffectiveness of the contract on that basis that a Contract Notice was not published to award the contract.

15.13 Procurement advice should be sought prior to confirming a decision to award contracts without prior publication in line with existing regulations. Procurement support should also be engaged regarding the use of a VEAT notice and support in drafting and publishing the notice.

16. "Lead", "Prime", or "Alliance" Provider Service Models

16.1 The CCG may decide to award a contract for a set of related health care services to a "Lead", "Prime", or "Alliance" provider that is responsible for delivering some of the services itself and arranging for other providers to provide the remaining services. Providers may also independently decide to sub-contract the delivery of certain services to other providers. Recent research and good practice guidance indicates that this model supports the development of integrated services.

16.2 PPCCR 2013 do not apply to providers. The CCG shall satisfy itself that it is complying with their obligations under the Regulations where services are procured through a "Prime", "Lead", or "Alliance" provider model.

17. Pilot Projects

17.1 Healthcare Service - The use of pilot projects may be considered when some of the requirements set out in 17.3 below apply and if the healthcare service is a new service that has been redesigned;

17.2 The following factors are relevant to projects relating to healthcare goods and or services:

17.2.1 (Patient) Outcomes are not defined
17.2.2 Service specification needs to be tested and through close monitoring which will during the term of the pilot, support the development of the final service specification and processes
17.2.3 Pilots must be applied for a limited period of time and should not exceed 18 months
17.2.4 Robust Plan /process for evaluation; and /or
17.2.5 Right to terminate a pilot must be included if it is found to be unsafe or the outcomes cannot be met.

17.3 It is important for the CCG to use pilot projects only in circumstances where the outputs are not known or cannot be accurately predicted and understand that if a pilot project is a success, with provider capacity and capability in the market the next step would be a competitive process.

17.4 In all instances, the use of a pilot project must not be used as a way to avoid a competitive procurements process or as a stop gap measure where the CCG has no intention of entering into a future competitive process and a Tender Waiver must be approved at the relevant committee / delegated committee dependant on the value of the project.

17.5 The CCG's procurement advisors will provide guidance on the suitability of the use of pilot projects to ensure compliance with current procurement and competition law.

18. Grants

18.1 Grants can be used to provide financial support to a voluntary organisation which provides or arranges for the provision of services which are similar to those in respect of which the CCG has statutory functions. NHS England has published a Grant Agreement, Guidance on the use of the draft model Grant Funding Agreement and a Bitesize Guide.

18.2 Grants should not be used to avoid competition where it is appropriate for a formal procurement to be undertaken.

18.3 The model grant agreement is non-mandatory and is for local adaptation as required. For further information, please visit https://www.england.nhs.uk/nhs-standard-contract/grant- agreement/

19. Strategic/Partnership Arrangements/Agreements

19.1 This is not partnership in a "legal" sense. Where collaboration and coordination is considered essential, for example in developing new integrated pathways, enabling sustainability of services, ensuring smooth patient handover, coordination etc. the CCG may wish to continue with existing "strategic/partnership" arrangement(s)/agreement(s). These must be formalised under a Memorandum of Understanding (MoU) in which will be provided a clear reference to the nationally developed NHS terms and conditions of goods and services. In addition to the MoU, Purchase Orders can be used to agree initial terms prior to a fully developed contract being agreed and signed. Purchase Orders must not be used for long term arrangements or in place of a contract. In all instances, these arrangement(s) must be formalised using the appropriate contract form and must provide:

19.1.1 Transparency particularly with provision of information sharing good and bad practice;
19.1.2 A contribution to service re-design;
19.1.3 Timely provision of information and performance reporting;
19.1.4 Evidence of improved patient experience year on year;
19.1.5 Evidence of value for money.

19.2 Partnership status must not be used as a reason to avoid competition and should only be used appropriately and be regularly monitored.

20. Service Specification and other considerations

20.1 The CCG, and where appropriate in partnership with Clinicians, commissioners, and external bodies, is committed to developing clear outcome-focussed service specifications for use in tender exercises, in order to provide bidders with sufficient information to understand what commissioners want to buy while allowing for innovation where this is required.

20.2 The degree to which the service specification has or can be developed will also inform the procurement model followed, for example, for AQP procurements, the service specification and funding model must be fully developed prior to procurement. Service specifications must address:

20.2.1 *Governance arrangements* required of any service being procured in order to assure CCG's commissioners that a clear and robust governance structure is in place both across the service specified and within the organisation(s) which win(s) the tender.

20.2.2 *Clinical engagement:* CCG commissioners will engage with a range of clinicians, where appropriate, both within the CCG and external to it to develop service specifications that are driven by clinical quality and have clinical buy-in.

20.2.3 *Provider engagement:* In addition to on-going engagement with providers, CCG commissioners may engage with providers in terms of financial, estates and workforce implications of potential procurements.

20.2.4 *Patient and public engagement:* Effective engagement with local patients and population could assist in identifying areas where health needs are not being adequately met, and where there is scope for improvement of services. This may include commissioners undertaking public and patient consultations before a procurement process begins, and potentially engaging patient and public representatives where possible in procurement evaluation panels. Service users could also inform the shape of planned changes to provision. Engagement may be an on-going process through established CCG mechanisms and stakeholder events.

20.3 Financial and Quality Assurance Checks - The CCG will require Financial and Quality assurance about potential providers. Where this is not achieved through a formal tender process, the following financial and quality assurance checks will be expected to be undertaken before entering into a contract:

20.3.1 Financial viability;
20.3.2 Implications of VAT;
20.3.3 Economic standing;
20.3.4 Corporate social responsibility;
20.3.5 Clinical capacity and capability;
20.3.6 Clinical governance;
20.3.7 Quality/Accreditation.

21. Documentation and Record Keeping

21.1 The CCG shall comply with its statutory obligations to keep and maintain appropriate records.

21.2 Accurate record keeping and documentation is also fundamental to any procurement process and is also consistent with the CCG's obligation of transparency. A robust audit trail shall be maintained which records all steps and decisions taken (and the reasons for those steps / decisions). This ensures the CCG's accountability, that decisions can be scrutinised, and that the CCG can accurately respond to formal complaints or challenges.

21.3 Formal document version control should also be implemented and all document versions retained in case of future need.

21.4 It is the responsibility of the CCG that these documents are maintained, in line with PCR 2015 Regulation 84, and that they are retrievable in a reasonable time period following any contract award and for not less than three years for any procurement.

21.5 The CCG maintains a register of procurement decisions which includes a record of any conflicts recorded and detail of how these have been managed (PPCCR 2013 Reg 9). The register is published on the CCG's websites with a hard copy available on request for inspection at the CCG's headquarters. For further details of population of the register, please refer to the Conflicts of Interest Policy.

22. Engagement and consultation

22.1 On-going provider engagement is part of the Commissioning Cycle. Particular engagement activities (such as Information Events) will be undertaken that relate to individual procurement exercises, but the CCG is committed to maintaining an on-going dialogue with providers in order to involve them in shaping the CCG's commissioning intentions, and for providers to be clear about the shape and quality of service provision those commissioning intentions require.

22.2 We will ensure that all our decision making processes are inclusive and open to ensure that every group, be they patients or staff, has the opportunity to participate, and their views are heard. Our Patient and Public Engagement Strategy lays out our approaches to public involvement while the Operating Plan will highlight what we need to do to engage our Governing Body, staff groups and the management teams.

22.3 The CCG will meet its statutory duty to engage and will adhere to the principles set out in both the Patient and Public Engagement Strategy and the Equalities Strategy.

22.4 The CCG will at all material times:

- 22.3.1 Support active engagement of the Governing Body, Executive Team, staff teams, forums and networks in promoting equality;
- 22.3.2 Clearly demonstrate, in actions, of consultation and survey outcomes with various internal and external groups; and,
- 22.3.3 Engage and consult the sections of the population that may, for whatever reason, be more difficult to reach out to and engage with.

23. Equality and Diversity

23.1 The CCG believes that services should be equally accessible to all community groups regardless of where they live, any protected characteristic(s) and their ability to pay for services. We need to ensure every patient in our locality is receiving high quality care based on their need. This means:

- 23.1.1 Embedding the equality framework into the quality management framework to raise standard and make continuous improvement;
- 23.1.2 Integrating equality, diversity and human rights in business planning, commissioning and service delivery activities;
- 23.1.3 Addressing the needs of the different equalities groups in the JSNA and in all other stages of the commissioning cycle;
- 23.1.4 Ensuring robust data monitoring across all commissioned services; and,
- 23.1.5 Meeting our statutory duties to engage, and demonstrate our commitment to engagement by following the principles set out in the Patient and Public Engagement Strategy and the Equalities Strategy.

24. Sustainable Procurement

24.1 The CCG recognises the role it plays in reducing the impact it has on the environment and aims to reduce both its carbon emissions and use of natural resources. Therefore, the CCG intends to utilise e-procurement methods as far as possible, and include tender questions and performance measures relating to environmental considerations in the contracts tendered. The CCG will encourage providers (and potential providers) to be innovative in reducing their environmental impact whilst maintaining excellent clinical quality standards and improved outcomes.

24.2 The NHS Carbon Reduction Strategy and the Climate Change Act proposes a 26% reduction in carbon emissions by 2020 and an 80% reduction by 2050 (2% pa). All NHS organisations are required to have an agreed environmental and sustainable clinical procurement policy in place which includes a number of environmental objectives and targets relating to sustainable development and environmental purchasing and supply activities in the NHS.

24.3 The CCG will implement a Carbon Reduction policy, which makes recommendations which must be fully taken into account in any procurement decision in ten key areas:

- 24.3.1 Energy and carbon management;
- 24.3.2 Procurement and food;
- 24.3.3 Low carbon travel, transport and access;
- 24.3.4 Water;
- 24.3.5 Waste;
- 24.3.6 Designing the built environment;
- 24.3.7 Organisational and workforce development;
- 24.3.8 Role of partnership and networks;
- 24.3.9 Governance;
- 24.3.10 Finance.

24.4 The key areas of the national Carbon Reduction Policy, of which the CCG will be mindful in the conduct of its business, are:

- 24.4.1 Improving energy efficiency and carbon reduction targets in line with those proposed by the NHS Carbon Reduction Strategy and for NHS Climate Change Act compliance;
- 24.4.2 Investing in clean, energy efficient technologies and developing potential for renewable energy production wherever feasible;
- 24.4.3 Raising staff awareness and commitment to deliver carbon reduction;
- 24.4.4 Reducing water consumption and employing systems for its efficient use into building development at design stage and also establishing opportunities for recycling and reuse of waste wherever possible;
- 24.4.5 Encouraging sustainable procurement terms in key suppliers' contracts;
- 24.4.6 Actively developing a travel plan for staff;
- 24.4.7 Signing up to and addressing the issues raised by the Good Corporate Citizenship Assessment Model.

25. Communication

25.1 The CCG recognises the need for effective and appropriate communication with its workforce, patients and the community. The CCG understands that the needs of each group may be different because of individual circumstance, and therefore will not take a 'one size fits all' approach. In developing our communication strategy the CCG understand the need to reach to the whole of the population it serves. Similarly the CCG aims to ensure that its internal communication is effective to meet the needs of all employees. The CCG's public and staff information will be linguistically accessible, sensitive to individuals' circumstances and promoted through effective channels.

26. Partnership and procurement

26.1 The CCG, health and social care providers and the London Boroughs within the CCG's geographical footprint will be required to build better and stronger partnerships to providing high quality healthcare services and to tackle health inequalities.

27. Decommissioning Services

27.1 The need to decommission contracts can arise due to a number of reasons, not limited to:

27.1.1 Termination of the contract due to performance against the contract not delivering the expected outcomes - This can be mitigated by appropriate contract monitoring and management and by involving the provider in this. The contract terms will allow for remedial action to be taken to resolve any problems. Should remedial action available under contractual terms not resolve the issues, then the contract will contain appropriate termination provisions;

27.1.2 There is an inability to demonstrate delivery of agreed outcome measures or failure to deliver outcomes, despite agreed remedial action as detailed in the relevant contract;

27.1.3 The service has limited clinical effectiveness or failure to meet relevant quality or safety standards;

27.1.3 The original decision to commission the service was made on assumptions that were not realised;

27.1.4 A service review demonstrates existing services are not meeting the health needs of the population - For example the service may be delivered in a location or at a time that may be unsuitable for patients or service changes may be required to reflect developments in medical technology and current standards of care;

27.1.5 Service does not deliver value for money, as demonstrated through financial review, utilising benchmarking tools;

27.1.6 The investment in a service does not maximise the health gain that could be achieved by reinvesting the funding elsewhere.

27.2 Prior to any decommissioning decision the following principles must be applied to the proposal:

27.2.1 The proposal must be based on sound evidence;

27.2.2 Appropriate engagement with patients and the public must have taken place;

27.2.3 Appropriate engagement with clinicians, including the senior clinician responsible for the delivery of the service, must have taken place;

27.2.4 An assessment of health impact and impact on Equality and Diversity must have taken place;

27.2.5 Consideration must be given to the potential adverse impacts of a decommissioning decision, such as patient safety or patient choice;

27.2.6 Consideration must be given to alternative options to decommissioning a service;

27.2.7 In the case of a service being decommissioned the CCG must seek full assurance that there is a robust process in place to transfer patients to other services and that it is clear to all stakeholders to which alternative services patients are being redirected.

27.3 Where services are decommissioned, the CCG will ensure, where necessary, that contingency plans are developed to maintain patient care. Where decommissioning involves Human Resource issues, such as TUPE, then providers will be expected to co-operate and be involved in discussions to deal with such issues.

28. Training Needs

28.1 It is not intended that the workforce generally will develop procurement expertise, but staff will need to know when and how to seek further support. The most urgent requirement is that all commissioning staff throughout the CCG should know enough about procurement to know to seek help when they encounter related issues. They must be able to give clear and consistent messages to providers and potential providers about the CCG's procurement intentions in relation to individual service developments.

28.2 Awareness of procurement issues will be raised through organisational development and training sessions for clinical and non-clinical members of the CCG.

29. Monitoring this Policy

29.1 This policy will be reviewed at least annually. In addition it will be kept under informal review in the light of emerging guidance, experience and supporting work. Given the changing environment it is likely that this Policy will need to be updated within a relatively short timescale. It shall be the responsibility of the Procurement Committee to keep the policy under review and ensure that recommendations for revisions are made to the Strategy and Commissioning Committee.

30 Raising Concerns

30.1 If an individual has concerns regarding the suspected or known breach of, or non-compliance with, this policy they are to contact the Board Secretary or Governance Team in the first instance, as soon as is reasonably possible (on an informal basis). Where deemed necessary, due to the severity and/or complexity of the material event, the Board Secretary or Governance and Risk Leads will escalate the report to the Head of Governance and Risk.

30.2 Where a suspected breach also includes suspected commission of fraud or bribery, this should be reported to the CCG's Local Counter Fraud Specialist team or directly to the NHS Counter fraud Authority.

The Local Counter Fraud Specialists:

matt.wilson2@nhs.net or +44 (0)7484 040691
kate.harrington-stillwell@nhs.net or +44 (0)7778 862 713

NHS Counter Fraud Authority:
https://cfa.nhs.uk/reportfraud or 0800 028 4060.

30.3 The CCG takes the failure to comply with this and other policies seriously. A breach of this Policy may result in disciplinary action being undertaken. Please see the CCG's Disciplinary Policy for more information.

30.4 Failure to comply with this Policy could lead to criminal proceedings including for offences such as fraud, bribery and corruption, in addition to any disciplinary action contemplated or taken. This could have implications for the CCG and any linked organisations, and the individuals who are engaged by them.

Appendix 1 General Procurement Guidance

1. Purpose

The purpose of this document is to provide a summary of the considerations the CCG should observe when making decisions as to whether to undertake competitive procurement for commissioning contracts for health services. The document provides a summary of the relevant legislation, the risks should the decision be challenged and the remedies available to bidders.

2. NHS Principles and Rules Cooperation and Competition

The Principles and Rules of Cooperation and Competition (2013) (PRCC) form part of the Operating Framework in establishing the system rules governing cooperation and competition in the commissioning and provision of NHS services in England.
A brief summary based on the principles and rules are:

- The CCG will comply with its statutory duty, level of responsibility and ensure service continuity and sustainability.
- The CCG will engage fully and transparently with existing and potential providers regarding future procurement requirements and timetables.
- The CCG must not create payment mechanisms which restrict choice or competition against patients and taxpayers interests.
- The CCG must be able to demonstrate that its financial and payments mechanisms are transparent and fair.
- The CCG must seek specialist procurement advice when required regarding competition process at the earliest stage possible to ensure the legislative compliance.

Further guidance and how they apply can be found at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216279/dh_118220.pdf)

3. National and Regulatory Compliance

Statutory Framework
The CCG was established under the Health and Social Care Act (2012) and is responsible for the commissioning of healthcare services for its population.

The CCG is led by an elected Governing Body which is responsible for authorising the award of any contract, if not delegated to the Primary Care Commissioning Committee (PCCC) or Strategy and Commissioning Committee or appropriate staff member with budget delegation:

- From a formal competitive procurement process;
- Any Single Tender Waivers; and
- Direct Awards.

Role of the Governing Body in the Procurement Process

The Governing Body is responsible undertaking procurements in accordance with their statutory requirements as described in the Health and Social Care Act (2012).

The Governing Bodies will be transparent when making procurement decisions both in terms of potential procurement and procurement awards once a competitive tender / waiver process has been undertaken.

CCG Delegated Authority

Primary Care Commissioning is part of the Strategy for Integrated Care System which can lead to a number of benefits for patients and the public. The CCG has been delegated full responsibility for the commissioning of general practice services (Delegated Commissioning (Level 3)).

NHS England and the CCG have the primary purpose of commissioning primary medical services for the people in their region. This includes the following activities:

- monitoring of GMS, PMS and APMS contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract contracts;
- design of PMS and APMS contracts;
- Development of newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”).

NHS Long Term Plan

The NHS Long Term Plan (2019) sets out specific intentions regarding the NHS and the use of Procurement Legislation, in that the NHS should become exempt from all procurement and competition legislation. At the time of writing this Procurement Strategy the current Procurement and Competition Legislation as set out in the sections below are still in force and need to be adhered to.

4. Legislative Background

The primary legislation governing the procurement of health services in the public sector are:

- The Public Contracts Regulations 2015 ('PCR 2015')
- The NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 ('PPCCR 2013').

Since 18th April 2016, the commissioning of health services by the CCG and NHS England are subject to the "Light Touch Regime" ('LTR'), under the PCR 2015. There may be instances that procurement procedures commenced prior to 18th April 2016 were regulated by the Public Contracts Regulations 2006 (as "Part B" services) and the PPCCR 2013 and NHS England and NHS Improvement ('NHSE/I')'s accompanying guidance.

The scope of the two principle sets of regulations, PCR 2015) may be summarised as follows:-

- PCR 2015 applies to all contracts whether for health services or otherwise above the defined financial threshold entered into by NHS bodies.
- PPCCR 2013 applies to all health service contracts of whatever value entered into by the CCG and health service providers.
- Both PCR 2015 and the PPCCR 2013 apply where the subject of the contract is the provision of health services with a value of over €750,000 and where the contracting authority is a CCG. In these circumstance the LTR applies.
- The existence of two tiers of regulation poses additional legal hurdles and constraints and these must be considered carefully in consultation with procurement professionals (within the CGG / CSU).
- As a matter of general principle EU law takes precedence over UK law but at the end of the Brexit transition period this may change (31 December 2020 as it currently stands).

The two sets of regulations overlap but compliance with one set does not automatically ensure compliance with the other. Each case should be approached on its own merits when a decision is to be made on whether to undertake a competitive procurement. A wide range of factors may need to be considered depending on which set of regulations is being considered at any one time.

5. The Public Contracts Regulations 2015

The procurement of goods, services and works by public sector contracting authorities (including the CCG) is regulated by the PCR 2015. Specifically the "Light Touch Regime" regulates the procurement of health, social and other services by bodies such as the CCG and NHS England.

When procuring goods, services and works, the CCG will ensure compliance with EU procurement law and the UK's implementing regulations to the extent that these are applicable to the goods, services or works being procured. In particular it will ensure compliance with the requirements of:

- The Public Contracts Regulations 2015 (as amended);
- The EU Treaty Principles;
- Directive 2004/18/EC and the Remedies Directive 2007/66/EC;
- Relevant EU and UK procurement case law.

Together the 'EU Procurement Rules' include any updated European and/or UK legislation and case law which updates, amends or replaces them.

As well as applying to the procurement of goods, non-clinical services and works, the EU Procurement Rules will apply where the CCG proposes to enter in to a legally enforceable, written contract for clinical services which has an estimated full-life value above the relevant financial threshold.

At the date of publication of this policy, the European Public Contracts Directive 2014/24/EU stipulates the following thresholds applicable to CCG procurement:

	Supply, Services[1] and Design Contracts	Works Contracts[2]	Social and other specific services[3]
Central Government	£122,976|€139,000	£4,733,252|€5,350,000	£663,540|€750,000
Other contracting authorities	£189,330|€214,000	£4,733,252|€5,350,000	£663,540|€750,000
Small Lots	£70,778|€80,000	£884,720|€1,000,000	N/A

The above thresholds were published on 1st January 2020. Please note that procurement thresholds are published every 2 years and the next change is anticipated to be on 31st December 2021. However, due to Brexit, thresholds may potentially change at an earlier date.

6. The Light Touch Regime

The LTR, as set out in the PCR 2015 at Regulations 74 to 77, describes the procurement regulations applicable to health service contracts with a total contract value equal to or exceeding the threshold of £663,540. The process has been called “light touch” as it allows departure from the full regime of regulation in a number of areas for those contracts within the LTR bracket such as health services. For example, it does not require that one of the official procurement processes be followed and contracting authorities are able to design bespoke procurement processes for LTR procurements. The Crown Commercial Service has issued guidance on how to design a compliant LTR process. The CSU adopt this and other best practice in the design of LTR procurement processes.
(Link:https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/560272/Guidance_on_Light_Touch_Regime_-_Oct_16.pdf).

Even where a clinical service contract falls under the LTR, there are only a limited range of steps required under the PCR 2015. Under the LTR, commissioners of services are not obliged to follow the detailed rules set out in the PCR 2015 to the letter- they may tailor and adapt them where necessary as long as they adhere to the main rules governing the LTR, and do not have to use one of the standard procedures (i.e. open, restricted, competitive dialogue, competitive with negotiation, innovation partnership, etc.).

7. Mandatory Requirements

A small number of new procedural rules exist for procurements above the stated threshold. The LTR imposes the following main mandatory requirements on Contracting Authorities:

- Obligation to comply with the following general principles when undertaking all procurement activities, regardless of value:
    - Equal Treatment
    - Non-discrimination
    - Proportionality
    - Transparency

- The publication of a contract notice (‘CN’) or prior information notice (‘PIN’). An exception is where the grounds for using the negotiated procedure without a call for competition could be used, for example where there is only one provider capable of supplying the services required (see section 3.3. below);

- Obligation to publish Contract Award notices in Official Journal of the European Union ('OJEU') for all contracts that exceed the above-mentioned threshold (no exemptions apply);

- Conduct the procurement in conformance with the information provided in the OJEU advert (CN or PIN) regarding: any conditions for participation; time limits for contacting/responding to the authority; and the award procedure to be applied;

- Time limits imposed by authorities on suppliers, such as for responding to adverts and tenders, must be reasonable and proportionate. However, the CCS suggests contracting authorities should observe the standstill period, as this will avoid the risk that the contract might be subject to the draconian remedy of ineffectiveness if the case law does clarify that these requirements do apply to the LTR.

8. Below-threshold Procurements

For below-threshold procurements, a tender process that utilises a pre-qualification stage (such as the Restricted process) cannot be used.

If the contract value is below the relevant threshold value at which an advert is mandatory, an advert should still be placed on a voluntary basis where it is likely that wider publication would result in substantially higher quality or lower priced bids.

Where the contract falls under the threshold of the EU Regulations the procedure employed must be still be consistent with the principles of the treaty, particularly the obligation of transparency and proportionality of timescales for response to tenders.

The number of tender or quotations required for below-threshold opportunities are stipulated within the CCG's SFIs:

Threshold	No. of Tender or Quotations Required – Lowest authority of sign off
£0 - £5,000	One written quotation – Budget Holder
£5,001 - £10,000	Two written quotations – Budget Holder

£10,001 – £19,999	Three written quotations – Head of Service/Assistance Director
£20,000 – Current EU Threshold	Three written quotations – Director and Finance Director

Irrespective of the Value of the contract, the CCG shall treat all providers equally and without discrimination and shall act in a transparent and proportionate manner.

9. Exemptions from the need to advertise

A number of narrow exemptions exist under the PCR 2015 from the requirement to advertise a contract opportunity. These include:

- where no suitable tenders or requests to participate have been submitted in response to an open or restricted procedure: i.e. you have already recently tested the market;
- where there is only one bidder to whom the contract could be awarded the contract for technical reasons, this requires demonstrable absence of competition;
- for reasons of extreme urgency, not brought about by the commissioner's own actions or where the need could not be *reasonably* foreseen;
- 'in-house' or co-operative contracts/collaboration arrangements as the procurement obligations rest with the lead commissioner (i.e. relevance of s75 and s76/256 agreements to partner with local authorities). Section 75 of the NHS Act 2006 allows NHS Bodies and Public Bodies to establish joint agreements for the provision of healthcare related services. Section 256 of the NHS Act 2006 allows Public Bodies to commission healthcare related services on behalf of the NHS. Please see detailed guidance in Section 9 below. These arrangements must be supported by the relevant section 75/256 agreement and where possible, the NHS Standard Contract must be used by the lead Public Body hosting the contract. For the avoidance of doubt, local authorities must also comply with the PCR and the LTR.
- Where an existing contract for the specific services exists and can be modified or varied in line with the PCR 2015 Regulation 72. If any one or more of the following statements are false it is likely that the modification would not be permitted under the PCR 2015 and may constitute a new contract award under the regulations and, therefore, would be subject to advertisement:
    - The contract in question was initially awarded via competitive procurement in line with the PCR 2015;
    - The contract itself permits such modification;

- The modification would not materially change the scope of the contract; or,
- The modification would not increase the contract value (compared to the originally awarded contract) by more than 50%

If any one or more of the above statements are false it is likely that the modification would not be permitted under the PCR and may constitute a new contract award under the regulations and, therefore, would be subject to advertisement;

- Where a Framework Agreement can be used to "call-off" the services. The Framework must name the specific commissioning organisation as a relevant contracting authority and the applicable rules of the framework must be observed when calling-off services.

10. Section 256 Agreements with Local Authorities

Section 256 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) enables the CCG to make grants to local authorities towards expenditure on specified community services and any of the local authority functions specified below.

Community Services - In respect of community services, the CCG may make payments to fund:

- A local social services authority in connection with any social services functions;
- A local education authority for the benefit of disabled persons;
- A local housing authority in connection with the provision of housing.

Local Authority Functions - In respect of local authority functions, the CCG may make payments in connection with the performance of any of the local authority's functions providing that in the opinion of the CCG the functions:

- Have an effect on the health of any individuals;
- Have an effect on, or are affected by, any NHS functions;
- Are connected with any NHS functions.

The CCG's obligations in respect of Section 256 Agreements - The CCG must also meet a number of conditions when making a grant under 256, these are set out in the NHS (Conditions Relating to Grant Payments by NHS Bodies to Local Authorities) Directions 2013[1]:

[1] https://www.gov.uk/government/publications/conditions-for-payments-between-the-nhs-and-local-authorities

- The CCG must be satisfied that the payment is likely to secure a more effective use of public funds than the deployment of an equivalent amount on the provision of health services;
- Where the grant payment is to meet all or part of the capital costs of a project, the grant amount must be determined before the project begins;
- Where the grant payment will be used by the local authority to fund part of a project, the CCG must be satisfied that the local authority intends to meet the remaining costs of the project. The CCG must also be satisfied that this will continue for as long as both the CCG and the local authority consider the project to be necessary or desirable;
- the CCG must ensure, so far as is practicable, that the payment is used by the local authority in such a way as will secure the most efficient and effective use of the amount paid;
- if during the course of the grant period, the local authority reduces the level of service it provides below the level originally agreed then the CCG may reduce accordingly the amount of any further payments;
- so far as is practicable, ensure that the payment is used by local authority in such a way as will secure the most efficient and effective use of the amount paid.

Section 75 Agreements - Where appropriate, the CCG may enter into Section 75 Agreements which are agreements made under section 75 of National Health Services Act 2006 between a local authority and an NHS body in England. Section 75 Agreements can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised.

Audit Trail - To ensure financial probity and a clear audit trail Section 256 specifies two prescribed documents must be completed when making a grant:

- A certificate of expenditure (Annual Voucher) - The Certificate of Expenditure must be completed by the recipient local authority. The auditors must certify that expenditure in relation to the project funded is fairly stated and in accordance with the relevant terms and conditions;
- A Memorandum of Agreement - This must include:
    - A statement of how the Section 256 transfer secures more health gain than an equivalent expenditure of money in the NHS;
    - A description of the scheme. In the case of revenue transfers, the services for which money is being transferred should be specified;
    - Financial details and timescales. This should detail the total amount of money to be transferred under the grant and the amount that is to be transferred in each year. If this subsequently changes the Memorandum of Agreement must be amended and then re- signed;

- Details of the evidence that will be used to indicate that the purposes of the grant, as outlined in the Memorandum, have been secured;
- The Memorandum of Agreement must then be signed by both the CCG and the local authority.

11. Enforcement and Remedies

Under the PCR 2015 parties can challenge CCG procurement decisions and processes under these regulations by issuing proceedings through the Courts. This section is divided into the following sub-sections:

- Above threshold;
- Below threshold.

Above Threshold

PCR 2015 Part 3 provides the following remedies:

- For a standstill period to be run where Regulation 86 applies;
- For an automatic suspension where Regulation 95 applies. This is likely to be the case in situations where there is perceived to be an illegal direct award without competition;
- For interim orders where Regulation 96 applies. This includes the ability to apply for a suspension of the contract award procedure under the usual provision of Part 23 of the Civil Procedure Rules and encompasses the ability to place an injunction on the process before the contract award decision is made.

For post-contract remedies where Regulation 98, the following remedies are available:

- A declaration of ineffectiveness and/or associated civil financial penalty;
- contract shortening;
- The award of damages.

The three grounds for ineffectiveness are:

- where the contract has been awarded without prior publication of a contract notice;
- where the contract has been entered into in breach of a suspension of its ability to enter into contracts under Regulations 87, 95 or 96:
- where an above threshold contract is awarded in breach of any requirement imposed by Regulation 33 (award of contract based on framework agreements through re-opening of competition), or Regulation 34(21) to (24) (award of contracts under dynamic purchasing system).

Claims brought under the 2015 Regulation which do not seek a declaration of ineffectiveness must be bought within 30 days of when the bidder knew, or ought to have known, that grounds for starting the proceedings had arisen. This period is extendable to a maximum of 3 months where Court considers that there is a good reason for doing so.

Below Threshold

There is the possibility to commence an action based on potential breach of the general EU Treaty ('TFEU') Principles of equal treatment, non-discrimination, proportionality and transparency. These principles will apply where there is a requisite degree of cross-board interest.

A challenge based on breach of TFEU principles would be actionable:

- By way of judicial review;
- Article 258 infraction proceedings; or
- Possibly a tortious claim from breach of statutory duty under the European Communities Act 1972, with a 6 year limitation period.

12. NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013

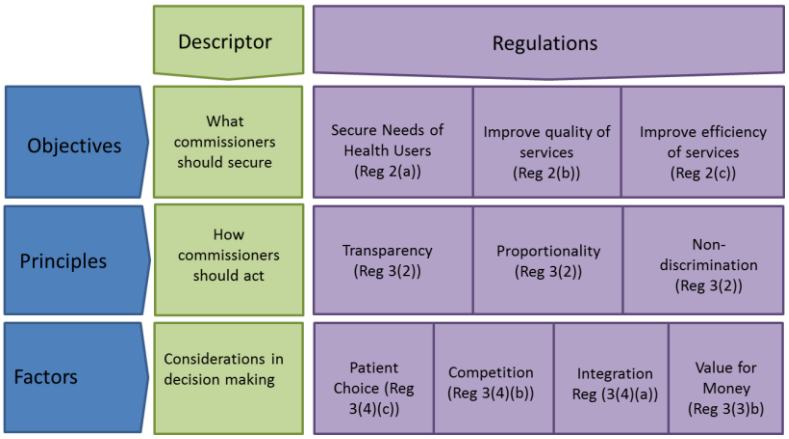
PPCCR 2013 provides that when the CCG procures health care services for the purpose of the NHS, they must act with a view to achieving the following objectives:

- secure patients' needs and improving the quality and efficiency of the service;
- act in a transparent and proportionate way and treat bidders equally and in a non-discriminatory way;
- where third parties, assist or support a commissioner in their procurement activity, the commissioner must ensure that they follow the requirements of the Regulations in the same way the commissioner must do itself;
- maintain and publish a record of each contract awarded for the provision of healthcare services through the development of a Procurement Register. In addition, Regulation 9(1) of the Procurement, Patient Choice and Competition Regulations requires commissioners to maintain and publish a record of all the contracts that they award on the website maintained by NHS England for this purpose. This is currently https://www.contractsfinder.service.gov.uk/;
- not engage in anti-competitive behaviour unless in the interests of patients;
- maintain a record of how any conflicts of interest between commissioners and providers are managed;
- maintain a record of how, in awarding the contract, the CCG complies with certain statutory duties under the NHS Act 2006;

- provide thorough justification if competition not required where services are only capable of being provided by a particular provider;
- publish contract notices (if applicable) and facilitate expressions of interest; and
- improving quality and efficiency of services through providing services in an integrated way, enabling providers to compete and allowing patients a choice of provider.

The following summary table sets out the PPCCR 2013 Objectives, Principles and Factors for Commissioners to consider when commissioning services:

TABLE A: GENERAL REQUIREMENTS FOR COMMISSIONERS



In acting with a view to achieving the objective in Regulation 2, there are a number of factors that a commissioner is likely to need to consider. The list below is not exhaustive, but covers some of the core factors a commissioner is likely to need to consider:

1.	What steps the commissioner should take to evaluate and identify the health care needs of the population for which it is responsible, including the extent to which it should engage with the local community, patients and patient groups, clinicians and others, to ensure that the services it procures will help to secure those needs.
2.	How the commissioner can make sure that all the needs of health care users are met when it procures particular services, including their needs for related services to those being procured.
3.	How the commissioner can secure the needs of all health care users for which it is responsible when procuring services, including: • What steps it might take to ensure equitable access to services by different groups of health care users;

	• Whether particular groups of patients have specific needs and how these can be addressed; • What steps the commissioner should take to address any potential impact that a procurement decision relating to one set of services may have on the continued availability of other services that health care users need
4.	What steps the commissioner should take to monitor the quality and efficiency of existing service provision and to identify any areas where improvements are needed or could be made in advance of procuring services.
5.	How the health care needs of the local population can be best secured and how the quality and efficiency of the services might be improved, including: • The way the services are procured; • The service specification and contract design; • Ensuring that the services being procured are delivered more effectively alongside other services.

13. Basic Principles of PPCCR 2013

Transparency

Commissioners must ensure that they conduct all of their procurement activities openly and in a manner that enables their behaviour to be scrutinised. Actions that commissioners could take to increase their transparency include:

- Publishing information on their future procurement strategies and intentions;
- Taking steps to ensure that providers are aware of their intention to procure particular services;
- Publishing details of contracts awarded;
- Maintaining appropriate records of decisions that have been taken, with reasons.

Proportionality

The process put in place to procure a service must be proportionate to the value, complexity and clinical risk associated with the provision of the service in question.

Non-Discrimination

Commissioners are under a duty not to favour one bidder, or one type of provider over another. Differential treatment between providers requires objective justification.

Potential behaviours which could be viewed as discriminatory include:

- Giving one provider a more extensive role in engaging with the commissioner on service design, which could then give that provider an unfair advantage ahead of its competitors;
- Not giving providers an adequate opportunity to express an interest in providing a service;
- Designing the service specification in a way that excludes a provider or category of providers unnecessarily and without objective justification in terms of service needs, efficiency etc.;
- Treating a provider, or type of provider, more favourably than any other provider, in particular on the basis of ownership;
- If a competitive tender process has been followed, the award criteria must not disadvantage a particular provider if this cannot be objectively justified. The award criteria must be applied in the same way to all providers.

Value for Money (VfM)

Commissioners must ensure that when they enter into new contracts they do so with the most capable provider or providers that provides best value for money. By common definition, this means Quality & Price.

A provider will provide best value for money where it delivers the best overall quality and price (where prices are not set). The best value will not necessarily be delivered by the provider that supplies services at the lowest price.

NHS Improvement in its December 2013 guidance stated that the factors it was likely to take into account when assessing whether commissioners have complied with Regulation 3 are:

1.	Has the commissioner taken steps to identify existing and potential providers interested in and capable of providing the services being procured by the commissioner?
2.	Has the commissioner objectively evaluated the relative ability of different potential providers to deliver the service specification and to improve quality and efficiency?
3.	Has the commissioner required prospective bidders to undergo suitable due diligence, as appropriate?
4.	Has the commissioner considered both the short-term and long-term-impact of their commissioning decisions (including the sustainability of services)?
5.	Has the commissioner taken account of the effect of bundling services together?

PPCCR 2013 also governs the circumstances when the CCG may award a new contract for clinical services without a competition (Regulation 5). They provide that the CCG:

"may award a new contract for the provision of health care services for the purposes of the NHS to a single provider without advertising an intention to seek offers from providers in relation to that contract where the relevant body is satisfied that the services to which the contract relates are capable of being provided only by that provider".

When advertising an intention to seek offers for a clinical services contract, PPCCR 2013 requires the CCG to publish a contract notice dedicated website, in place from time to time. The notice must include a description of the services to be provided and the criteria against which any bids for the contract will be evaluated. The CCG must also have arrangements in place which enable providers to express an interest in providing clinical services.

The obligation of transparency which is imposed on the contracting authority consists in ensuring, for the benefit of any potential tenderer, a degree of advertising sufficient to enable the services market to be opened up to competition and the impartiality of procurement procedures to be reviewed.

14. Regulation 10 Exemptions and Anti-competitive Behaviour

When commissioning health care services for the purposes of the NHS, the CCG will not engage in anti-competitive behaviour, unless to do so is in the interests of people who use health care services for the purposes of the NHS which may include:

- by the services being provided in an integrated way (including with other health care services, health-related services, or social care services); or
- by co-operation between the persons who provide the services in order to improve the quality of the services.

Regulation 10 also provides that an arrangement or contract for the provision of clinical services must not include any term or condition restricting competition which is not necessary for the attainment of the intended outcomes which are beneficial for the people who use the services or, the overarching objective referred to in Regulation 2.

Where there is judged to be tension between the PPCCR 2013 and the PCR 2015, guidance should sought from this Guidance or from the CCG's procurement support service provider.

15. Remedies Available Under the PPCCR 2013

Whilst a provider has greater control over the conduct of the litigation if it challenges under the PCR 2015, NHSE/I does have extensive powers under the PPCCR 2013 and will adopt a more inquisitorial approach when it takes on a complaint. It is likely to investigate the overall impact on the provision of health care services in a way which the Court will be unwilling to do.

NHSE/I has power to investigate complaints that a CCG has failed to comply with the regulations or initiate its own investigation into whether a CCG has failed to comply with the competition provision of the regulations.

NHSE/I can provide the following remedies:

- Declaration of ineffectiveness under Regulation 14. – In relation to an arrangement or to a term or condition of an arrangement. This ability to set aside a contract already entered into goes wider than the powers of the Courts in such situations under PCR 2015.
- Directions under Regulation 15- to put in place measures to prevent failures to comply with the regulations, and measures to mitigate the effects of failures. NHSE/I may vary or withdraw an ITT to prevent or remedy a failure, and to vary an arrangement for the purposes of preventing failure to comply with the competition provision. Whilst the power to give directions is a wide ranging, NHSE/I may not require a CCG to hold a competitive tender.
- Undertakings under Regulation 16 – accept undertakings to prevent or mitigate specific failures in the same way as the directions.

In its Enforcement Guidance, NHSE/I notes that its formal action can include providing guidance, issuing advisory letters or issuing a warning letter. The timing of investigation carries out to date suggest that Court action may result in a speedier outcome.

16. Approach of NHS England and NHS Improvement (NHSE/I)

In options set out in paragraph 15 above, NHSE/I offers an additional option for bidders considering grounds of challenge for healthcare commissioning. It is not subject to the same time constraints as imposed on claims under the PCR 2015. However, there is less control over the process because there is no certainty that NHSE/I will take the complaint on and although bound by public law principles, NHSE/I is not bound by precedent.

NHSE/I takes a more investigatory role than would the Court. Whereas the Court would confine itself to deciding issues of law on the basis of facts solely as presented to it, NHSE/I will raise questions of its own accord with the parties, requesting responses both in writing and requesting meetings as fact-finding investigations. NHSE/I has the remit to consider a more holistic impact of a particular procurement on the wider health locality, or indeed nationally.

As a result, the NHSE/I investigations can become protracted and time consuming, requiring input from both all parties involved and comparable to if not more lengthy than Court Proceedings. There is no precedent to anticipate the outcome of a NHSE/I investigation in the same way that the parties can anticipate the outcome of a claim issued through the Courts. A party who objects to a final NHSE/I decision would have the ability to challenge that decision by way of Judicial Review.

17. The Public Services (Social Value) Act 2012

The Public Services (Social Value) Act 2012 ('Social Value Act') applies to the CCG when carrying out its clinical procurement activities. In accordance with their obligations under the Social Value Act, the CCGs will consider, at both selection stage (such as Selection Questionnaire) and award stage:

- how the services to be procured may improve the social, environmental and economic wellbeing of its area; and
- how in conducting a procurement process the CCG might act with a view to securing that improvement, including whether to undertake a consultation on these matters (or as part of the CCG's wider statutory obligations to consult).

It is mandated that 10% of the overall weight at the pre-procurement stage is allocated to social value. The only permissible exception to this minimum 10% of the overall weight rule is where pre-market engagement demonstrates that this approach would significantly reduce competition due to lack of market maturity in delivering social value. In these exceptional cases, the CCG may specify social value weighting to be 10% of the quality score.

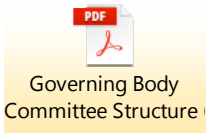
18. Conclusion

There are two sets of regulation governing the procurement of health services in the public sector: PCR 2015 and PPCCR 2013. The circumstances allowing an award without competition are different under each set of regulation. The CCG must consider both in order to mitigate the risk of challenge.

The LTR in the PCR 2015 implements parallel provisions in the new European Public Contracts Directive. Since 18 April 2016, commissioners need to advertise health services contracts in the OJEU that are over-threshold, and follow the CCS guidance around the design of a compliant LTR process. There are situations where the CCG can award contracts without a full procurement but the CCG must meet the requirements of the current Regulations. The CCG is also advised to keep full audit trail of decision-making process and carry out extensive market engagement and/or analyse to evidence any conclusions on level of competition.

Please note that some of the above guidance will change based upon the Brexit deal and any measures being put in place by the UK government.

Appendix 2 North Central London Clinical Commissioning Group's Governance Structure



Appendix 3 North Central London Clinical Commissioning Group's Single Tender Waiver Form

Appendix 4 North Central London Clinical Commissioning Group's Standing Financial Instructions


SFIs


SFIs Annex 1