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Dear Mike

Thank you for voluntarily agreeing to undertake a pilot of the new Integrated Support & Assurance Process (ISAP) in relation to the current procurement of both community and urgent care services in West Lancashire CCG.

The assurance framework itself is still draft and is currently being developed by PWC for NHS England. Any learning from this pilot review will contribute to the further development of the assurance framework.

A desktop review of the key procurement documents was undertaken by NHS England. The review team compromised NHS England staff based in Lancashire and colleagues from the North regional office. The desktop review were followed by a face to face meeting with key representatives of the CCG to further probe and clarify any issues raised. The review considered the overall process of the procurement across 7 critical risk areas, rather than considering individual decisions made on bidders.

1. **Noncompliance with procurement regulations.**

The CCG had used Midlands & Lancashire CSU to manage the procurement process on its behalf. We found that the CCG had complied with current procurement regulations having followed the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. This had been reviewed by the CCGs Internal Auditors to provide confirmation to the governing body and included both an Equity Impact Assessment and a Quality Impact Assessment.

2. **Market testing being poorly defined so that the data provided by respondents is not comparable.**

The CCG adopted a Competitive Dialogue (CD) approach to the procurement. They appointed lawyers Mills & Reeve, specialist in procurement processes for advice on an approach that allowed dialogue with bidders. The market testing was based on OJEU Request for Information that shaped the Pre-Qualifying Questionnaire (PQQ). The CCG had

numerous bidders apply for Lots 1 and 2 at PQQ stage and four were shortlisted for Lot 1 and two for Lot 2. Incumbent providers were not shortlisted past PQQ evaluation because their bid was non-compliant in respect of the proposed model of care and the level of integration.

3. **Ineffective governance structure in procurement phase resulting in key issues not being identified and managed effectively.**

There is good evidence that the CCG has a clear governance structure established and a programme board risk register is regularly updated with any risks. Conflicts of interest have been managed appropriately. The CCG has used its membership structure to engage with GPs along with a range of stakeholders (including staff working in the service) throughout the process as outlined in the stakeholder matrix and involvement report, to identify issues with current service provision and set ambitions for a future service.

The CCG established a procurement programme board subcommittee to review and score each bid against the evaluation criteria and make recommendations to the CCG governing body at each stage of the process. The CCG has quite properly reserved all key decision to the governing body. The CCG has appropriately used the part 3 Record of Decision and Access to Documents regulations for public bodies to maintain the confidentiality of bidders.

4. **Delivery is undermined by an incoherent delivery organisation management strategy whereby issues are not resolved on a timely basis or misleading/conflicting information is provided to the delivery organisation.**

The ISFT (Invitation to submit final tender) required a mobilisation management strategy and plan from each bidder. The CCG has proposed throughout the course of mobilisation to have weekly meetings of the Mobilisation Operational Delivery Group. We would suggest prior to mobilisation the CCG agree to a draft Gateway 3 assurance process to provide further assurance with regard to their management strategy.

The CCG has appropriately assessed the level of current demand for the service, and has increased this to reflect both demographic change, an increased specification and current thinking on delivering more care outside hospital settings. This has been reconciled from the outgoing provider.

The specification sets out clear and measurable targets for the incoming service provider. The CCG should ensure that the basis for any metrics used within the specification is explicitly written into the contractual agreement to minimise the risk of future disputes with the new provider.

The delivery organisation risk of all bidders was reviewed at PQQ stage and was clearly and appropriately used to exclude bidders as necessary. Particular checks were undertaken to ensure that bidders understood the treatment of VAT and this was confirmed at the Competitive Dialogue stage that all bidders understood the treatment of VAT.

The CCG has discussed option of sustainability partner with the incumbent provider to ensure contingency plans are in place to address any risk of failure by the new provider.

The CCG considered the delivery organisation risk in the areas of business continuity, quality of service delivery, safety, reputation and financial issues as part of the ISFT. The risks associated with mobilisation should be fully captured and sufficient internal capacity should be available to ensure a smooth handover process.

5. **Transition could be delayed leading to concerns over the durability of the contract. Service delivery is not monitored, leading to drop off in performance levels after awarding the contract. No formal mechanism to resolve issues or disputes.**

The specification for the contract is clear on measurable targets; this should therefore translate well into both the contract and monitoring arrangements. Issues such as TUPE and vacancies have been reconciled to staff budget. A contract mobilisation timescale is in place.

Bidders as part of their bid have been asked to identify financial risks, cost the impact, and assess the likelihood to produce an evaluated risk sum. Each risk has an identified owner (bidder or CCG). There is a clear escalation process to formal contract levers. The community contract specification has clearly defined the risk appetite and has this been communicated and understood by the delivery organisation, along with clearly defined critical success.

6. **Noncompliance with procurement regulations exposing the organisation to legal challenge post award.**

The CCGs internal review of the procurement process has been thorough, and the CCG have used external support from MIAA (Mersey Internal Audit Agency) to supplement this and provide additional assurance.

7. **Delivery is undermined by incumbent provider**.

With regard to the existing community contract, there is a clear agreement and this has been contractualised. With regard to the Out of Hours contract, the current provider is a cooperative and relies heavily on sessional staff. Mobilisation will be dependent upon the incoming provider's ability to attract sessional staff within the market place. The CCG should set clear targets for monitoring as part of their oversight of contract mobilisation. A market for such sessional staff does exist, but can be price sensitive, contractual terms should be clear on the provider's responsibility for managing this risk.

ADDITIONAL QUERIES:

a) Has the financial envelope been set correctly? Including any specification changes for future requirements?

We sought assurance that the contract value was reasonable, and therefore the incoming provider should not have problems meeting the specification.

We found evidence that there was explicit agreement between the CCG and the existing provider on the value to be removed from the current contract. The CCG had increased this sum to reflect specific additional items included in the new specification. We further tested the schedule of staff that is proposed to TUPE transfer, this provided us with additional assurance that the contract value reflects the cost of delivering the service.

Finally in this heading, we shared our findings with NHS Improvement, and asked them if they had any further concerns about the provider's financial plans for next year that could be factored into these deliberations. NHSI raised no such concerns.

b) Financial standing of providers?

This was thoroughly tested at PQQ, using both internal expertise to review documents submitted by the bidders and also using external agencies including credit checks/ liquidity, Dunn and Bradstreet reports and contract turnover.

c) Why did other bidders pull out?

One international bidder withdrew as they wanted to bid for Lot 1 and Lot 2 in a combined bid, rather than standalone bids as outlined in the procurement ITT.

d) Does mobilisation strategy test ability to mobilise?

There is evidence that bidders have mobilised successfully elsewhere. This to be tested at next gateway and is particularly relevant where TUPE does not deliver the required workforce.

e) Unanticipated stranded costs?

Discussions with the current provider are ongoing. There is still a potential additional estate cost which would fall on NHS Property Services or the CCGs. The CCG is clear on its liability in this regard.

Overall the CCG has provided assurance into the procurement process; however we wish to draw your attention to the following advisory points which arose as part of the meeting:

- The CCG should ensure that the basis for any metrics used within the specification is explicitly written into the contractual agreement to minimise the risk of future disputes with the new provider.
- The risks associated with mobilisation should be fully captured and sufficient internal capacity should be available to ensure a smooth handover process.
- The CCG should ensure robust contingency plans are in place.
- Mobilisation will be dependent upon the incoming provider's ability to attract sessional staff within the market place. The CCG should set clear targets for monitoring as part of their oversight of contract mobilisation.
- The CCG should ensure that any additional stranded costs associated with the outgoing provider and any estate is clearly defined.

The assurance framework also contains a further checkpoint prior to full mobilisation. We would recommend that the CCG voluntarily participate in this next phase of this exercise to provide assurance over the mobilisation aspect of the contract.

Finally, we would like to extend our thanks to the individuals involved in the review for their time and cooperation in this process.

Yours sincerely

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