The rules are not your enemy

Liberating clinical commissioning through procurement and contracting

The opportunity for large-scale improvement in the NHS is now. Clinical commissioning groups are working hard in their first year to make a real difference to the long-term health outcomes of their patients and local communities. However, for many CCGs, the guidance and rules around procurement and competition can feel restrictive and pose unnecessary burdens to their strategic ambitions.

We understand from our members that in order to succeed CCGs must be supported to think through the ‘art of the possible’ in relation to procurement in the new system. We firmly believe the system must create the right environment for bold strategic commissioning that is seen as supportive of competition as a driver of change but not the only or primary tool available. This briefing summarises key learning points for members and the new system on the best ways of facilitating that change. The content for this briefing was developed by our members, our leadership group, and senior policy leads in health policy, commissioning, competition, procurement and contracting who participated in a recent roundtable.
Introduction

Clinical commissioning is already demonstrating enormous potential to improve services for patients and increase efficiency. Ambition, creativity, collaboration and innovation are beginning to reshape the NHS to meet the challenge of delivering higher quality at lower cost. But the task is unprecedented, and clinical commissioning groups (CCGs) can only succeed if the rules and regulations governing their work enable them to do what is best for patients and help them realise their ambitions for their local communities.

Used appropriately, competition between NHS providers can help commissioners improve service quality and value, freeing up funds to be used elsewhere. However, we, as the independent membership body of CCGs, recognise there are a number of practical difficulties within the current system when clinical commissioners try to secure the best outcomes for patients. As such, the rules around procurement and competition often seem like a distraction from – and even an impediment to – improving services and saving money.

We are confident there are ways through and wish to focus on the ‘art of the possible’; no clinical commissioner need be prevented from providing a better service for patients by the regulations.

To help our members make known their views on the realities around how they feel the competition and procurement rules work, and appreciate the wide range of options available to them, we invited senior policy leads and experts in health policy, NHS commissioning, procurement and contracting to sit alongside our steering group, leadership group and wider members, to explore how to make a real difference to the health of patients and communities by understanding the ‘art of the possible’ in procurement and contracting.

This briefing presents a number of insights gleaned from a roundtable we held on 30 July 2013, and pulls together a number of key messages for our members and the wider NHS.

Key messages for CCGs

- Always start with defensible strategic decisions for patients and communities. Under current procurement regulations, CCGs must ensure their commissioning strategies are publicly defensible in terms of either raising quality, improving outcomes, access, integration or value for money. Decisions do not always have to be justified in terms of slavishly following every clause in the regulations, but defending a set of broad objectives.

- Focus on opportunities rather than barriers. Procurement should not be seen as a bureaucratic process bogged down by competition law, but rather a powerful tool that enables commissioners to reshape the local health economy to improve patient outcomes.

- Be bold and ambitious in the new system. Working in complex, financially tight environments, CCGs have a small window of opportunity to create transformational change. Have the confidence to do what is right for patients and populations and be willing to take risks to achieve the best outcomes.

- Own and shape the regulations. As the new system is settling in, now is the time for CCGs to collectively take responsibility for shaping how procurement rules are interpreted and operated. The more CCGs, and those who advise them, take a robust approach to shaping the way rules are implemented, the more the application of new regulations will be shaped by patient need and less open to challenge.

- Take the broadest possible view of resources. This includes those of the local authority, area team, public and private providers, local businesses, emergency services and the community and voluntary sector. Commissioners within a health economy need to bring all these elements of the wider care system together, working through different fora, such as the health and wellbeing board.

- Have an open mind to innovative investment and delivery. In a tight fiscal environment, CCGs will naturally search for innovative investment models, and need to have the tools ready to procure them. This opens up partnerships with foundation trusts, local authorities, the private sector, GPs, mutuals, charities, and also beyond the traditional NHS boundaries to include social enterprises, joint ventures and private equity. CCGs need to be aware and open to the use of alliance contracting, outcomes contracting and social investment bonds in the new system.

- Ensure commissioning support works to support strategic interests. CCGs have choice in the support they receive from commissioning support units (CSUs). Early involvement from CSUs in strategic decision-making can support CCGs to realise their ambitions. If CCGs believe they are being provided with excessively cautious advice, seek advice and interpretation from elsewhere. Also take advantage of the advisory support that organisations like Monitor offer at a national level.

- Work collaboratively to find the right solution for the management of primary and secondary provider risk. Most transformation work is through negotiation – explore all the options. The primary integrator model is one option, but CCGs must not lose sight of the reality that, overall, the greatest risk to providers and patients is commissioner inaction in the face of the need for substantial and rapid change.
Key policy messages for the system

- **Time for a commissioner-led definition of procurement.** The roundtable highlighted that procurement as a practice has a restrictive, process-driven narrative around it. In order for CCGs to have the right environment to make bold, strategic decisions, the NHS needs an enabling narrative that puts commissioners at the heart of procurement. Commissioners have a choice of contracting tools and levers to support their population-level purchasing. At a similar level, the Government needs to ensure good procurement is freed up in the system by clarifying the interface between it and other initiatives, such as Any Qualified Provider (AQP).

- **Further clarity on competition law is needed to reduce perceived risk.** Discussions around the operation of competition and procurement laws invariably highlight significant differences of interpretation between UK and EU law. Of particular concern is the legal perspective and the risk of CCGs being challenged in courts of law. CCGs must be involved in any national initiatives to provide clarity of interpretation, and the key triggers for procurement, to really support their local decision-making. While commissioners always have the option of seeking the opinion of CSUs, greater consistency of understanding across NHS commissioning about how the system is supposed to work would be far more valuable.

- **More longer-term planning across the system.** If CCGs are to progress their ambitious schemes, they need to be able to break out of the annual planning cycle, which imposes administrative burden on CCGs. This is often a consequence of annually imposed processes, budgets and out-of-kilter growth models. We urge for more discussion on the alignment of current contracts system (including the standard contract) to procurement models.

- **Procuring with leverage across commissioning budgets.** We understand that there is considerable room for improvement in the alignment between CCGs, NHS England and local authority spend and this impacts on the ability to enact whole-scale transformational procurement. This is about having a mature commissioning relationship between CCGs, NHS England and local authorities, one that is supported at a national level by a shared understanding of the role of procurement and shared contracting processes.

Over the next few months, we will be supporting members to navigate the practical side of procurement and contracting, through a series of workshops in 2014 and working with national stakeholders on the system voice of CCGs, to create an enabling environment.

---

The Fiscal Sustainability Report published by the Office of Budget Responsibility (OBR) in July 2013 left no doubt about the task facing health commissioners. If the annual improvement in healthcare productivity remains at the current level of 1 per cent, significantly lower than the rest of the economy, then by around 2062 public sector net debt will exceed 200 per cent of GDP – more than double the current figure. In the short term, the OBR predicts a tougher financial climate for the NHS in the second half of this decade. This all means the current pattern of care is unsustainable.

But despite this spur to radical action, there are worrying signs that in their first few months, CCGs are in danger of settling in to a risk-averse culture. Rules and restrictions, both real and imagined, are stymying ideas, while the complexity of issues such as reconfiguring acute services is making it difficult for CCGs to gain traction in reshaping their local health economies.

**Patients or process first?**

Our roundtable revealed that an excessive focus on the procurement process is undermining effective commissioning. CCGs are in danger of being overly led by procedures so that they lose sight of the outcomes they need to achieve for their patients and communities. Too often this ends up with commissioners sticking with existing services and suppliers when they could have found more effective solutions.

Even superficially simple decisions, such as determining whether the service being commissioned is a new one that does need a procurement process, or an improvement on an existing service that may not, are causing confusion and delays. The regulations cite furthering integration as a reason not to go to tender, but exactly how that exemption works is unclear. After all, few service proposals are going to advocate the idea of separation.

“In order for CCGs to have the right environment to make bold, strategic decisions, the NHS needs an enabling narrative that puts commissioners at the heart of procurement”
Commissioners or lawyers in charge?
Legal advice, whether from internal lawyers, law firms or CSUs, varies in its interpretation of when and how procurement processes should be triggered. Commissioners are often struggling to obtain good advice on innovative investment vehicles and service structures.

Relationships between commissioners and CSUs are still in their early stages of development. While the contribution of CSUs is highly valued, there are examples of commissioners feeling that CSUs are being excessively cautious in their advice, possibly out of fear of making a mistake and damaging their reputation in the commissioning support market.

While commissioners always have the option of seeking the opinion of another CSU, greater consistency of understanding across NHS commissioning about how the system is supposed to work would be far more valuable.

Conflicts of interest
Conflicts of interest are often raised as an issue for CCGs when they seek to procure for enhanced primary care provision and wider community provision. In their briefing ‘Managing conflicts of interest in clinical commissioning groups’, the NHS Confederation and Royal College of General Practitioners warned that failing to manage conflicts effectively risks undermining confidence in the probity of commissioning decisions and the integrity of the clinicians involved. To ensure CCG are clear on what constitutes a conflict, Monitor has clarified this in ‘Substantive guidance on the procurement, patient choice and competition regulations’, published in May 2013.

However, it is the ‘perception fear’ from conflicts of interest that may be inhibiting the development of more community-level service offers, as CCGs seek to find transparent processes for tendering. A typical concern is whether it is safe to involve particular GPs (who are also providers) in developing the specification for a new service. The roundtable highlighted that CCGs do have examples of good practice and have worked through these issues locally.

To reduce reputational risk, CCGs must establish clear, robust mechanisms for managing real and perceived conflicts. These include a clear statement of the conduct expected of those involved in commissioning, maintaining an up-to-date register of potential conflicts, and ensuring that conflicts arising at a particular meeting are addressed clearly and openly, according to policies that stipulate when conditional participation, or partial or total exclusion, are required.

Commissioning for outcomes, not activity
Writing a good contract built around health outcomes for patients or populations is hard, especially when trying to identify which measures to use. Clinical commissioners are often frustrated with how difficult it is to enshrine the values and goals they are trying to achieve in the technical wording of the documents that are eventually signed. Our roundtable highlighted a few solutions for members, which are highlighted later in this briefing.

Alignment with NHS England and local government
NHS England has been keen to promote the idea of a more collaborative, less directional relationship between itself and CCGs compared to the way the previous system used to oversee primary care trusts. However, some CCGs have flagged that NHS England’s area teams can be overly directive, and this makes it difficult to align the considerable resources area teams control – notably the budget for commissioning primary care – with their own objectives and procurement approaches.

Alignment is also a concern with local government’s public health role. There are indications that councils are taking a robust approach to decommissioning services that they believe do not offer value for money. This may be the right decision, but CCGs need to work quickly to ensure that public health service changes, and their own assessment of local health needs, are synchronised to avoid gaps in the health economy.

How can CCGs liberate their potential?
CCGs need to shift the axis of their thinking and reinvent how commissioning works. By their background, GPs are instinctively entrepreneurial and must use that skill to be bold clinical commissioners. We have outlined, below, some solutions identified by roundtable participants.

Be ambitious, imaginative and disruptive
Commissioning is pointless unless there is long-term ambition and imagination about the outcomes commissioners are trying to achieve. The greater the ambition, the more disruption to existing patterns of care will be required.

Disruption must not be pursued for its own sake, but neither must it be avoided. Unless there is disruption, the provider landscape will never change. But it needs to be managed in a way that leaves providers motivated and able to respond to changing demand.

It is almost certainly not about disrupting the whole supply chain and bringing in a whole raft of new providers, but it might be about ensuring providers work together, or targeting new services from the public, private, social enterprise or voluntary sectors at particular points in the care pathway to raise standards or improve integration.

Lateral thinking and creativity need to be at the centre of discussions around outcomes and how to achieve them. Countries such as India and Brazil provide striking examples of low-cost, high-volume, high-quality primary and secondary care that may be the forerunner of how some NHS services will be provided.
Shaping the rules and regulations

Far from allowing the uncertainty and confusion around the precise operation of procurement and competition rules to inhibit progress, CCGs have the space to collectively take responsibility for shaping how those rules are interpreted and operated.

There is a powerful precedent for rules being rewritten to keep pace with developments that were outside the existing regulations, but were defensible in terms of what is best for patients. In 1998, the personal medical services (PMS) contracts introduced a new way of paying GPs for primary care services (effectively a fixed-price contract for providing a service) in response to consultations that identified that excessive bureaucracy under the general medical services contract was impeding good quality care. PMS contracts did not meet the letter of the existing regulations, but were clearly in the interests of patients.

The more CCGs, and those who advise them, take a similarly robust approach for shaping the way the rules are implemented, the more the application of the new regulations will be shaped by patient need. Ministers, regulators and providers inside and outside the NHS will find it difficult to criticise or legally challenge a decision demonstrably taken in the interests of local people. CCGs need to assert that this is the right approach.

How to approach competition and the market

When deciding whether to put a service out to tender or to remain with a single provider, CCGs must think about the market, but can decide, after an objective assessment of the evidence, not to use it. This should reduce the risk of falling foul of competition law.

For example, our roundtable suggested that when deciding whether to sign a new contract with an existing provider, a good approach would be to assess the quality and value for money of the existing contract compared with possible alternatives; look at the evidence of patient satisfaction and consider whether moving the service elsewhere may undermine other services at the provider or detract from the objective of better integration.

If, after considering the issue in a fair, transparent and evidence-based way, CCGs decide to place another contract with the existing provider, Monitor is far less likely to support a complaint from an aggrieved competitor than if it looks as though commissioners have been subjective in reaching their decision, or not considered all the issues.

Public engagement is vital; the views of service users should be a component of commissioning decisions and may well be significant in the case of a challenge. Acting in the best interests of patients is a powerful argument.

All this means that simply rolling over a contract without considering the issues could leave CCGs open to challenge.

A reasonable assessment of the market evidence needs to be made, not just because of competition law, but because it is the only way to ensure patients receive the best service.

Monitor is adamant that it does not want to stifle innovation in the way it oversees the competition process. As it says in Substantive guidance on the procurement, patient choice and competition regulations:

“It is for commissioners to decide what services to procure and how best to secure them in the interests of healthcare service users. The regulations adopt a principles-based approach that is intended to give commissioners flexibility. Monitor's role will be limited to ensuring that commissioners have operated within the legal framework established by the regulations.”

Monitor is clear that its competition team can provide informal advice to help CCGs navigate the rules and build the services their patients need. We urge our members to take up the offer where they have questions.

Leading local services

CCGs provide clinical leadership to the local health economy, and as such need to take the broadest possible view of the resources in their area, including those of local government, NHS England, emergency services, local businesses and community and voluntary sector. For example, reducing emergency admissions through fewer night-time street injuries and providing a safe and supportive environment in the community for people with dementia both involve working with providers, the council, emergency services, local businesses and voluntary groups. Building strong, mutually supportive relationships with shared priorities is key.

All this is about creating real integration. Pooling budgets can certainly help achieve this but, just like the procurement process, difficulties in bringing money together must not be allowed to impede better integration to improve outcomes.

Raising the quality of residential and nursing home care is a powerful example of how CCGs can achieve significant improvements in patient care by acting as a catalyst for the activities of others – bringing together private providers, the local authority, the voluntary sector and GPs as providers, as well as getting acute trusts to provide services out of hospital and into the community.

“CCGs must establish clear, robust mechanisms for managing real and perceived conflicts”
Being open-minded to new models and tools

The prospect of a further tightening in NHS funding in the later years of this decade – at precisely the time when CCGs and providers will need to be introducing more efficient and effective care pathways – is compelling CCGs to search for both investment and new models of care delivery. This opens up partnerships with foundation trusts, local authorities, the private sector, GPs, mutuals, charities, social enterprises, joint ventures and private equity.

One delivery approach attracting interest is the medical home model, developed in the US by Group Health. The aim is to provide active rather than reactive care. Care is patient-centred, with decisions respecting patients’ wants and needs; patients have the education and support to make decisions and participate in their own care. It is also comprehensive; a team of care providers looks after all aspects of a patient’s health, including prevention, mental health and chronic care.

In the UK, the contracting tool required to establish such a model requires a process similar to alliance contracting. An alliance contract brings together commissioners, providers and funders under one contract to deliver an integrated service. Alliance contracts align objectives, share risk, and judge success by overall performance. This means there is collective accountability based on trust and transparency. The contract is outcomes based.

This approach, which fosters collaboration without the need to set up complicated new structures, has been used successfully in the oil and construction industries. NHS Oldham CCG is developing an alliance contract to provide urgent care, involving local trusts, the primary care provider and Oldham Borough Council.

When it comes to investment, social impact bonds are an example of a model that can help CCGs get capital into services that deliver cashable savings beyond the financial year. Commissioners agree to pay a fixed sum in the future if agreed outcomes are achieved that yield cashable savings. This allows commissioners to partner with investors and providers willing to cover the upfront costs in programmes they believe will deliver both savings and service success.

Social impact bonds have been growing in local government since 2010. The Greater London Authority has established a bond with charities St Mungo’s and Thames Reach to work with 850 rough sleepers. Social impact bonds are now attracting interest in health, with encouragement from the Government, the Big Lottery Fund and the Association of Chief Executives of Voluntary Organisations, among others.

All these approaches need to be considered as tools in the CCG procurement and contracting toolbox.

Taking a fresh view of hospital trusts

CCGs and acute trusts can have a narrow view of the services that trusts can provide and need to be open-minded in thinking through how the role of the provider can change. But this in turn requires financial incentives to work in a way that encourages providers down this road.

Foundation trusts (FTs) have around £2.7 billion of reserves (though not spread evenly); this is a largely untapped potential resource for CCGs, who need to work with FTs to encourage investment in community and other services and to help manage the risk of reconfiguring acute services.

Working with commissioning support

Close collaboration between CCGs and CSUs is part of the bedrock of successful commissioning. Engaging a CSU early and fully is crucial to making the most of the relationship.

If a CSU is approached for advice late in the process, when it has not been involved in the discussions that shape the commissioner’s goals, the legal opinion the CSU offers will almost inevitably be cautious and rule driven. If, however, it is fully engaged in the development of ideas and has a strong understanding of the commissioner’s vision, it will be better placed to offer innovative solutions.

Outcomes-based commissioning

Internationally, increasing numbers of health systems are focusing on commissioning for outcomes to improve the lives of patients and communities. The Netherlands is just one example.

Commissioning for outcomes means being both more disruptive and more collaborative in working with providers. But new forms of collaboration with providers can also play a role, such as a provider acting as the prime integrator in the local health economy, or a foundation trust investing in community services. Under the prime integrator (or prime contractor) approach, a provider with the financial strength to carry the risk and the capacity to organise other providers integrates those services on behalf of the commissioners. A group of providers might also collaborate in sharing the risk.

The prime integrator model can help commissioners to settle the risks for acute and primary care providers by moving some of the risk to the integrator. This helps free commissioners to focus on outcomes. This is particularly beneficial for commissioners using outcomes-based funding, because it is riskier for providers to meet their fixed and variable costs if they are uncertain about achieving the outcomes required, compared with the relative safety of predictable income from activity-based funding.
Managing the risks to providers

The extent to which commissioners believe they have to own and manage the risks faced by their providers will profoundly affect what they decide to do.

The use of competition has to be carefully calibrated. Competition has an important part to play in the search for greater innovation, productivity and effectiveness, but most of the improvements needed to improve quality and cut costs will have to be delivered by existing providers.

The risk to providers of changing and moving contracts is a massive issue for commissioners who want to sustain a range of local services but are getting poor quality from their local trust, particularly in the context of a financial structure in which a significant number of trusts are already struggling to remain viable.

In crude terms, trusts are a conglomeration of numerous businesses. If contracts are lost, the fixed costs are likely to remain, and other service lines in the trust may in turn have their viability threatened. A parallel issue exists with primary care. ‘Enhanced services’ currently provided by GPs are often important in bolstering GP surgeries’ income. If CCGs change the way these services are provided, such as by greater use of community medical services or the local authority, the viability of some surgeries may be undermined. CCGs and providers will need to explore innovative models for risk sharing, including through lead provider models and risk pooling.

The COBIC approach

In England, the most familiar model for outcomes-based contracting is capitated outcome-based incentivised commissioning – the COBIC approach. It supports CCGs to undertake contracting for outcomes by looking at the relevant care for a given group of people, with the budget based on an understanding of the needs of that population and includes financial rewards for achieving the specified outcome measures. To deliver those outcomes and make the efficiency savings necessary to stay within the allocated budget, providers must collaborate and problem solve.

Case study: Outcomes in action – Milton Keynes’ substance misuse service

It was recently reported that Milton Keynes is the first area to develop a capitated, outcomes-based contract in England. Substance misuse services used to be delivered by several providers, resulting in fragmented care. Users found services difficult to navigate, so many dropped out. For commissioners, the large number of contracts and poor collaboration were inefficient and ineffective.

Milton Keynes CCG and Milton Keynes Council developed an outcomes-based approach to commissioning. They thought carefully about the outcomes they wanted, such as keeping people in housing, getting people into jobs, and ensuring the courts had access to a treatment service as an alternative to imprisonment. A contract was offered that combined capitation with rewards for improved outcomes; providers were also able to retain savings from delivering care more efficiently.

The contract was let to a third sector organisation, acting as prime contractor for the complete substance misuse service. It was quickly transformed, with improved outcomes for service users and savings of 15 to 20 per cent.

Case study: Outcomes in action – cancer care in Staffordshire

Five CCGs in Staffordshire are planning to tender the first integrated ten-year contracts for cancer and end-of-life care.

Macmillan Cancer Support is helping design the specification for two outcomes-based contracts to cover a population of one million. The scale and duration would make them the largest contracts yet tendered for integrated NHS care.

The CCGs are working with the Staffordshire and Lancashire Commissioning Support Unit to design the contracts around nine outcomes identified by Macmillan as being essential for good cancer care, such as patients being diagnosed early and being given the information to make good decisions.

The CCGs are considering a prime provider model. This would involve making a single organisation accountable for delivering the outcomes for an identified group of patients, such as those receiving care for a particular condition. This lead contractor would then subcontract to NHS, private or voluntary sector providers to provide seamless care.
Provider risk is not a reason for inaction, but commissioners need to take a view on the extent to which they see it as their role to manage this issue. The more the providers are able to manage their own risks, the more commissioners can focus on outcomes.

**How can policymakers and regulators help CCGs do the best for patients?**

**Defining procurement**

Procurement and contracting are important tools for commissioners, which have the potential to support broader change in the NHS. In practice, however, they have a restrictive, process-driven narrative around them.

In order for CCGs to have the right environment to make bold strategic decisions, the NHS needs an enabling narrative that puts commissioners at the heart of procurement. This means CCGs need to be aware of the choices they have in relation to procurement and contracting tools/levers to support their population-level purchasing. At a similar level, the Government needs to ensure good procurement is freed up in the system by clarifying the interface between it and other initiatives, such as Any Qualified Provider (AQP).

**Clarifying competition law to avoid multiple interpretations**

Discussions around the operation of competition and procurement laws invariably highlight significant differences of interpretation. There are differences between EU and UK-level legal interpretation and interpretation between commissioners. Roundtable attendees highlighted that in the UK, procurement regulations are seen to be more restrictive.

Furthermore, the EU policy environment is rapidly developing and has implications for CCGs. In June 2013, the European Parliament reached provisional agreement with member states on the new EU Public Procurement Directive. It is expected to come into force in 2014 and the Cabinet Office, which leads the implementation in the UK, has indicated its intention to transpose the directive into national regulations as soon as possible.

For CCGs, the directive will introduce a new light-touch procurement regime for clinical services, which will replace the current ‘Part B’ procurement rules. While contracts for clinical services of a value below €750,000 will not be covered by the new directive, those over this threshold will have to be advertised in the Official Journal of the European Union (OJEU), with national rules necessary to ensure that the key principles of equal treatment and transparency are complied with during the procurement process.

A more flexible, competitive negotiation procedure, allowing NHS organisations greater ability to negotiate with suppliers, will also be introduced. This should help CCGs procure innovative products and services adapted to their specific needs. The directive will also introduce a new procurement procedure specifically for the development of innovation. For the first time, an exclusion will allow public bodies to pool their public service delivery activities without always having to go to tender. There will also be a possibility to reserve health, social and educational contracts for employee mutuals and social enterprises. It will place greater emphasis on considering environmental and social issues in public procurement, including life-cycle costs.

In the UK, competition regulator Monitor consistently stresses the importance of commissioners focusing on what is best for their patients, and seeing procurement as a tool to help them achieve this, which should be considered only when commissioners are clear on the outcomes they want to achieve.

However, it is inescapable that the prescriptive wording of the competition rules under the Health and Social Care Act 2012 imposes limitations on how commissioners can approach their work. In particular, there is convincing anecdotal evidence that the way the UK operates competition for healthcare services is considerably more rigid than many other members of the EU find necessary.

Health minister Lord Howe gave clear commitments in the closing stages of the debates around the Health and Social Care Bill that commissioners would be in control of the use of competition. It would be invaluable if ministers clarified aspects of how competition policy works – if necessary through legislation – to ensure that commissioners are able to work in the way that the Government intended.

We understand that NHS England and Monitor are releasing further guidance on how competition and procurement rules should work. CCGs need to be part of their development to highlight the realities of making large-scale change work. This would provide much-needed clarity at a local level and encourage CCGs to not feel railroaded by process. Including guidance on the point at which CCGs can trigger a particular procurement process, which does not impede competition law, would be a priority.

“Provider risk is not a reason for inaction, but commissioners need to take a view on the extent to which they see it as their role to manage this issue”
Creating the right environment for long-term procurement strategies

If CCGs are to progress their ambitious schemes, they need to be able to break out of the annual planning cycle, which imposes administrative burden on CCGs. This is often a consequence of annually imposed processes, budgets and out-of-kilter growth models, such as payment by results.

CCGs are restricted in their ability to plan for long-term change when they are subject to the frequent retendering of individual contracts. Clinical commissioners need to have the space to have a stocktake of the totality of their procurement decisions across a health economy.

So, our question is how can good procurement be freed up within the system? There is an urgent need for case studies and principles that show CCGs what good procurement with long-term planning looks like.

Procuring with leverage across commissioning budgets

Ministers have stressed repeatedly that CCGs, not NHS England, set the vision and overall strategy for local health services. Our roundtable revealed that CCGs do not feel they have the leverage to make sure their procurement approaches have influence across the wider health economy and hence wider budgets – the reality is they have control of only part of the commissioning spend.

There is considerable room for improvement in the alignment between CCGs and NHS England’s regional and area teams, as direct commissioners. Between them, the area teams hold around 35,000 primary care contracts. It is also vital that NHS England takes a collaborative approach when it is directly commissioning specialist services, which amount to around £12 billion a year. To work well, specialist services need to be integrated with a wide range of local services.

The procurement and budget setting for local authorities is different from the NHS, though some of this is brought together through health and wellbeing boards.

It is difficult to overstate how important it is that these contracts are structured and managed to further the goals of CCGs and their strategic interests. This is about having a mature commissioning relationship between NHS England, CCGs and local authorities, one that is supported at a national level by a shared understanding of the role of procurement.

Clinical commissioning: a historic opportunity

This briefing is designed to reinforce the determination of CCGs to do what is right for patients, and use the procurement regulations in a way that gives maximum flexibility. The practical difficulties facing commissioners must not detract from the fact that the Health and Social Care Act 2012 is a historic opportunity for clinical commissioning to reshape the NHS for the benefit of patients and local communities.

NHSCC viewpoint

We held the roundtable in 2013 as a direct response to our members highlighting their concerns around the section 75 regulations, and its restrictions. We had many private conversations with the Department of Health, NHS England and Monitor to get the regulations to a place that sits well with CCGs.

Our work is not complete and we are pursuing change at a national policy level, using the insights from the roundtable to press the Government and regulators to make improvements, so that the commitments made in Parliament to place power in the hands of commissioners can be fully realised. Over the next few months, we will also be supporting members to navigate the practical side of procurement and contracting through a series of workshops in 2014.

But we also need our members to have courage in their strategic ambitions to shape the implementation of the regulations locally to ensure they use the procurement regulations as tools as opposed to being led by their process and perceived risk. There is no better time for clinical commissioning to make bold decisions and really change outcomes for patients and communities.

Share your views with us

As a member-driven organisation, we are keen to hear the views of members on the issues we have raised in this briefing. If you would like to speak to us, please contact office@nhscc.org
## Acknowledgements

- Report author – Richard Vize, Public Policy Media Ltd
- Report commissioner and editor – Julie Das-Thompson, Senior Policy Manager, NHS Clinical Commissioners

We would also like to thank the following people for their contributions to our roundtable on 30 July 2013:

- Dr Niti Pall (Co-Chair), member of the NHS Clinical Commissioners Leadership Group and Vice Chair, NHS Sandwell & West Birmingham Clinical Commissioning Group (currently on sabbatical)
- Mike Farrar (Co-Chair), former member of the NHSCC steering group and former Chief Executive, NHS Confederation
- Dr Amit Bhargava, member of the NHS Clinical Commissioners Leadership Group and Chief Clinical Officer, NHS Crawley Clinical Commissioning Group
- Jonathan Blackburn, Legal Director, Cooperation and Competition, Monitor
- Dr Mark Britnell, Chairman and Partner, Global Health Practice, KPMG LLP
- Alistair Brown, Director of Competition Policy, Monitor
- Naomi Burgoyne, Legal Adviser on Cooperation and Competition, Monitor
- Julie Das-Thompson, Senior Policy Manager, NHS Clinical Commissioners
- Dr Michael Dixon, Interim President, NHS Clinical Commissioners
- Dr Nick Hicks, Senior Associate, Nuffield Trust & Chief Executive of Cobic Ltd
- Dr Clare Highton, Chair, NHS City & Hackney Clinical Commissioning Group
- Dr Steve Kell, Co-Chair of the NHS Clinical Commissioners Leadership Group and Chair, NHS Bassetlaw Clinical Commissioning Group
- Rakesh Marwaha, member of the NHS Clinical Commissioners Leadership Group and Chief Officer, NHS Erewash Clinical Commissioning Group
- Neil Moore, Director of Procurement & Market Development, NHS Mansfield & Ashfield Clinical Commissioning Group and NHS Newark & Sherwood Clinical Commissioning Group
- David Owens, Commercial Health Partner, Bevan Brittan
- Jon Sacker, Communications Lead, NHS Clinical Commissioners
- Toby Sanders, member of the NHS Clinical Commissioners Leadership Group and Chief Officer, NHS West Leicestershire Clinical Commissioning Group
- Jay Sinclair, Chief Executive Officer, Pathfinders Healthcare Development
- Richard Vize, Writer (for NHS Clinical Commissioners)
- Elizabeth Wade, Head of Policy, NHS Confederation
- Chris Walker, Head of Procurement, NHS Central Eastern Commissioning Support Unit
- Elliot Ward, Systems Policy Manager, NHS England
- John Warrington, Deputy Director for Policy and Research, Procurement, Investment and Commercial Division, Department for Health
- Julie Wood, Director, NHS Clinical Commissioners
- Elisabetta Zanon, Director of European Office, NHS Confederation
briefing The rules are not your enemy

Notes
NHS Clinical Commissioners is the only independent membership organisation exclusively for clinical commissioning groups.

Our job is to help CCGs get the best healthcare and health outcomes for their communities and patients. We’re giving them a strong influencing voice from the front line to the wider NHS, national bodies, Government, Parliament and the media. We’re building new networks where they can share experience and expertise; and providing information, support, tools and resources to help CCGs do their job better.