

Procurement guide for commissioners of NHS-funded services



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1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

Contents

Chapter 1 Introduction	01	Policies	22
What is this guide for?	01	Documentation	23
Who is the guide for?	01	Conflicts of Interest	23
What is the status of this Guide?	01	Conflicts of Interest pre-procurement	23
What is the scope of this guidance?	02	Conflict of interest during procurement	23
Why the Guide has been revised	02	Conflicts of interest post procurement	24
Overarching Principles of Procurement	04	Practical Steps regarding Conflicts of Interest	24
<i>Transparency</i>	04		
<i>Proportionality</i>	05		
<i>Non-discrimination</i>	05		
<i>Equality of treatment</i>	05		
<i>Other Principles of Procurement</i>	06		
Provider Engagement	06		
Joint venture and other partnerships between providers	06		
Chapter 2 When and how to use procurement	07		
Patient Choice under the 'Any Willing Provider' (AWP) model	07		
Contract Management	09		
Tendering	09		
Contract termination or expiry	10		
Securing new contracts	12		
Further considerations in determining which procurement model to use	15		
Decisions on Contract Award	17		
Chapter 3 Pricing, Risk and Contract Duration	18		
Funding models and pricing	18		
Pricing	18		
Pricing, risk and incentives	19		
<i>Performance Risk</i>	19		
<i>Demand risk</i>	19		
<i>Gainsharing</i>	20		
<i>Contract Duration</i>	20		
Chapter 4 Governance	22		
Introduction	22		
Joint commissioning	22		
Management	22		
		Annex A Provider Engagement	25
		Introduction	25
		Provider engagement is an integral component of good commissioning	25
		Forms of provider engagement	25
		Prior Information Notice (PIN)	26
		Testing / Competition of ideas	26
		Public / Private Reference Groups	26
		Provider Fairs	27
		Websites	27
		Ongoing engagement	27
		Annex B Engagement with Staff and their Trade Unions	28
		Introduction	28
		Responsibilities of Commissioners' Boards	28
		Staff engagement in commissioning strategies	28
		Staff engagement in reviewing services and care pathways	29
		Staff engagement in procurement	29
		Annex C Competitive Procurement Models overview	30
		Competitive Tenders	30
		Open Procurement Route	30
		<i>Description</i>	30
		<i>Considerations</i>	30
		Restricted Procurement	30
		<i>Description</i>	30
		<i>Considerations</i>	30
		Competitive dialogue	30
		<i>Description</i>	30
		<i>Considerations</i>	30
		Endnotes	31

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

1 Introduction

This version of procurement guidance for commissioners of NHS services supersedes the previous 'PCT Procurement Guide for Health Services' (March 2010). If necessary, it may be reviewed in the future to take account of the results of the consultation documents prepared following the White Paper 'Equity and Excellence: Liberating the NHS'

What is this guide for?

1.1 The role of commissioners, (ie PCTs or their agents) is to secure services to meet the health needs of their local populations, which deliver the best combination of quality to patients and value for taxpayers. Procurement enables this by securing services through transparent engagement with providers, normally culminating in an award of new contract(s)¹ albeit that this process may culminate in the award of a new Contract to an existing provider. Procurement is an integral part of the commissioning cycle².

1.2 This Guide provides a framework for decisions regarding procurement. Its aim is to support commissioners, their delegated authorities and providers (where applicable) in making appropriate and effective decisions about procurement, and ensuring consistency with the overarching principles for public services procurements. These principles include transparency, proportionality, non-discrimination and equality of treatment.

1.3 The purpose of this guide is to enable commissioners to:

- Decide when to use procurement for a clinical service;
- Determine what procurement approach to use if they are running a procurement;
- Outline some key aspects of procurement including the scope of a service specification, financial and risk issues

1.4 Commissioners are expected to ensure procurement activity complies with this guidance and in turn, use the processes outlined within this document to inform their procurement decisions.

Who is the guide for?

1.5 *Commissioners* of NHS-funded healthcare services and their agents, (including, but not limited to PCTs, Practice-Based Commissioning Consortia, Shadow GP Commissioning consortia as they are established, and Commercial Support Units - 'CSUs'); and SHAs in holding commissioners to account for their actions and managing local disputes; and, the Co-operation and Competition Panel in advising on procurement disputes referred on appeal.

1.6 *Providers* of NHS-funded service, where they are the prime contractor and are sub-contracting specific services or elements of services, for example part(s) of a long-term condition pathway.

1.7 As set out in the White Paper 'Equity and Excellence: Liberating the NHS' and its supporting consultation documents, our intention is to create an NHS that is much more responsive to patients and achieves better outcomes. Our intended arrangements for the future include:

- More autonomous providers
- A responsibility for GP consortia to commission most healthcare services
- An NHS Commissioning Board
- An Economic Regulator
- Any willing provider being able to provide services in most sectors of care

1.8 We will update the Guide substantially for 2011/12 to reflect the transition to shadow GP commissioning consortia and the shadow NHS Commissioning Board, the phased introduction of an Any Willing Provider model (starting with community services), and with the aim of simplifying procurement and contracting processes.

What is the status of this Guide?

1.9 This Guide supersedes the PCT Procurement Guide published in March 2010 and the elements of 'Commercial Skills for the NHS' concerned with the procurement of clinical services. The Guide is part of the Operating Framework for 2010/11 (and its revision) and it should be read in that context and also in conjunction with the 'Principles and Rules for Cooperation and Competition'³ published in July 2010 and the national standard contracts guidance. The Guide is effective for all procurement activity commencing from August 2010.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

1.10 Commissioners are expected to comply with this guidance as part of the 2010/11 Operating Framework (and its revision). This guidance applies to commissioning of NHS-funded healthcare services and is applicable wherever a commissioner is:

- The lead commissioner⁴
- A joint signatory to the contract⁵
- Acting on behalf of another commissioner(s) or Local Authority under delegated commissioning authority⁶
- Awarding contracts under a Practice Based Commissioning Consortium or Shadow GP Commissioning Consortium acting under delegated authority from a PCT

1.11 The guidance does not introduce any general policy requirement that all NHS services should be subject to competitive tendering. Moreover, the government has announced in the recent White Paper and revised Operating Framework that the current offer of choice of any provider will be increased significantly, giving patients choice of any willing provider where relevant. Further guidance on Any Willing Provider will follow, starting with community services. For now, it remains a matter for commissioners to determine when and how to use procurement as a tool for securing contracts. The onus is therefore on commissioners to demonstrate a rationale for their actions and decisions (eg. Tender/No Tender decisions). It does not obviate the need to take legal advice, or advice from other sources such as SHAs, and CSUs, as necessary.

1.12 Providers of NHS-funded services are also expected to comply with this guidance where they are the prime contractor or are sub-contracting specific services or elements of services, for example part(s) of a long-term condition pathway.

What is the scope of this guidance?

1.13 This Guide is intended to apply to the procurement of health and social care services by or on behalf of commissioners in pursuance of the Secretary of State's general duty under the National Health Service Act 2006 to provide a comprehensive health service in England. This guide does not address any additional requirements that may apply for non-clinical procurements (eg goods and equipment), if in doubt, commissioners should refer to their CSU.

1.14 Procurement law, both at EU and domestic level, distinguishes between Part A and Part B services.⁷ Part A services are subject to a more rigorous procurement regime which mandates particular timescales and procedures that must be followed (for example, the open, restricted, competitive dialogue or negotiated procedures). Part B,

which includes health and social care services, is much less prescribed and does not set out a particular procedure. Commissioners should, however, note that there are other services that will be Part A services notwithstanding that they are carried out in a health environment, for example cleaning or waste disposal, and that they must comply with all appropriate Part A requirements for such services. In such circumstances, commissioners should note the legal requirements in relation to standstill periods, particularly the provision of appropriate written information and the potential consequences resulting from the new remedy of ineffectiveness in particular. This Guide does not explore Part A requirements in any detail and commissioners are referred to OGC guidance on this matter.⁸

1.15 It is up to each individual commissioner to decide the form a procurement for a Part B service takes. Whichever process is used, commissioners must satisfy themselves that it complies with the overarching principles of transparency, equality of treatment and non-discrimination, as well as an objective evaluation process for assessing expressions of interest. Commissioners should note that these principles apply regardless of whether the Public Contracts Regulations 2006, the domestic legislation implementing Directive 2004/18/EC, applies.⁹

1.16 In specific circumstances, a commissioner may wish to adopt a Part A procedure, notwithstanding that it is a Part B service. In these circumstances, OGC recommends that commissioners follow the associated processes and timescales in Part A in full. However, in most cases, commissioners will adopt a procurement form that suits the nature of the services being commissioned and their particular objectives.

Why the Guide has been revised

1.17 This Guide sets out current government policy on procuring healthcare services. It supersedes the previous (March 2010) Guide and the sections of 'commercial skills' concerned with the procurement of clinical services. This Guide takes effect for all procurement activity that commences from August 2010. It has been updated to ensure it is consistent with the key messages of the White Paper and the revision to the 2010-2011 Operating Framework, including:

- The development of the healthcare system including the transition towards a responsibility for GP consortia to commission most healthcare services and the creation of an independent NHS Commissioning Board.
- The intention to increase the current choice offer and move to an any willing provider model set out in the White Paper. (see table over)

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

Extending choice

The Government will:

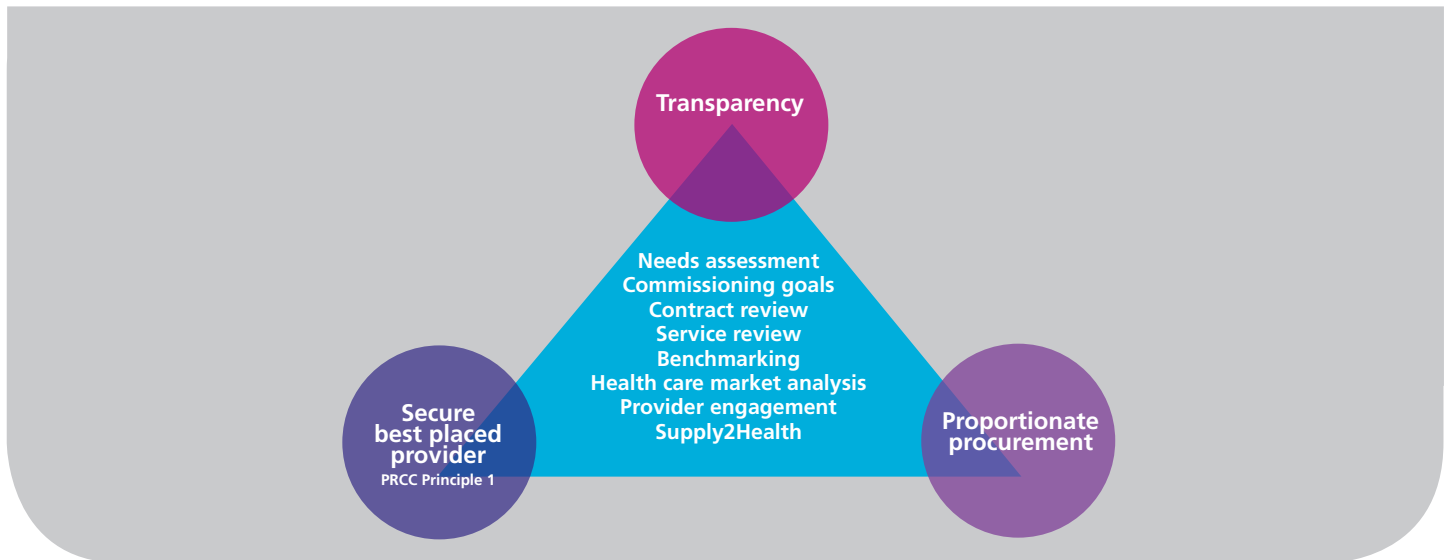
- Increase the current offer of choice of any provider significantly, and will explore with professional and patient groups how we can make rapid progress towards this goal;
- Create a presumption that all patients will have choice and control over their care and treatment, and choice of any willing provider wherever relevant (it will not be appropriate for all services – for example, emergency ambulance admissions to A&E);
- Introduce choice of named consultant-led team for elective care by April 2011 where clinically appropriate. We will look at ways of ensuring that Choose and Book usage is maximised, and we intend to amend the appropriate standard acute contract to ensure that providers list named consultants on Choose and Book;
- Extend maternity choice and help make safe, informed choices throughout pregnancy and in childbirth a reality – recognising that not all choices will be appropriate or safe for all women – by developing new provider networks. Pregnancy offers a unique opportunity to engage women from all sections of society, with the right support through pregnancy and at the start of life being vital for improving life chances and tackling cycles of disadvantage;
- Begin to introduce choice of treatment and provider in some mental health services from April 2011, and extend this wherever practicable;
- Begin to introduce choice for diagnostic testing, and choice post-diagnosis, from 2011;
- Introduce choice in care for long-term conditions as part of personalised care planning. In end-of-life care, we will move towards a national choice offer to support people's preferences about how to have a good death, and we will work with providers, including hospices, to ensure that people have the support they need;
- Give patients more information on research studies that are relevant to them, and more scope to join in if they wish;
- Give every patient a clear right to choose to register with any GP practice they want with an open list, without being restricted by where they live. People should be able to expect that they can change their GP quickly and straightforwardly if and when it is right for them, but equally that they can stay with their GP if they wish when they move house.
- Develop a coherent 24/7 urgent care service in every area of England that makes sense to patients when they have to make choices about their care. This will incorporate GP out-of-hours services and provide urgent medical care for people registered with a GP elsewhere. We will make care more accessible by introducing, informed by evaluation, a single telephone number for every kind of urgent and social care and by using technology to help people communicate with their clinicians; and
- Consult on choice of treatment later this year including the potential introduction of new contractual requirements.

The key drivers from the previous Guide remain important:

- The quality and productivity challenges facing the NHS, requiring commissioners to secure value for money for patients and tax-payers, driving-up quality and productivity, challenging existing service provision and securing innovative, more cost-effective means of service delivery;
- To help meet these challenges, commissioners will need to take a consistent and rigorous approach to managing the expiry of existing contracts, undertaking thorough service reviews and health market analysis, to secure improved quality and productivity, to ensure that services are provided in the most appropriate settings;
- To enable this, commissioners may need to develop longer-term strategic partnerships to support major service re-design and reconfiguration;
- The strategic aim of shifting more demand risk to providers¹⁰;
- The results of the last round of WCC assurance, highlighting the need to strengthen commercial skills, including procurement and contract negotiation and management.¹¹
- The need to make best use of scarce procurement resource to reduce management costs, avoid duplication and focus on priority areas.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

Figure 1 The procurement balance



Overarching principles of Procurement

1.18 Figure 1 illustrates that commissioners need to satisfy the overarching obligation of transparency. Commissioners must comply with the Principles and Rules for Cooperation and Competition and should adopt proportionate practices.

1.19 Commissioners¹ will be expected to demonstrate consistency with the overarching principles of public procurement in relation to all procurement activities. These principles are referred to throughout this document and are as follows;

- Transparency
- Proportionality
- Non-discrimination
- Equality of Treatment

Transparency

1.20 The requirement of transparency is fundamental to the accountability of commissioners as public contracting authorities and is applicable to all commissioning activities, including procurement and contracting. At any stage, commissioners' should be able to publicly account for expenditure, by contract and by provider, and in terms of the services commissioned and the quality provided.

1.21 There are four main areas of activity where commissioners must be transparent;

(i) Stating commissioning strategies and intentions

1.22 Commissioners are expected to state their short-to-medium term commissioning intentions¹² on their websites providing a link to them via NHS Supply2Health® as the portal for NHS healthcare opportunities¹³. These notices should clearly state the services they are prioritising for the next 12-36 months and should outline, at a high level, those services which they expect to use competitive procurements to deliver and those which will likely be delivered via Single Tender Actions (eg where only one provider is available).

(ii) Stating the outcome of service reviews and whether a competitive tender is to be used

1.23 Turning specifically to individual services and contracts, commissioners should clearly state how they intend to secure that service, eg whether this be via Any Willing Provider, Single Tender Action, or through competitive tendering. Commissioners' boards will be responsible for procurement decisions which will be informed by health care market analysis, benchmarking, provider engagement and other inputs. Notices of commissioning strategies, upcoming tenders, and other such information, such as Prior Information Notices (PIN)¹⁴ are useful to ensure current and potential providers have opportunities to engage with commissioners (perhaps by expressing interest to deliver a service) prior to any formal procurement process.

1 PCT Boards, and their agents

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

(iii) Advertisement of Procurement (where applicable) and notification of Contract Award

1.24 From September 2008, it has been mandatory for PCTs to advertise procurements and contract awards on the NHS Supply2Health® website. Commissioners must notify all award(s) of new competitively tendered contracts with a lifetime total value of over £100k on NHS Supply2Health® and to OJEU¹⁵ for contracts over £156,442 (as amended from time to time)¹⁶. It is good practice to notify of any other contract award (subject to the lifetime contract value of £100,000) on NHS Supply2Health®¹⁷. This threshold may change according to cross government policy on procurement, at which point guidance will be issued.

1.25 Once procurement has resulted in the award of new contract(s), it is good practice to provide feedback to any unsuccessful bidders and to allow a standstill period¹⁸ between notifying the contract award decision and executing the contract. The standstill period is statutory for many procurements¹⁹. As set out at paragraph 1.14, in the limited circumstances that a commissioner chooses to follow a Part A procedure for a Part B process, commissioners should be aware of the consequences that may result from a breach of those processes.

(iv) Transparency of Documentation and process/decisions

1.26 Commissioners should retain an auditable documentation trail, that is itself transparent, regarding key decisions (eg tender / no tender), which provides clear accountability and could be subject to review (including Freedom of Information requests).

Proportionality

1.27 The level of resources a commissioner puts forward into the procurement process should be proportionate to the value, complexity and risk of the services contracted, ie more resources will be required where higher benefits / costs savings / quality can be gained²⁰.

1.28 Decisions on procurement options, pre-qualification and bid evaluation criteria will be informed by the services to be commissioned and will be determined locally, including any streamlined processes for low value contracts or services to be provided over a relatively small geographical area. The contractual framework (eg. type of standard contract used) will need to be appropriate to the services being commissioned and should also be proportionate. For example, the contract duration should be proportionate

to the scale of investment required of the provider and the degree of risk transfer involved. The national standard contracts guidance emphasises the need for the commissioner to seek clearance from SHAs on contract duration questions. Commissioners may obtain specialist advice via the regional Commercial Support Unit. Best practice guidance is available on the OGC website²¹.

1.29 When designing the procurement process commissioners should ensure that quality standards, including patient safety, are not compromised. Any additional criteria such as financial information for the purposes of due diligence should not be disproportionately demanding (ie to the value of the contract or level of clinical risk associated with the services), as this could discriminate against smaller organisations, including social enterprises and the wider Third Sector, where the Government is committed to reducing barriers to entry²².

1.30 Furthermore, when designing and delivering procurements, commissioners should have regard for the bidding costs providers incur and seek to avoid wasted costs due to significant delays or material scope changes. This can be mitigated by engaging the market in advance of procurements.

Non-discrimination

1.31 The commissioning process, including any form of procurement, should be non-discriminatory and transparent at all times, neither including nor favouring nor excluding any particular provider. This includes documentation and, particularly, the identification of criteria and weightings that will be used as part of any evaluation process.

1.32 All appropriate information should be supplied in good time to enable potential providers to properly assess whether they wish to express an interest in providing the relevant services.

Equality of treatment

1.33 The procurement process should not give an advantage to any market sector (public, private, voluntary, charitable and social enterprise). This includes ensuring that decisions are taken, not with regard to the type of organisation specifically, but rather to how well that organisation meets the evaluation criteria²³. See Chapter 4 for further information.

1.34 The basic financial and quality assurance checks should apply equally to all types of providers, but be proportionate to the service being procured (see 'proportionality', above).

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

1.35 All providers must operate under these same principles when being asked to respond to any tender specification and pricing payment regimes and currency must be transparent and fair. Annex A discusses provider engagement in more detail.

Other Principles of Procurement

1.36 In addition, this guidance requires that commissioners also undertake the following as part of the procurement decision-making process

- Undertake Service reviews to identify areas for improvement and ensure alignment with commissioning strategy (eg QIPP)
- Apply benchmarking to existing services
- Use healthcare market analysis
- Specify relevant service specification, outcomes, KPIs and expected prices
- Engage early with providers, staff and representatives / Trades Unions to assess the potential impact / deliverability of the service (see Annex B).
- Engage with service users local communities and other key stakeholders eg Health Overview Scrutiny Committees and successor arrangements
- Ensure the process is transparent, proportionate, and non-discriminatory
- Give all providers fair and equal opportunity to bid²⁴
- Have regard to Equality considerations in the procurement process²⁵
- Have regard to any sustainable development aspects of the procurement²⁶.

Provider Engagement

1.37 Throughout this document, references are made to provider engagement. Effective engagement with providers is essential for effective commissioning and a key factor in any successful procurement. To get the maximum benefit, this engagement should be with both current and potential providers and take place as part of an ongoing exercise, ie it should not just be limited to procurement activity – it should be part of an iterative process to inform and be informed by, the commissioning strategy and procurement priorities. As a result of ongoing engagement with a range of providers, commissioners can be confident that their commissioning intentions are well informed and well understood.

1.38 This Guide encourages engagement with providers from the NHS, independent, voluntary and charitable sectors and in annex A, discusses some of the common methods for provider engagement.

1.39 Competition for services will be transparent and fair, with all providers having an equal opportunity to bid, potentially in new partnerships and joint ventures.

Joint venture and other partnerships between providers

1.40 Joint ventures and other models of partnerships enable providers to combine their respective talents and potentially offer higher quality, more productive services than individual providers could deliver by working alone. This is likely to be particularly important where new service models are required, for example, in the development of home-based end of life care, or the community management of long-term conditions such as COPD or diabetes. Voluntary or charitable sector providers may have particular expertise in reaching out to ‘at risk’ groups and communities and in developing responsive services and co-production with users. Independent providers may bring to a partnership expertise in risk management and logistics, or the innovative use of telemedicine and assistive technology.

1.41 Procurement will afford commissioners opportunities to encourage and facilitate partnership working, for example, by inviting joint bids. This may be underpinned through use of service specifications and bid evaluation criteria aimed at encouraging partnership working, and long-term contracts and innovative funding and risk-sharing mechanisms which may help to support sustainable strategic partnerships. Commissioners could specify requirements to improve quality and outcomes for a particular subset of patients / population group or specify prices that encourage shared use of facilities or overheads.

1.42 These opportunities would be further enhanced through effective engagement with providers, prior to commencing procurement (see Annex A).

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

2 When and how to use procurement

This section describes where and when procurement is the applicable mechanism for securing contracts to deliver healthcare services. It refers to the government's commitments as set out in the White Paper to significantly increase patient choice. The White Paper includes the presumption that patients will have choice and control over their care and treatment, and in the future, choice of Any Willing Provider wherever relevant.

2.2 Local commissioning strategies should identify priorities for service improvement, for example: implementation of improved quality standards; care pathway redesign; increased patient choice; more personalised care and promoting equality; increases in productivity; and, where necessary, investment in additional capacity. Commissioners will use either AWP, contract management or other forms of procurement to secure services for patients.

2.3 Any Willing Provider should be used where commissioners are seeking to extend the current offer of choice of any provider in elective care and where, in the future more services will be subject to a phased Any Willing Provider model. The Department is developing guidance on any willing provider and the Guide will be updated as necessary in light of this.

Contract management can be used where an existing contract is in place in order to secure incremental improvements/changes to existing services, or to address underperformance as an alternative to procurement (eg to reduce cost)

Procurement options should be considered for securing services outside the scope of existing contracts, including: additional choices for patients; new service models; significant increases in capacity and where existing contracts are due to expire or be terminated (eg where contract management is unable to address underperformance).

2.4 Decisions on which of the above approaches to take will be informed by DH guidance and analysis of the existing healthcare market (eg through 'Healthcare Market Analysis'). The Department of Health has produced a decision support tool to aid decision-making²⁷. However, national guidance cannot be definitive and determining the best course of action will depend on detailed local knowledge and judgement. Commissioners' boards must act transparently and be able to demonstrate rationale for decisions. Furthermore, commissioners must treat providers fairly and ensure that their actions are consistent with their contractual obligations.

Patient Choice under the 'Any Willing Provider' (AWP) model

2.5 Commissioners must have regard to the NHS Constitution. It is now a legal duty to ensure that patients are offered 'free choice' of provider for their first outpatient appointment when referred by a GP. Commissioners must also have regard to extending patient choice into other areas in line with the development of national policy (eg. care and support planning for patients with Long-Term Conditions, and maternity care). This is an example of competition 'in' the market (ie where a patient can choose between two or more providers of the same service).

2.6 The Any Willing Provider (AWP) model is designed to facilitate patient choice and offers rewards to providers that attract patients by demonstrating high levels of quality, responsiveness and user satisfaction. AWP may be described as an accreditation process underpinned by a 'call-off' contract (ie payment is determined according to patients' choice of provider). AWP has been defined nationally in its application to routine elective care, but can be adapted locally to facilitate patient choice in other services. Guidance will follow later this year on the application of AWP to community services and this Guide will be updated wherever relevant to be consistent with it.

2.7 For routine elective care, the accreditation requirements and the underpinning contractual terms, including tariff, are determined nationally. Where a commissioner is seeking to offer patients a choice of provider for services other than routine elective care, then a local implementation of the AWP model may be used whereby the accreditation requirements (including clinical governance) and key contractual terms (eg. non-tariff prices) are determined locally.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

2.8 The process for AWP is summarised at Figure 2a below. When commissioners operate an AWP model to secure a range of providers to support patient choice, before awarding an NHS Standard Contract, commissioners need to concern themselves with ensuring that all providers have been subject to appropriate due diligence. As a minimum, potential providers must demonstrate that:

- 1) They are registered with CQC (or other relevant body) for that service
- 2) They agree to the tariff that commissioners are willing to pay
- 3) They receive no guarantees of volume / payment
- 4) they are prepared to abide by the NHS standard contract terms and conditions
- 5) They are financially and legally sound
- 6) For certain services, additional due diligence will be required and commissioners may determine that the provider organisation or their members should demonstrate a track record of delivery. Wherever this additional due diligence is undertaken, it must be non-discriminatory and proportionate to the service and types of organisations being sought.

2.9 For elective care, for choice of first outpatient appointment, national policy has defined an Any Willing Provider (AWP) model for procurement and where a provider meets the criteria above and has been accredited, they may list their services on the national menu (ie. Choose and Book)²⁸.

2.10 For other services, where a commissioner is seeking to extend choice of provider beyond first outpatient appointment in elective care, the accreditation requirements will need to be determined locally under an AWP procurement model. This local implementation of the AWP model enables the commissioner to determine contractual requirements specific to services outside of elective care and/

or that reflect local circumstances. Providers that demonstrate that they can meet the locally specified contractual requirements and appropriate due diligence, (proportionate to the service and contract value) should be accredited to list their services on the local menu. This does not mean that commissioners can seek only local providers, but rather, that providers must be able to meet locally defined requirements. As the choice offer is extended and Any Willing Provider model is used more widely, this will be refined to reflect the changing commissioning landscape.

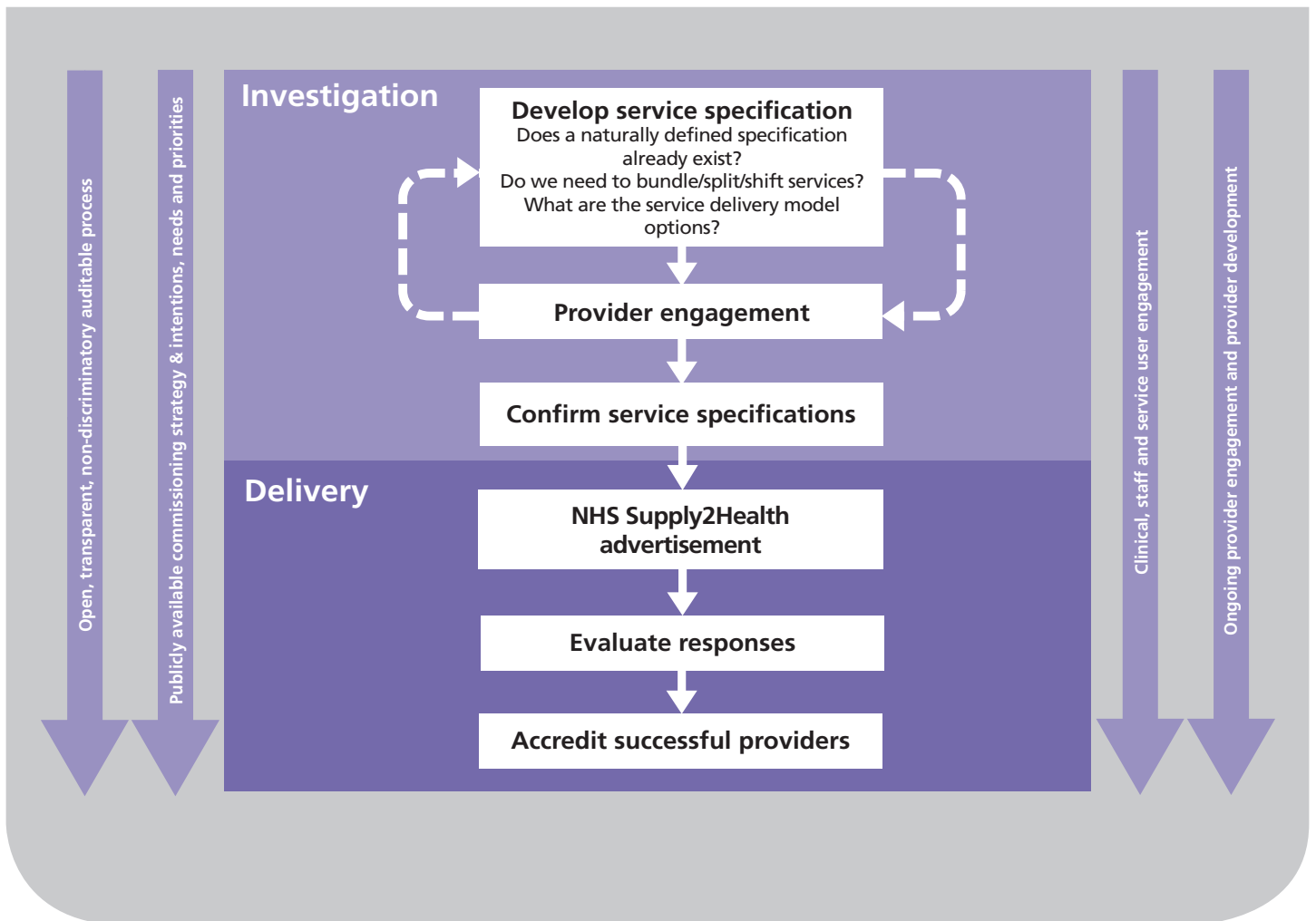
2.11 When running an AWP process, a commissioner should not unreasonably refuse to award a contract to a provider that meets the accreditation requirements. However, acting transparently, a commissioner may operate a 'managed' process for procurement under the local implementation of AWP which can operate in two ways;

- Providers are only accredited during specified periods or 'windows', to enable a PCT to manage its accreditation capacity;
- More exceptionally, the number of providers are limited for defined and objectively justifiable reasons (eg clinical safety, sustainable market considerations) notwithstanding the overarching requirements of transparency and non-discrimination.

2.12 Where a commissioner is running an AWP model, a provider would be able to challenge a commissioner's unreasonable refusal to award a contract, under AWP. Any challenge will initially be sent to the commissioner and possibly through the SHA dispute resolution procedure and ultimately to the Cooperation and Competition Panel on appeal. (These arrangements will be affected by the changes in accountabilities that are introduced following the publication of the White Paper and response to consultation documents).

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

Figure 2a **The process for AWP**



Contract Management

2.13 Where there is a contract in place, commissioners should use the process in that contract to address concerns about that contract (eg underperformance). The procedures for this are set out in the national standard contracts guidance. Using this process can be a cost effective way of discharging commissioning requirements without the need for procurement which can be costly. Contract Management can also be used for incremental change where this provides a cost effective alternative to procurement.

Tendering

2.14 Where services are not contracted for on an AWP model, tendering can be used to secure a new contract especially when

- A current contract expires or is terminated or
- A new service model or significant additional capacity is needed

2.15 Once the commissioner decides to use procurement, they may choose variations on some of the following tendering approaches²⁹.

- Single Tender Action (ie uncontested procurement)
 - Open competition
 - Restricted competition
 - Competitive dialogue
- } Competitive tender

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

This guide does not discuss all possible procurement routes, but, focuses instead on those which are most commonly applied in healthcare services to competition ‘for’ the market (eg where providers compete for contracts). Annex C contains a summary of the formal Part A types of competitive tender, but commissioners are free to decide the form a procurement under Part B takes, subject to the considerations set out in paragraph 1.15.

2.16 The commissioner’s decisions must be made in accordance with procurement law and from assessments made following engagement with providers. The commissioner’s requirements should be informed (but not decided) by working with clinicians and other appropriate staff, to review care pathways and develop service specifications, including quality standards, outcomes and KPIs. The commissioner should engage with both current and a wide range of potential providers, signalling commissioning intentions to gauge the level of potential interest, prior to a decision on whether or not to competitively tender.

2.17 The decision-making process and range of factors to be considered may be broadly similar in different scenarios (see Figures 2b and 2c) and Boards are responsible for ensuring that the process is transparent, proportionate, and non-discriminatory. Key considerations that would inform the commissioner’s decisions may include:

- The commissioner’s assessment of patient and population need (eg. outputs from Joint Strategic Needs Assessment)
- Commissioning priorities (eg. improved outcomes for particular patient or population groups and increased productivity)
- Service reviews
- Historical performance and user satisfaction data
- Benchmarking
- Quality standards and best practice advice (eg NICE guidelines)
- Analysis of the healthcare market (ie current and potential provision)
- Public, patient and staff engagement.

Contract termination or expiry

2.18 The process for contract termination or expiry is illustrated overleaf in figure 2b. The service review process should commence at least nine months before the end of the existing contract. Where a commissioner is evaluating options upon termination or expiry of an existing contract, the decision-making process and key factors to be considered will be broadly similar to scenarios where the commissioner is seeking to secure new service models or significant additional capacity (see Figure 2c). The main difference is that the commissioner is considering options and making decisions in relation to existing services. Considerations for commissioners would include:

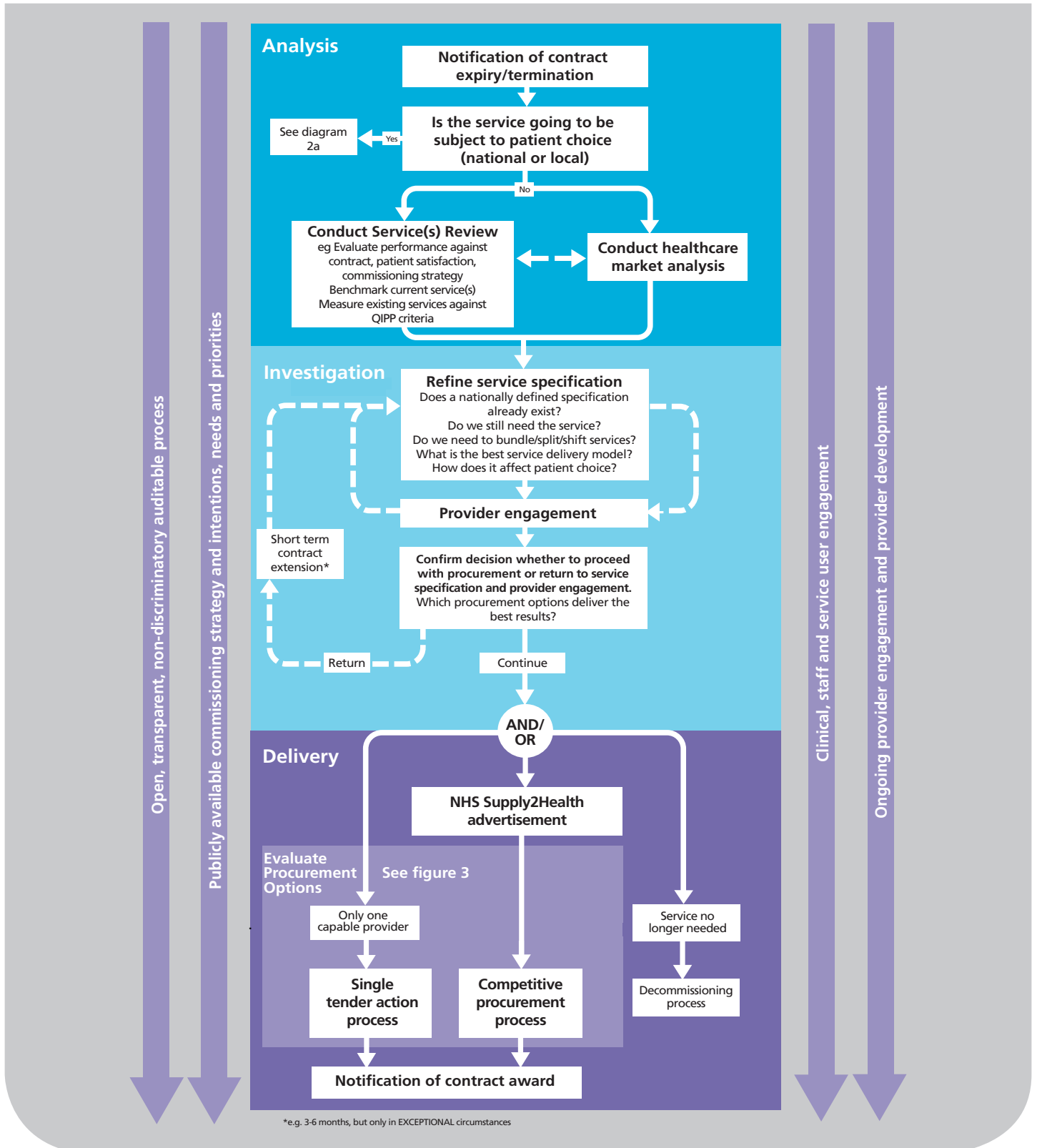
- Commissioning priorities for service redesign (eg. Shifting care from hospital into community settings)
- The performance of existing provider(s)
- The existence of viable, alternative providers
- The potential for incremental improvements/changes to existing services
- Any advantages of bundling/unbundling services
- The need for new service models
- The case for decommissioning existing services
- Sustainable Development practices and performance

2.19 As with all scenarios where procurement options may be considered, the commissioner’s decisions should reflect the priorities identified in its commissioning strategy and informed by the outputs from service reviews, benchmarking and analysis of the healthcare market.

2.20 Commissioners’ Boards must act transparently and non-discriminatorily by notifying intentions in advance of termination or expiry of existing contracts and engaging with providers prior to finalising decisions on next steps. In any event, commissioners’ boards are responsible for advertising competitive tenders and notifying award of new contracts, or material contract variations/extensions, on NHS Supply2Health® and OJEU as appropriate.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

Figure 2b **Contract termination or expiry**



1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

2.21 As can be seen from diagram 2b, any outcome is possible from this process, from using a Single Tender Action (STA) to award the service to the existing provider, should the process identify them as the only capable provider, to decommissioning part of the service, or, running an open tender.

2.22 The service review process will determine the scope and nature of the services required. Specifically it will consider whether there are any necessary clinical interdependencies which would justify the bundling of services, as well as considerations as to affordability. However, commissioners must ensure that any bundling of services or affordability criteria that they are considering does not unfairly discriminate against or exclude any providers. In addition, commissioners should not approach a service review with any preconceptions about the outcome. Commissioners should be able to demonstrate the robustness of this process through a clear audit trail.

2.23 Following a robust service review, a commissioner might conclude that it is justified in bundling a number of services in a particular way. If that is the outcome of the service review, commissioners must satisfy themselves, before proceeding with a Single Tender Action, that there is no other provider capable of providing the services required and meeting the commissioner's other criteria. Therefore, the outcome of this process might be, by way of example, that a commissioner decides to bundle A&E, together with Trauma, appropriate emergency and urgent care, Critical Care and Maternity services and that there is only one capable provider of these services for a particular population.

2.24 Commissioners should take care when undertaking variations to existing contracts. It is possible that, in some circumstances, this may lead to the award of a new contract if amendments are made to terms that are materially different in character from the original.³⁰

Timelines

2.25 Commissioners should commence the service review process at least nine months before the expiry of the existing contract. This timescale is to ensure that there is sufficient time for an existing provider to improve services if required. It is also expected that any procurement law obligations should also be complied with in good time so as to avoid any detrimental impact to patient services caused by delays. This includes any procedural requirements arising out of the recent implementation of the Remedies Directive, whether mandatory or whether a commissioner has chosen to comply with them as a matter of best practice (for example, a 'standstill period').

Securing new contracts³¹

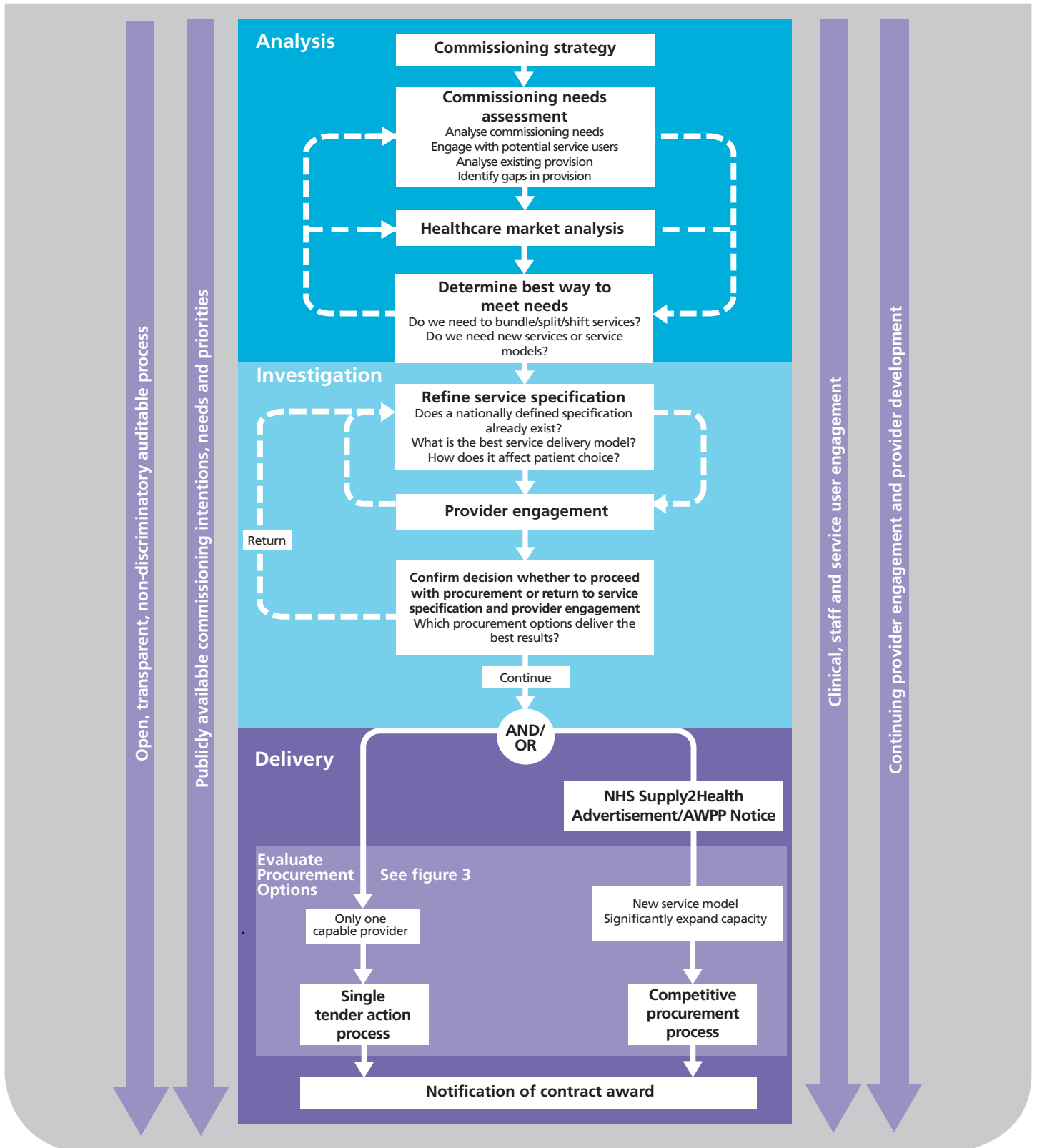
2.26 Procurement must be used where a commissioner is seeking to secure new contracts to deliver a new service model or significant additional capacity, as described below:

- **New service models** - the commissioner is seeking to procure a new service model to address defined commissioning priorities (ie identified by reviewing current provision against an assessment of patient and population needs). It might be a completely new service, an existing service delivered in a completely different way, or in the case of Primary Care, an enhanced service. Commissioning priorities may include increasing productivity. As with all public bodies, a commissioner will be expected to ensure that it secures 'value for money'³².
- **Additional capacity** – the commissioner is seeking investment in significant, additional capacity to supplement existing services and/or to improve access to services in particular geographical areas.

2.27 Figure 2c shows an indicative illustration of the decision-making process and key factors to be considered. It is important to recognise that, in reality, this may not be a linear process and there may be significant iteration between the various stages leading up to a decision of whether or not to proceed with procurement.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

Figure 2c **New Service Models and Additional Capacity**



1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

2.28 Stage 1 Commissioning strategy –

The commissioning strategy will identify priorities for addressing patient/population need and for improving quality and productivity in the provision of services. The commissioning strategy will be regularly updated and informed by the outputs from Joint Strategic Needs Assessment and reviews of services and care pathways (Service Reviews). Commissioners’ Boards must act transparently in publishing details of commissioning priorities and intentions on the commissioner’s website and provide a link via NHS Supply2Health® and OJEU (where appropriate)

2.29 Stage 2 Commissioning needs assessment –

Service requirements should be reviewed against the commissioner’s assessment of patient and population need and informed by the commissioner’s analysis of the healthcare market³³. Needs assessment should involve clinicians and gauge requirements against relevant benchmarks, standards and best practice. The outputs from this will inform the commissioning strategy and help to prioritise where new service models or additional capacity may be required to meet patient/population need, or to improve quality and productivity.

2.30 Stage 3 Service Specification – Service specifications will need to be developed where the commissioning strategy, informed by outputs from needs assessments which identify the need for investment in new service models or significant additional capacity. The purpose of the service specification is to describe the patient/population need to be addressed, outcomes to be achieved, quality standards, KPIs and any other relevant factors such as location, information requirements, requirements of service users and access requirements and, if appropriate, addressing environmental or social impacts. Service specifications provide a useful basis for provider engagement and, in turn, the outputs from provider engagement may inform refinement of service specifications.

2.31 Stage 4 Provider Engagement – Commissioners should engage with providers to develop and refine service specifications and to explore resource implications, including workforce requirements. The outputs from provider engagement will inform further development of the service specification and inform decisions on how services could be bundled/unbundled. Bundling services together may be essential to address clinical dependencies (eg. A&E, Trauma & Orthopaedics, Critical Care and Radiology), or to increase efficiency. However, unbundling of services may enable greater choice and personalisation of services for particular population groups (eg. Black and Minority

Ethnic communities and disabled people) and is important to avoid discriminating against smaller providers³⁴. Provider engagement will also help to identify where there is more than one potential provider for a particular service or bundle of services and inform consideration of procurement options. Commissioners’ Boards must act transparently and non-discriminatorily in engaging with providers and it is good practice to notify details of potential procurements on NHS Supply2Health® in the form of a Prior Information Notice (PIN).

2.32 Stage 5 Evaluating Procurement Options –

The iterative processes of service reviews and analysis of the healthcare market will have identified where new service models or significant additional capacity are needed. Outputs from provider engagement will also have informed the development of service specifications, including bundling/unbundling of services, and will help the commissioner to identify where more than one provider may be able to deliver a particular service. This will inform the commissioner’s decision on whether or not to proceed with procurement, including any decision to competitively tender, and, if so, whether a multi-staged and / or competitive dialogue approach will be pursued (see below ‘Evaluating Procurement Options’ for further details). If, following this process, it appears that the service specification does not or can not deliver the service benefits required, then it may be necessary for commissioners to revisit the service specification stage and refine the specification, or end the process altogether. Commissioners’ Boards must act transparently and non-discriminatorily and be able to demonstrate rationale for decisions on whether or not to competitively tender. In particular, where the commissioner decides to procure through single tender the rationale must demonstrate that there is only one capable provider to deliver the services and, therefore, that could provide better value for money.

2.33 Stage 6 Advertising of procurement and notifying contract award –

Where the commissioner decides to proceed with procurement this should be notified to providers via NHS Supply2Health®. Commissioners’ Boards must act transparently and both advertise all competitive tenders and notify all new contract awards on NHS Supply2Health® and (where appropriate) OJEU.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

2.34 For competitive tenders, advertising should provide sufficient detail of the services (what they are, how they are to be delivered, how they are to be priced, what outcomes are expected etc) as well as how the commissioner is to assess which provider is awarded the contract to deliver these services. This must allow potential bidders to clearly understand the requirements and express any interest in providing this service.

2.35 Where a commissioner receives an expression of interest, it should use a non-discriminatory, transparent and objective process to set out its evaluation of that expression and engage with that interested party in a proportionate way.

2.36 Where the commissioner determines through analysis of the healthcare market and transparent engagement with providers that there is only one capable provider for a particular service or bundle of services, the Commissioner's Board will need to confirm whether this demonstrates rationale for a Single Tender Action (ie uncontested contract award). However, single tender action carries inherent risk of challenge and a Commissioner's Board must be assured of the rationale for its decision. For part B services, including health and social services, whilst there is no express requirement to advertise single tender in advance of the contract award in a manner similar to part A services, commissioners should still act transparently and it is good practice to advertise Single Tender Actions as it transparently sets out the commissioner's rationale for a Single Tender Action.

Further considerations in determining which procurement model to use

2.37 In addition to deciding upon whether or not to proceed with a particular procurement, the commissioner will need to determine which procurement model to use. Commissioners will want to carefully consider and determine the rationale for their proposed approach before commencing procurement and, where necessary, should engage the support of the regional Commercial Support Unit (CSU) and/or SHA. The rationale for procurement decisions must be approved by the responsible Commissioners' board(s) (or under delegated authority) and should be documented to ensure transparency and accountability.

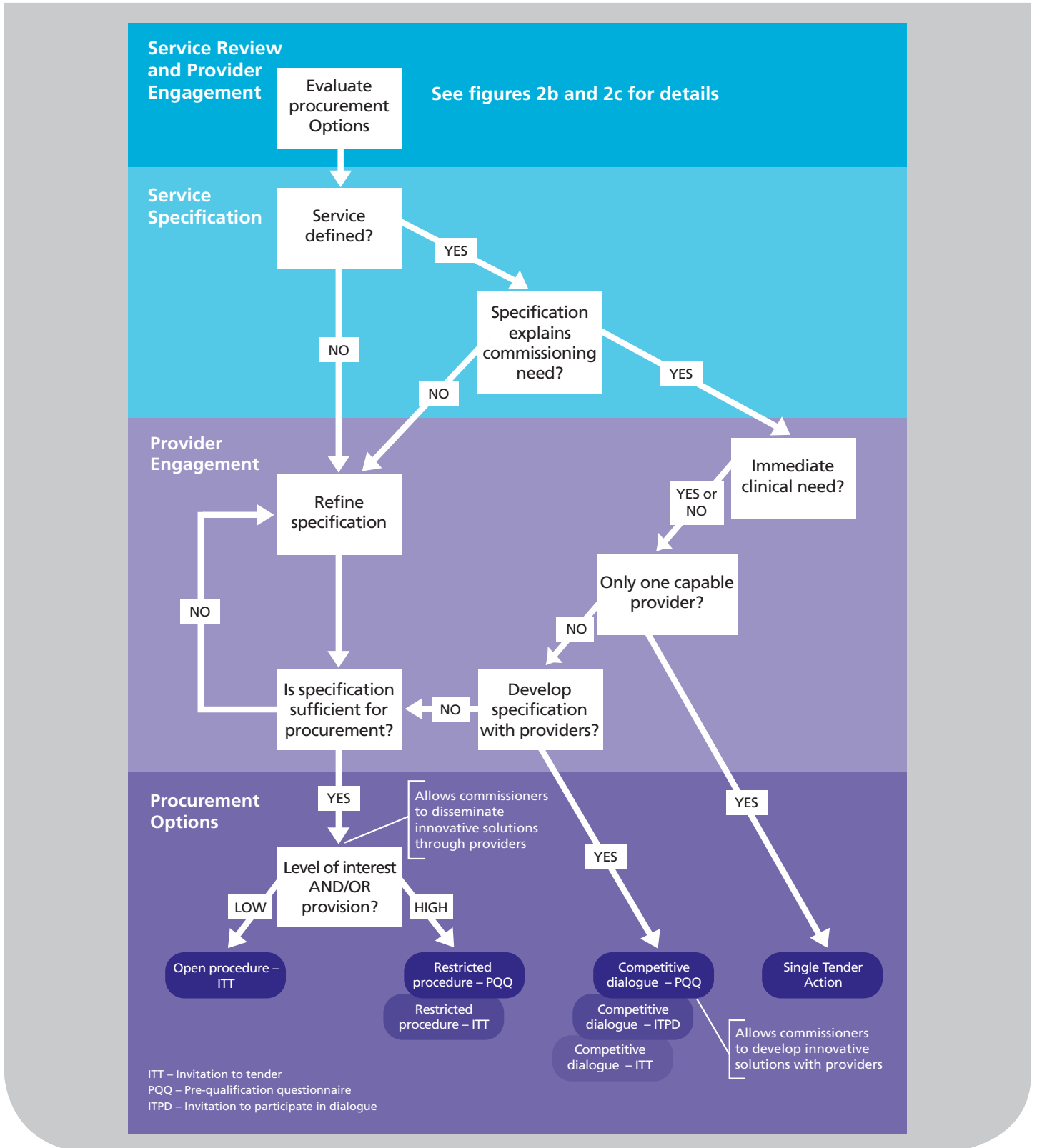
2.38 Decisions on which procurement model to use will largely be determined by what the commissioner is seeking to achieve, the nature of the healthcare market and outputs from provider engagement. Further considerations may include:

- The scale/importance of the new contract(s) being procured
- Is there an urgent clinical need (eg. where existing services have been suspended and interim provision is urgently required)?
- Can the commissioner define the outcomes required, service specification, funding model and prices upfront?
- The degree of innovation being sought
- Is there more than one provider that could potentially deliver the services?
- Capacity of the commissioner to invest its commissioning resource and/or availability of support from the regional Commercial Support Unit.

2.39 Figure 3 below gives an illustration of the procurement models and how decisions on which model to use may flow from the original commissioning intention, how well defined the service specification is and what healthcare market analysis and provider engagement is indicating. In all procurements, the contract awarded must be the appropriate NHS standard contract³⁵, or appropriate Primary Care Contract³⁶.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

Figure 3 High-level flowchart for procurement option appraisal



1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

2.40 Once a decision to tender has been made, and where there is more than one capable provider, a competitive process will ensure fairness and help to demonstrate value for money (ie highest quality for the available resources). The commissioner will be able to identify where there is more than one potential provider through engagement prior to procurement and by notifying intentions via NHS Supply2Health®. However, there may still be a case for using a multi-stage tendering process to restrict the number of providers invited to bid for a new contract, for example, to control the costs of running the procurement process and the potential investment in ‘failed bids’.

2.41 Where there is only one capable provider for a particular bundle of services or the objective of the procurement is to secure services to meet an immediate interim clinical need there will be a case for Single Tender Action (ie uncontested procurement). By definition, an immediate need scenario will be exceptional and likely to only arise on clinical safety grounds or, for example, where existing services have been suspended following intervention by the Care Quality Commission. A decision to procure through a single tender action should always take account of the potential to secure better value by investing in a competitive process, as long as this is justified by the scale and importance of the opportunity (ie it has to be worth it).

2.42 A further consideration is the extent to which the service specification and funding model have been developed prior to procurement. For example, the AWP model is essentially an accreditation process that result in providers being included on a framework agreement (ie call-off contract). The AWP model requires that service specifications and funding models are determined prior to procurement because the accreditation process does not involve negotiation.

2.43 Conversely, negotiation is allowable with one or more ‘pre-qualified bidders,’³⁷ under the competitive dialogue- or restricted procedure- style procurements. However, where significant negotiation is likely to be required then a single-stage process involving written responses to an Invitation to Tender document would not be appropriate.

Decisions on Contract Award

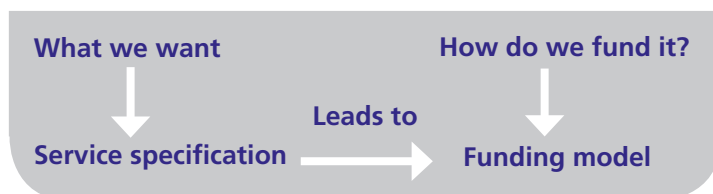
2.44 Public procurement policy usually requires that commissioners award contracts by selecting the Most Economically Advantageous Tender. This is often synonymous with value for money, as set out in OGC guidelines on the use of public resources, and includes factors relating to quality and patient safety, amongst other factors³⁸ that would be appropriate in an NHS environment. It is particularly important, therefore, for the commissioner to specify quality standards and KPIs as part of the service specification. Moreover, where alternative providers are offering to provide the services at lower cost it will be important to undertake appropriate due diligence as to whether quality standards³⁹ will be delivered, as part of the evaluation process. Commissioners’ Boards will be accountable for any tender evaluation process and for decisions on contract awards and for ensuring that procurement processes are transparent, proportionate and non-discriminatory. Sound governance is therefore particularly important and processes and decisions should be documented for the purposes of accountability and to establish a clear audit trail.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

3 Pricing, risk and contract duration

Funding models and pricing

Service specifications describe what a commissioner is asking bidders to provide (but not necessarily how to provide it) and will have implications for the appropriate funding model. As the approach to service specification should be determined by the patient/population need and the key outcomes that are being sought, consideration of funding models and prices should reflect what is being commissioned and seek to maximise alignment of clinical and financial incentives.



3.2 Commissioners should also consider the use of appropriate funding models, (including Grant funding to strengthen partnership working between commissioners and the voluntary and community sector⁴⁰). The funding model should reflect what is being commissioned and the commissioner will wish to communicate information on the core funding model and potential supplementary elements (eg performance incentives) alongside the service specification, informed by engagement with providers prior to commencing procurement. However, depending on the procurement options being considered there may also be scope to develop the funding model and negotiate with providers during the procurement process

Pricing

3.3 The decision on the funding model is an internal decision regarding how the services would be funded; but there are separate decisions to be made about what prices will be applied, which is of key interest to providers, as this determines what they will be paid.

3.4 To derive prices (for non-tariff services), the commissioner should have clear objectives in mind. For example, for non-tariff services, will the commissioner seek competition on price, (whilst ensuring minimum quality standards are not compromised as prices are reduced) or does the commissioner wish to set prices in advance and seek competition on service delivery? A key consideration to these decisions will be the information required to assure performance against the contract – ie where more of the payment relies on performance metrics and other indicators being met, the greater need for data to enable payment

validation. Where competition is sought on price, more resources are needed within the procurement stage, but potentially, greater savings are delivered in the service itself.

3.5 The price the commissioner will pay is usually a product of the costs of the services adjusted to reflect balance of risk (eg the National Tariff for acute elective care is based on average costs and the AWP model of patient choice transfers demand risk to providers). However, prices may also be calculated to reflect value to the commissioner and to incentivise behaviours

3.6 The commissioner may want to consider when to fix prices, prices may be fixed prior to the final stages of a procurement process, for example, to encourage competition on quality and/or to facilitate patient choice (eg. as per AWP). Alternatively, prices may be negotiated with providers during the procurement process, for example, where costs are not known at the pre-procurement stage or where the commissioner is seeking to use price competition to drive efficiency. A hybrid approach may be necessary where the commissioner does not know costs in advance so uses a preliminary stage of procurement to identify potential costs and then sets prices to encourage competition on quality and/or facilitate patient choice (eg local implementation of AWP for choice outside of elective care where prospective prices may be determined through market testing).

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

3.7 There may be occasions when the commissioner wants to set out the proposed funding envelope alongside the service specification and avoid commencing procurement without any indication of prices and funding model. This is because price signals are important for providers in determining whether they can make a viable bid and, clear price signals can help to reduce transaction costs associated with failed bids or abortive procurements. Alternatively, commissioners may wish to provide indicative information on price and funding model (eg. price ceilings) and, therefore, allow for differences in price to be taken into account when evaluating bids. Where commissioners are unable to determine indicative costs and prices prior this will be an indication that further work is needed to engage with providers and develop the service specification; or consider a competitive dialogue approach where it is justified by the scale or relative importance of the procurement.

Pricing, risk and incentives

3.8 All of the commissioner's decisions in relation to procurement should be determined by what it is trying to achieve for its patients and population, including decisions on how prices, funding models and contract durations will reflect risk transfer and create incentives. Commissioners will wish for transparent engagement with bidders, but commercial confidentiality must remain intact

3.9 A commissioner will wish to review pricing mechanisms to complement the service specification and ensure they will drive the behaviours it is seeking to achieve, for example;

- Increased activity / throughput / productivity
- Improved outcomes
- Availability of certain (and / or more appropriate) types of care
- Addressing health inequalities
- Services delivered in certain settings
- Availability of particular interventions within a service

3.10 In turn, adjusting the funding model and prices to reflect an appropriate balance of risk will impact upon the extent to which revenues are determined by:

- Performance in delivering those services (ie performance risk)
- Demand for the services (ie demand risk)

3.11 However, the commissioner must act responsibly in allocating risk to where it can be controlled. An inappropriate transfer of risk could result in detrimental impact.

Performance Risk

3.12 As providers will generally be in control of performance, an appropriate transfer of risk would link prices and payments to performance, for example, patient satisfaction. Going forward, the NHS will be held to account against clinically credible and evidence-based outcome measures, not process targets.

3.13 Taking an example of musculo-skeletal services, a commissioner may seek to incentivise desired outcomes through use of CQUIN schemes or similar performance-related payment mechanisms to increase the proportion of payments determined by patient satisfaction levels.

3.14 Commissioners may also wish to consider strengthening the focus on outcomes by including these in contracts. This may enable providers to produce more innovative bids. Nevertheless commissioners must ensure that clinical safeguards are always met.

3.15 By taking a strategic approach and aligning performance goals across contracts, the commissioner can also use performance-related payments to encourage effective collaboration (ie 'system alignment'). However, it is important that any sanctions for underperformance are proportionate because punitive sanctions (ie. penalties) may be detrimental to the services and, furthermore, may be unenforceable.

Demand risk

3.16 When undertaking procurements, commissioners should consider how to manage risks of demand being higher than anticipated or lower than expected. Contracts can be constructed so that the risk of greater demand lies with the provider of the services. However providers are likely to require greater compensation if they are taking more risks, so contracts that transfer risk are likely to be more expensive. This may be appropriate, but commissioners also need to consider who is best placed to manage the risk of higher or lower than expected volumes. As part of this, commissioners need to consider if schemes for managing demand could create perverse incentives. Approaches to the management of risk are covered in 'The commissioning framework (2006)'⁴¹

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

3.17 Appropriate care and resource utilisation within the NHS is a shared responsibility for commissioners and providers as set out in previous Operating Frameworks. As such providers and commissioners should be working together to ensure that demand leading to inappropriate activity is managed out of the system.

3.18 We will update the Guide, as necessary, as new arrangements for commissioners and providers are established.

Gainsharing

3.19 Gain-sharing can create incentives for the provider to make quality and productivity improvements, with a proportion of the 'gain' shared with the commissioner (see Box 1). The main points to note regarding Gainsharing are;

- Providers require freedom over the outputs
- An effective baseline is required to measure performance targets
- Potential Gainshare needs to be affordable (and fundable)
- Time is required to understand and test innovative solutions, senior buy-in is required
- Contracts need to be of sufficient size and scale
- HR issues need to be identified, managed and resolved early
- Where services are fragmented, gainsharing is more challenging to operate
- Financial incentives can help to increase scale of productivity
- Year on year savings are likely to decrease over time
- Risk structures need to be worked through appropriately

Contract Duration

3.20 The NHS Standard Contract duration is 3 years (with an option to extend by no more than a further year). In the current environment of financial pressures, in seeking innovation and building longer term relationships with providers, commissioners may want to consider longer contract duration (eg 5-7 years⁴²), but in line with national standards contract guidance, derogations from the national standard contract require SHA approval. The intended duration of a new contract is a firm indication of scale and will have direct implications for the level of resource required in the procurement process and the provider's cost recovery model.

3.21 Longer-term contracts may be appropriate if there are substantial costs to the commissioner in running the procurement, where investment is required by the provider or where there is substantial service reconfiguration. When a longer contract duration is used, alongside the NHS standard contract review process (and with regard to contract extension guidance elsewhere in this Guide), commissioners should structure the contract to allow adequate opportunities for managed exit. In addition any such contract should have robust break clauses which can be used if the provider is not delivering good value for money. Longer-term contracts will not generally be applicable if awarded through a Single Tender Action.

3.22 Where longer-term contracts are to be used, it is essential that commissioners take more time in ensuring the robustness of the contract, for example, taking steps to ensure appropriate risk apportionment, break clauses, performance management regimes and other robust contractual levers.

3.23 Commissioners need to balance the advantages of longer contracts against the risk of being locked into inappropriate contracts. If a service or supplier landscape is changing rapidly, then commissioners should consider shorter contract lengths. They also need to consider if longer term contracts are blocking out other potential suppliers.

3.24 Shorter contract duration (eg 1-2 years) may also be useful if there are temporary commissioning needs, such as reducing waiting times for a particular type of treatment, or during transition phases of major reconfigurations. They are also useful if a commissioner wishes to test an approach.

3.25 Commissioners should carefully consider how contract duration underpins incentives to improve performance. For example, contracts with options for extension linked to improvements against specified outcomes or KPIs.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

Box 1: gainsharing

Gainsharing is a tool that allows commissioners to drive behaviours in providers which leads to cost savings. It allows both provider and commissioner to identify and share savings, and can be useful in developing longer-term strategic partnerships.

Gainsharing can use a programme administrator to maintain an arm's length relationship between provider and commissioner. Where cost-savings are found and then shared between the two bodies, the administrator checks those drivers are safe, effective and appropriate (against benchmarks where possible), before considering the cost savings and benefits which are then independently verified and shared as contractually agreed. To help drive ongoing value for money, savings can be identified via open-book accounting. Contractual terms can encourage the reinvestment of those savings into patient care/other efficiencies.

The involvement of clinicians in this process is paramount as they are in a unique position to understand how processes may be streamlined to reduce costs and strengthen efficiency and improve quality.

Although gainsharing can drive behaviours towards identifying improved quality and/or cost savings, there will be a contract management and administration burden. Experience from the US suggests gainsharing works best in high-cost, high-volume specialties for providers with a sufficient level of activity.

Some good practice points to note regarding gainsharing are:

- Basing gainshares on transparent and clearly documented actions to improve quality and reduce costs
- Ensuring clinical and financial transparency of quality indicators – the use of robust KPIs is key to ensuring behaviours are not distorted towards savings at the expense of clinical safety and other performance metrics
- Implementing ongoing measurement and monitoring to determine the program's success and to confirm that the program is not having an adverse impact on clinical outcomes
- Using baseline thresholds to guard against inappropriate reductions in service
- Providing clear feedback to the system about their quality and efficiency.

Gainsharing promotes and requires transparency, so where savings are identified, both parties can see why and where these savings are made and this can lead to disseminating of best practice.

Gainsharing might allow a commissioner to include a service that would otherwise be unaffordable, by testing ideas to do it differently. For example, from benchmarking and patient satisfaction surveys, a commissioner might conclude that a service is too expensive and inappropriate to continue in the

existing setting. The commissioner might test with providers some options to deliver this service elsewhere, in a different way and if commissioned under a gainsharing arrangement with existing providers, it provides incentives for providers to do things differently and make savings.

The commissioner might test with providers some options to deliver this service in the community and if commissioned under a gainsharing arrangement with existing providers, it provides incentives for providers to do things differently and make savings.

Provider benefits

- keeping some of the savings
- incentivised to innovate
- reduction in destabilisation risk

Commissioner benefits

- facilitates new patterns of provision where appropriate
- getting better prices
- reduced risk of the destabilisation of existing providers
- bringing providers on the strategic journey

Patient benefits

- receiving treatments in more appropriate settings
- financial benefits are reinvested to improve services

A commissioner must take particular care to not favour one provider above another and be open, transparent and non discriminatory regarding which providers it works with. Commissioners should also consider opening up these opportunities to new providers as soon as possible to ensure the best possible chance for innovative solutions.

Duration and level of gainshare

In the example above, the duration and level of gainshare are key. The commissioner would need to make it clear to the provider that there are potentially negative consequences if efficiencies cannot be found, (eg that the service may be discontinued as currently provided). However, positive incentives are also needed to drive appropriate behaviours, ie the level of gainshare. A commissioner might offer a provider a greater proportion of the gain and/or the arrangement might be offered for a longer period of time.

A longer gainshare duration allows for greater cooperation between the commissioner and provider and allows more opportunity for efficiencies to be identified and tested. Furthermore, it allows the provider to benefit from those efficiencies it has identified for longer before that innovative service model forms part of a standard service specification opened up to greater competition. This is an example of how appropriate cooperation can lead to innovation and then, in turn, be used to drive competition.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

4 Governance

Introduction

Commissioners and their Boards’ are accountable for the actions and decisions of the organisation in carrying out its statutory functions. In this way, they are responsible for securing services to meet the needs of its population and delivering value for money. They are also responsible for ensuring compliance with law, including the Public Contracts Regulations, and for satisfying the organisation’s obligations of transparency and non-discrimination. Similarly, where in-house services are transferred to another provider the parties must comply with specific legal requirements, such as TUPE⁴³ and relevant codes of practice.⁴⁴

4.2 Appropriate governance arrangements will enable commissioners and their boards to discharge their responsibilities and ensure that decisions are made with due authority, including, where necessary, with approval of the Strategic Health Authority. Governance arrangements will include Standing Orders, Standing Financial Instructions, Schemes of Delegation, Reporting Structures, Policies and Documentation.

4.3 OGC has produced guidance on governance.⁴⁵ SHAs should agree with commissioners local processes for governance, derogations and dispute resolution.

4.4 When a commissioner is seeking to make decisions that it identifies as potentially contentious, it should liaise with the SHA to test their rationale for decision-making and seek SHA approval for that decision. In the same way a commissioner’s board delegates authority and uses policies to frame that decision-making, an SHA will be expected to support and assure the commissioner in doing the same in line with the regional strategy. This could be exercised initially through the use of commissioning plans and organisational development plans.

4.5 As accountability arrangements change reflecting changes in the White Paper, then new governance arrangements may be required.

Joint commissioning

4.6 Commissioners may also enter into joint commissioning or partnership arrangements with local authorities, which often involves senior individuals from both organisations that participate on a steering committee, usually under delegated authority from their respective organisations. Again, both commissioners and any service providers must comply with any legal requirements in relation to staff transfers, as well as any appropriate codes of practice governing staff transfers⁴⁶ that they will be expected to comply with. In circumstances where staff are transferring from both joint-commissioning organisations, more than one code of practice may be relevant, however, the parties should seek legal advice, if

appropriate, as well as consulting their local and regional workforce leads. It is advisable under such circumstances, to decide in advance of any procurement activity who the senior partner (or lead commissioner) is for decision making (if at all). Where a commissioner has the substantial interest in the service being commissioned (either by financial contribution or staff affected), then the Cabinet Office Code⁴⁷ and staff passport⁴⁸ should apply and this should be assured during due diligence work undertaken by the commissioner prior to contract signature.

4.7 Where a procurement is the subject of joint commissioning between several commissioners and/or with Local Authority partners then decision-making should be consistent with the governance of the joint commissioning arrangement⁴⁹.

Management

4.8 The management of procurements at the operational tier will require a clear scheme of delegation to enable decisions to be made quickly and in line with the overall commissioning and strategic objectives of the commissioner. For example, decisions with a financial impact below a certain financial threshold can be discharged by operational managers, with other decisions being referred to the Board or steering committee – these thresholds, roles and delegated authorities will be reflected in the commissioners Standing Financial Instructions / Standing Orders.

Policies

4.9 To assist managers in discharging procurement duties, commissioners will need to develop policies on a wide range of issues, to enable robust and informed decision-making. These will include tender documentation, (including electronic tendering), managing conflicts of interest, and appropriate scoring and evaluation techniques for the assessment of ‘value for money’, as well as dispute resolutions processes in case of complaints. Assuring workforce standards and protections and sustainable development are key policies that inform decision-making.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

4.10 The policies should allow for decision making within parameters to ensure they are taken with the overall procurement approach the Board wishes to see discharged. For example, Chapter 2 of this document highlighted some common scenarios that might lead to a decision to procure. However, it is still for local decision making how and when to procure to best meet local commissioning needs. It is therefore for individual Boards to set out the policies that enable decisions to be made aligned with their commissioning strategies.

4.11 EU Procurement principles should be applied consistently, objectively and in a transparent manner. Commissioners need to satisfy the overarching obligation of transparency, comply with the Principles and Rules for Cooperation and Competition and should adopt proportionate practices (as referred to at 1.18) to ensure the procurement processes used are defensible under scrutiny, and the outcome represents value for money as well as being the best for the patient and the population.

Documentation

4.12 Governance requires transparency to work; this is both in terms of policies used, decisions made and the process used to arrive at a decision. Both the board and the delegated tiers below should ensure a documented and transparent record of decisions is kept, so that they can withstand scrutiny if necessary. This is particularly necessary for all material decisions regarding tendering (ie including both decisions to tender and not to tender).

Conflicts of Interest

4.13 Conflict of interest is an issue that commonly arises during procurement activity and can occur when a commissioner is developing a service specification, when a commissioner is engaging incumbent or potential providers in preparing them to provide solutions to deliver that service, or during the procurement process itself. When conflicts of interest arise, it is the responsibility of the commissioner to manage them appropriately to ensure a robust and transparent procurement.

Conflicts of Interest pre-procurement

4.14 As previously discussed elsewhere in this document, commissioners should engage with a range of providers, patient groups, clinicians and other appropriate staff (which may including their representatives or trade unions) from both incumbent and potential providers, to design, assess and test service specifications and explore procurement

options. In doing so, a commissioner needs to manage potential conflicts of interest where a provider is working with them on a specification for which they may later bid. Good practice is for commissioners to require all those supporting a procurement as commissioners (evaluators etc) to sign a declaration in respect of confidentiality and conflict of interest) – this will also include CSU members and other commissioning support functions, which may liaise with the commissioner and providers prior to and during a procurement exercise.

4.15 Commissioners must assure themselves that incumbent providers declare all potential conflicts of interest (eg, see standard NHS acute contract clause 53). The use of contractual mechanisms will normally be sufficient to mitigate such conflicts of interest. Where a contract does not yet exist with a potential bidder, they should declare a conflict of interest if it is proposing to bid for the service once the specification is developed.

4.16 Commissioners should engage with providers and potential bidders regarding commissioning intentions. A commissioner can engage with staff side unions when deciding on service specifications and procurement approaches in order to inform their thinking. See Annex B for further details. It is not a conflict of interest for staff side unions to be involved in discussions regarding potential future service models etc, however, it would be a conflict of interest, if these bodies were involved in procurement decisions. Any information shared with parties as part of the procurement process must also be shared with other parties to a procurement.

Conflict of interest during procurement

4.17 In some circumstances, a bidder's involvement in previous or parallel projects, its participation in multiple bids, or its participation in the commissioner's activities (eg as a provider of commissioning or consultancy services) may give rise to a possible conflict of interest in bidding for certain contracts. Ideally, this should have been identified at the pre-procurement stage. The use of contractual mechanisms or ethical walls may be sufficient to mitigate such conflict of interest.

4.18 In other cases, it may be appropriate to exclude the bidder and associated parties from the tender process to ensure equality of treatment between bidders if it is concerned about conflicts of interest. The bid documentation should clearly state the commissioner's policy on managing conflict issues, which should be applied consistently.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

Conflicts of interest post procurement

4.19 Where a conflict of interest might apply in referral of patients, medical Practitioners must tell the commissioner, as GMC Good Medical Practice 2006, para 76 states ‘if you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest. When treating NHS patients you must also tell the healthcare purchaser’ which is reflected in PRCC Principle 10: ‘All referring clinicians (such as general practitioners and hospital consultants) must tell their patients about any financial or commercial interest in (or that they are employed by) an organisation to which they plan to refer a patient for treatment or investigation. This could include the situation where the referring GP is a director of the provider organisation.

4.20 All tendering documentation should clearly state the commissioner’s policy on managing conflict issues. Prior to any decision to exclude bidders on conflict of interest grounds, care is needed as this decision could be challenged if the bidder can show they were excluded on grounds that are not consistent with the selection criteria.

4.21 Each commissioner should have its own disputes resolution process and policy pertaining to how it deals with conflicts of interest.

Practical Steps regarding Conflicts of Interest

- Advertise the fact that a service design/re-design exercise is taking place widely (eg on NHS Supply2Health®) and invite comments from any potential providers and other interested parties (ensuring a record is kept of all interactions) – ie do not be selective in who works on the service specifications unless it is clear conflicts will not occur.
- As the service design develops, engage with a wide range of providers on an ongoing basis to seek comments on the proposed design – eg via the commissioner’s website or workshops with interested parties.
- If appropriate, engage the advice of an independent clinical advisor on the design of the service.
- When specifying the service, specify desired (clinical and other) outcomes instead of specific inputs.
- Any potential conflicts should be identified early and interests declared on a conflicts of interests register, held by the commissioner. It is the role of a commissioner to be vigilant regarding conflicts of interest.

4.22 A commissioner needs to strike an appropriate balance between working with providers to ensure innovative and deliverable service specifications, and working too closely to provide an unfair advantage. Therefore, transparency and equality of treatment are paramount.

4.23 Commissioners should have a clear policy on identifying and acting on potential conflicts of interest, which should form part of all tender documentation and listed under the relevant section of their websites so providers and potential providers are aware of these policies when engaging with the commissioner.

4.24 It is essential that trade union representation is bound by the same rules including confidentiality as other parties to the procurement process.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

Annex A provider engagement

Introduction

Effective engagement with providers is essential for effective commissioning of health services and a key factor in any successful procurement – this is assessed as part of WCC competences 3 and 4⁵⁰.

A1.2 This chapter sets out the role of provider engagement in

- Assessing the responsiveness and capability of providers to meet the commissioning need,
- Working collaboratively to develop service specifications,
- Assessing appropriate procurement routes and
- Testing how a commissioner can deliver innovation and productivity through procurement.

A1.3 It provides some examples of how commissioners may discharge provider engagement and in the next chapter, how these interactions inform service specification.

Provider engagement is an integral component of good commissioning

A1.4 Provider engagement is an ongoing and integral part of the commissioning cycle and will involve both current and potential providers. It does not stop and start with procurement exercises. Provider engagement needs to take place early and should be a continual process to allow providers to be aware of and interact with the development of service opportunities that may arise. Without effective prior engagement with providers procurement will be unlikely to achieve the commissioner's objectives and may result in excessive costs.

A1.5 Moreover, provider engagement should be a two-way dialogue, rather than a top-down process. Engagement with a wide range of providers⁵¹ should inform commissioning intentions and decisions, just as commissioning intentions should inform the development of services. Where this works well incremental service changes and effective cooperation between providers will reduce the need for intervention by commissioners.

A1.6 Engagement with all providers should follow a strategy, cognisant with the overall objectives of the commissioner and dependant in individual cases on what the commissioner is seeking from its provider base. Knowing these factors will then affect the way the commissioner engages providers. Some of the elements that a commissioner will consider when deciding how much and when to engage providers

include;

- Considering provider willingness / capability to deliver a service
- What providers are currently offering / delivering
- Lessons learned from previous interactions
- Assessing barriers to entry
- What level of competition is possible / required
- Development of service specifications
- Testing of service specifications
- Which procurement routes are preferred
- Provider approaches and attitudes to;
 - Cost
 - Risk
 - Innovation
 - Capacity available
 - Practical considerations (eg testing locations and staffing requirements)

A1.7 From the above, an assessment of which procurement options will best suit the situation can be made

Forms of provider engagement

A1.8 There are several stages at which provider engagement may take place and each has its own purpose. It might be that a commissioner wishes to review what provision there is or potentially will be ('horizon scanning'), a commissioner may wish to engage providers early to manage expectations of upcoming opportunities so the providers can make preparations to take advantage of the opportunity, or it could be to test proposals with the providers to ensure that they are deliverable. (Chapter 4 provides some additional detail on pre-procurement conflict of interest). As there are different requirements and objectives from provider engagement, the form of provider engagement is crucial. The form, formality and type of engagement prior to and during a procurement process will be different. At any level, when undertaking provider engagement, a commissioner needs to ensure transparency, non-discrimination, proportionality and equality of treatment across all providers, incumbent and potential. A commissioner should also consider;

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

- That early and wide engagement gives opportunities for providers to contribute to service reviews as specifications are developed
- That providers should be engaged on an equal and inclusive basis, commissioners should ensure openness of access to staff and information.
- That good communication channels are needed to keep providers informed (eg NHS Supply2Health®, via CSU and other [formal and informal] networks).
- Ensuring the commercial confidentiality of information received
- The possibility of using grants, commissioning pilots or proof of concept exercises to test ideas providing these opportunities are let in line with procurement rules
- That any methods used should ensure consistency with consultation exercises no conflicts of interest and the engagement should avoid giving an unfair advantage to any particular provider – otherwise the procurement exercise may be challenged

A1.9 OGC has produced guidance, which commissioners should refer to before engaging with providers⁵². An illustration of different approaches to engaging providers is described below.

Prior Information Notice (PIN)

A1.10 This is useful for testing service specifications and gaining provider interest. Prior to formal procurement process, a commissioner may decide to publish a Prior Information Notice (PIN) on NHS Supply2Health® and seek provider feedback – this allows for testing and for the commissioner to write more realistic and suitable specifications.

A1.11 This is also an important method of alerting providers to procurement intentions prior to issuing a formal invitation to tender. Providers will have the chance to respond to the PIN and any provider feedback gained at this stage can be used to inform the service specification, or take alternative routes (eg if no provider interest)

Testing / Competition of ideas

A1.12 This is useful for development of service a specification. commissioners may approach suppliers directly to seek new and innovative solutions to current areas of concern in order to identify priority areas for further research and development and (potentially) procurement. ‘Competition of ideas’ involves disseminating problems or issues to a range of providers and seeking proposals.

commissioners will need to have a clear idea of what the issues are and adequate expertise and time in-house to analyse responses. This can therefore be quite resource intensive. The benefit to providers is that it gives a forum for them to test their ideas with a receptive commissioner and should the approach be selected, would enable them to be well placed to bid for the opportunity. Contractual mechanisms may be required to adequately protect providers’ intellectual property, whilst also ensuring dissemination of innovation.

A1.13 Any procurement of resulting ideas cannot be seen to be prejudiced through early engagement with a representative group of suppliers. Therefore, the specification should focus on the outcomes sought, rather than on specific technologies or products. OGC has prepared further guidance on this⁵³.

Public / Private Reference Groups

A1.14 These are useful to test ideas and to engage providers regarding future opportunities. These might include members from incumbent providers across all sectors and also be open to other providers who may or may not deliver services in that region. It is likely these are best formed on an SHA-region basis.

A1.15 Setting up these groups can be resource intensive, as there are a range of stakeholders from different sectors. However, if used properly, these groups allow a commissioner to get its message across quickly and effectively to a range of stakeholders and also allows cross cutting themes to be explored. commissioners may wish to ‘horizon scan’ with providers about where it plans to go in the future, what its priorities will be and where it considers the focus of its evaluations to be (eg innovation or cost)

A1.16 Commissioners would find these groups useful in terms of feedback from providers in identifying barriers to entry, issues to discuss or innovative approaches that can be explored further. These could also be developed via questionnaires for completion post tender.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

Provider Fairs

A1.17 These are discrete, usually ‘one-off’ events which bring together current and potential providers and are generally useful where commissioners are considering developing new services or new service models. Provider fairs also have the benefit of creating strong linkages in the supply chain and foster cross-boundary working amongst providers and commissioners which can help provide a more seamless service for patients. Providers will need to ensure that these discussions do not relate to competitive levers between them (ie pricing discussions etc would not be appropriate)

Websites

A1.18 Commissioners should consider using NHS Supply2Health® to notify providers regarding forms of pre-procurement engagement. This has the benefit of reaching a wider audience and does not discriminate amongst providers. Commissioners can also use their own website for other material that helps to prepare and engage providers for procurements, such as;

- Publication of strategy documents
- Listing priority areas for further investigation / procurement
- Decisions to tender or not to tender for new services and underlying rationale
- Lists of awarded contracts and expiry dates
- Subcontracting opportunities

A1.19 Commissioners may also wish to use the websites of partnering organisations to ensure the widest possible reach, for example, Local Authority, Education, Children’s Trust, Partner websites, etc)

Ongoing engagement

A1.20 Once current (and potential) providers are identified, commissioners should consider active management of providers to ensure outcomes are delivered eg setting up formal and regular meetings to discuss current performance, current opportunities and to strengthen the relationships between commissioner and supplier. This should be in addition to the contractual relationship and focus on strategic (rather than operational) issues.

A1.21 In the context of procurement, there will be a set of defined interactions⁵⁴ between commissioners and bidders along the procurement route. However, as described earlier, some procurement processes have more interaction and negotiation with bidders than others (eg competitive dialogue vs. AWP) and therefore some are more suited to occasions when a commissioner needs ongoing engagement to develop service specifications for example.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

Annex B engagement with staff and their trade unions

Introduction

The NHS Constitution pledges that staff should be engaged in changes that affect them. Staff engagement is principally the responsibility of employers and the NHS Constitution is embedded within the terms of the National Standard Contracts for Acute, Mental Health and Learning Disability, Community and Ambulance services. Good staff engagement improves the quality of commissioning and procurement. Staff engagement covers individual members of staff, teams and the trade union representatives of staff. Commissioners are also legally obliged to have regard to the NHS Constitution, including in procurement of NHS-funded services on behalf of their populations. Over time, as GP consortia are formed, the roles and responsibilities described in this annex will change, whereupon new guidance will be issued.

Responsibilities of Commissioners' Boards

B1.2 Commissioners' boards are responsible for the legal duties of their organisations in having regard to the NHS Constitution, including its pledges. Commissioners will wish to develop staff engagement policies with employers and trade unions at an early stage. It is good practice for commissioner Boards to signal a staff engagement strategy in relation to commissioning, including:

- Developing and implementing commissioning strategies
- Reviewing services and care pathways
- Developing service specifications
- Procurement

Staff engagement in commissioning strategies

B1.3 It will be good practice for commissioners to publish policies for engaging staff in the ongoing development and refinement of commissioning strategies and ensuring that providers undertake effective workforce planning. Commissioners, as commissioners, will determine priorities for improving quality, productivity, increasing choice and delivering more personalised care. Priorities would then be addressed through the commissioning strategy. This could include, for example, procurement of new service models and/or redesign of care pathways. In this way, commissioners are key agents of change that may affect staff across the local health system. They therefore have a responsibility to engage staff under the NHS Constitution.

B1.4 Staff engagement by commissioners should be complementary to the role of employers. At a strategic level, commissioners should therefore engage regularly with staff and employer representatives through local/regional Social Partnership Fora. This would help to ensure that employer and staff-side representatives both have access to the same information and create opportunities for partnership working in helping to inform commissioning intentions and in managing the impact of change.

B1.5 Commissioners' policies on staff engagement in commissioning strategies should include:

- Identification of the local/regional Social Partnership Forum, or alternative, as the principal vehicle for staff engagement at strategic level
- Scope of engagement (eg. commissioning priorities; plans for service/care pathway reviews; potential procurements)
- Criteria for evaluating engagement with staff and their trade union representatives
- Where commissioning is linked to development of social enterprise, structures of engagement to test staff support and 'buy-in' will be particularly important

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

Staff engagement in reviewing services and care pathways

B1.6 Commissioners should publish strategies for engaging staff in reviewing services and care pathways.

B1.7 Staff can make a valuable contribution to reviews of services and care pathways because of the expert knowledge and unique insight they possess. Employer and staff-side representatives/trade unions can help to facilitate this.

B1.8 Commissioners' policies on staff engagement in reviewing services and care pathways should include:

- Forward planning of service and care pathway reviews
- Involving clinicians and other staff in service and care pathway reviews
- Involving employer and staff-side representatives in service and care pathway reviews

B1.9 As is the case when reviewing services and care pathways, commissioners will want to involve staff in developing service specifications because of their valuable knowledge and expertise.

B1.10 Commissioners' policies on staff engagement in developing service specifications should include:

- Forward planning of work to develop service specifications
- Involving clinicians and other staff in developing service specifications
- Involving employer and trade union representatives in developing service specifications

Staff engagement in procurement

B1.11 Commissioners should publish policies for engaging staff in procurement.

B1.12 Commissioners should have regard to the NHS Constitution in their procurement activities, including in engaging staff on change that may affect them. For example, commissioners must ensure that service specifications, pre-qualification criteria, bid evaluation criteria and contracts reflect appropriate workforce standards, including compliance with legal requirements and relevant codes of practice. In addition, commissioners should work in partnership with employers and staff-side representatives in implementing new contracts, particularly where this would involve transfers or other changes that could affect ways of working. Commissioners' policies on staff engagement in procurement should include:

- Forward planning of potential procurements
- Appropriate involvement of employer and staff-side representatives in developing pre-qualification and bid evaluation criteria
- Appropriate involvement of employer and staff-side representatives in implementation of new contracts
- Managing potential conflicts of interest arising from involvement of employer and staff-side representatives in procurement.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

Annex C competitive procurement models overview

Competitive tenders

C1.1 ‘Competitive Tender’ refers to a procurement process which promotes the use of competition between bidders, in order that the commissioner can seek the best bid and ideally, select the provider who best meets their commissioning need. There are three versions of competitive tender commonly used in Part A that have been listed below, however, commissioners should note that, as set out in paragraph 1.15, it is up to each individual commissioner to decide the form a procurement for a Part B service takes. If Part A procedures are used for any reason, commissioners should take account of paragraph 1.16. The 3 versions are:

- Open
- Restricted
- Competitive Dialogue

C1.2 Each of these models is described below;

Open Procurement

Description

C1.3 Under the open procedure, all interested candidates who respond to an NHS Supply2Health® advertisement must be invited to tender. This is similar to AWP but does allow a commissioner to negotiate with bidders and drive down price / increase quality in order to choose the best bid, according to evaluation criteria.

Considerations

C1.4 Under this procurement route, the advertisement and service specification must be very clearly defined so that bidders know exactly what is being procured, as well as to enable them to fully assess whether they are interested in expressing an interest in providing the service in question.

Restricted Procurement

Description

C1.5 Under the restricted procedure, interested candidates are invited to respond to the NHS Supply2Health® advertisement by submitting an expression of interest. A shortlist of candidates is then drawn up and invited to tender. There is no scope to negotiate with tenderers following receipt of bids.

Considerations

C1.6 This procedure is quite common, because it reduces cost and improves manageability of bids. As there is no ability to negotiate under this route, commissioners must have a clear pricing structure in mind, in advance of advertisement. This is therefore well suited to existing services that require re-provision.

Competitive dialogue

Description

C1.7 Competitive Dialogue is a flexible procedure for use in more complex service procurements where there is a need for the commissioner to discuss all or particular aspects of the proposed contract with candidates. This helps to refine the requirement through supplier input and gives the opportunity for meaningful negotiations.

C1.8 This procedure is quite common, particularly when, given the nature of the services in question, the commissioner will need to engage with providers in developing its service specifications. This is particularly useful when commissioners are seeking to take advantage of innovative approaches.

C1.9 Under competitive dialogue, short-listed parties are invited to participate in dialogue, which may have several stages. Once this stage is concluded, suppliers are invited to submit a final tender. There is only one provision for the contracting authority to ask bidders to ‘clarify, specify and fine-tune’ their final bids before a preferred bidder is chosen.

C1.10 It is essential that trade union representation does not represent the provider interest and is prepared to be bound by the same rules including confidentiality as other parties to the procurement process.

Considerations

C1.11 This procurement route can be more labour intensive than other procurement routes and has many benefits in terms of seeking innovation and dealing with particularly complex or technical procurements. Robust governance is needed as there needs to be careful management of bids and avoidance of conflicts of interest to ensure equality of treatment and avoiding any unfair advantage between bidders.

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

Endnotes

1. 'Contract' includes those defined in the 2006 National Health Service Act, ie, with Secretary of State as the final arbiter, or legally enforceable contracts awarded to providers
2. This definition of procurement as an integral part of the commissioning cycle is consistent with the concept of 'Strategic Sourcing' whereby use of procurement and contracting mechanisms are prioritised according to need and informed by systematic review of current and potential alternative provision.
3. Link to PRCC to be provided once document published
4. Including PBC
5. Eg as PCTs work in partnership with Local Authorities to commission integrated health and social care services.
6. Such as to a Mental Health Trust.
7. For more information on 'Part A' and 'part B' services, see www.ogc.gov.uk/documents/Introduction_to_the_EU_rules.pdf
8. http://www.ogc.gov.uk/procurement_policy_and_application_of_eu_rules_guidance_on_the_UK_regulations.asp
9. http://www.ogc.gov.uk/procurement_policy_and_application_of_eu_rules_eu_procurement_thresholds_.asp for further details of the EU thresholds
10. Taking the providers' ability to manage risk and impact on value for money into account. Contracts also need to support providers to ensure service delivery is not at risk of disruption.
11. http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_080964.pdf
12. Using an NHS SUPPLY2HEALTH Notification and selecting the 'summary of commissioning intentions' option
13. Users may register on NHS Supply2Health to receive e-alerts when new items are posted, or may search the site directly
14. OJEU term, see OGC for more details www.ogc.gov.uk/priorinformationnotice
15. By completing a form at SIMAP www.simap.eu
16. Therefore, 2 notifications will have to be made for contracts over £156,442 – one to OJEU, 1 to NHS Supply2Health
17. Using an NHS SUPPLY2HEALTH Notification and selecting the 'notification of contract award' option
18. Also known as the Alcatel period often referred to as part of the Part A procurement process and which OGC strongly recommends as good practice as part of Part B competitive procurement processes. Non-compliance can have serious consequences and further information can be obtained from: http://www.ogc.gov.uk/procurement_policy_and_application_of_eu_rules_guidance_on_the_UK_regulations.asp
19. Please refer to Public Contracts (Amendment) Regulations 2009 SI No 2992. and to http://www.ogc.gov.uk/documents/Remedies_EXPL_MEMO.pdf for more information
20. This includes considering, as a cost, any disruption this might have to existing provision, for example any clinical and / or financial unsustainability, impact on workforce etc that may result (see http://www.ogc.gov.uk/implementing_plans_introduction_life_cycle_costing_.asp)
21. (http://www.ogc.gov.uk/procurement_-_the_bigger_picture_policy_and_standards_framework.asp).
22. <http://www.thecompact.org.uk/>
23. For further information on this matter please consult the Office of Health Economics paper: 'How Fair? Competition between independent and NHS providers to supply non-emergency hospital care to NHS patients in England', Office of Health Economics, Sep 09
24. Including incumbent and potential providers
25. http://www.ogc.gov.uk/policy_and_standards_framework_equality.asp
26. See the following links for further details; NHS Carbon Reduction Strategy (http://www.sdu.nhs.uk/page.php?area_id=2)
Procuring for Carbon Reduction supporting materials (http://www.sdu.nhs.uk/page.php?page_id=159)
Ethical Procurement for Health (we are expecting imminent sign off by MS(H) on this and then publication on DH site. We suggest the following link in anticipation of this being published <http://www.dh.gov.uk/en/index.htm>)
Training on sustainable procurement available to NHS Purchasing Organisations (<http://www.loreus.co.uk/trainingcentre/>)
Any queries with regard to sustainable procurement should be sent to sustainable.procurement@dh.gsi.gov.uk
27. Commissioners wishing to access the Decision Support Tool should email HMA@dh.gsi.gov.uk to register
28. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4112428
29. http://www.ogc.gov.uk/documents/Introduction_to_Public_Procurement.pdf; also see paragraphs 1.14 and C1.1
30. ECJ judgement, Case C-454/06
31. This is referring to the service itself, not the organisational form(s) of provision
32. 'Value for money' is the combination of cost and quality factors. For more information, see; http://www.ogc.gov.uk/procurement_documents_value_for_money.asp <http://www.ogc.gov.uk/documents/vfm.pdf>
33. Please see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_105117 PDF document and refer to competency 4 'collaborate with clinicians' (page 78)
34. The Government has recognised the importance of unbundling services to facilitate bids by smaller providers in The Compact on relations between government and the voluntary and community sector was first agreed between Government and the voluntary and community sector (VCS) (Cabinet Office; December 2009)
35. NHS standard contract: http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dH_091451

1 Introduction	2 When and how to use procurement	3 Pricing, risk and contract duration	4 Governance
Annex A Provider engagement	Annex B Staff engagement	Annex C Competitive procurement models	Endnotes

36. Primary Care Contract: <http://www.dh.gov.uk/en/Healthcare/Primarycare/Primarycarecontracting/index.htm>
37. ie bidders who have passed earlier stages of the procurement process
38. Including, for example, the ability of bidders to mobilise the service and integrate with existing parts of the pathway etc.
39. Including workforce standards and the staff passport compliance
40. http://www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Section64grants/DH_4032519
41. http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4137230.pdf
42. OGC guidance is that for framework agreements (including AWP) 4 years is the maximum
43. <http://www.berr.gov.uk/whatwedo/employment/trade-union-rights/tupe/page16289.html>
44. This may include: the Cabinet Office Code of Practice on Workforce Matters in Public Sector Service Contracts (<http://www.cabinetoffice.gov.uk/workforcematters/code.aspx>); The Cabinet Office Statement of Practice on Staff Transfers in the Public Sector (January 2000, revised November 2007) and the Treasury Annex, A Fair Deal for Staff Pensions (http://www.civilservice.gov.uk/Assets/stafftransfers2_tcm6-2428.pdf); ODPM Circular 03/2003 (<http://www.communities.gov.uk/documents/localgovernment/pdf/134855.pdf>); Department of Health Joint-Statement (http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_073148.pdf)
45. http://www.ogc.gov.uk/delivery_lifecycle_governance.asp and
46. http://archive.cabinetoffice.gov.uk/opsr/workforce_reform/code_of_practice/index.asp and <http://www.lge.gov.uk/lge/core/page.do?pagelid=119743>
47. <http://www.cabinetoffice.gov.uk/workforcematters/code.aspx>
48. <http://www.socialpartnershipforum.org/StaffPassport/Pages/StaffPassport.aspx>
49. <http://www.dh.gov.uk/en/Healthcare/IntegratedCare/HealthAct1999partnershiparrangements/index.htm>
50. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080958
51. Including incumbent and potential providers
52. http://www.ogc.gov.uk/policy_and_standards_framework_identify_need,_strategic_planning_and_early_market_engagement_8037.asp and http://www.ogc.gov.uk/getting_the_best_out_of_gems_market_creation.asp
53. http://www.ogc.gov.uk/delivering_policy_aims_through_public_procurement_innovation.asp
54. PCTs should be aware that during a procurement process, the ways and means for bidder engagement are very defined and any deviation from these will potentially result in a void procurement.