NHS

PCT Procurement Guide

for Health Services

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Executive summary

Introduction

The *PCT Procurement Guide for Health Services* supports NHS commissioners in deciding whether and how to procure health services through formal tendering and market-testing exercises. The Guide is intended to complement and build upon wider system management initiatives and the world class commissioning programme. It is one of several system management tools and guidance documents announced in Annex C of the 2008/09 NHS *Operating Framework*. The Guide is also referenced in Annex D (Principles and rules for Cooperation and Competition (PRCC)) of the *Operating Framework*. Principle 3 of the PRCC requires PCTs to follow the guidelines set out in this Guide. In addition, the national Cooperation and Competition Panel will, where relevant, use the Guide as a benchmark when considering disputes concerning breaches of the PRCC.

Audience

The Guide is aimed principally at primary care trusts (PCTs). However, strategic health authorities (SHAs) will note that the PRCC sets out considerable responsibilities for the oversight of PCT commissioning and procurement practices, and thus they should familiarise themselves with the Guide. Providers (from all sectors) should find the Guide helpful in clarifying the approaches and behaviours they should expect of PCTs in pursuing procurement strategies.

Summary

The Guide covers the following topics:

Policy context

- There is no general policy requirement for NHS services to be subject to a formal procurement process, and the Guide does not create such a requirement.
- However, the use of independent and third sector providers to provide NHS-funded services has become more common. Furthermore, increasing numbers of NHS providers are foundation trusts, with a greater degree of autonomy including the right to hold legally binding contracts.
- The *Commissioning Framework* (July 2006) required commissioners to undertake reviews of service provision on a systematic basis.
- From April 2008, free choice of provider applies to routine elective services funded by the NHS.
- The PRCC sets a requirement for commissioning and procurement to be transparent and non-discriminatory, and restates the policy requirement for commissioners to use providers who are best placed to deliver the needs of patients and populations.

EU principles and criteria

- The EU Treaty and various Directives on procurement require competition as the mechanism by which contracting authorities ensure equality of treatment, transparency and non-discrimination. Nevertheless, it remains for each contracting authority to decide whether a formal tender is required for healthcare services.
- Contracting authorities should consider the following criteria when deciding whether to competitively tender:
  - estimated value of the contract;
  - level of market interest and capability (and potential for innovation);
  - government policy on protected services; and
  - circumstances under which competition is not appropriate, e.g. where partnership funding is in place.

NHS principles and practice

- PCTs should agree with their boards a procurement strategy for large, novel, contentious or repercussive tenders.
- Considerations when developing a procurement strategy include the following (summary of Table 3 under section 4.3):

Assess relevant markets	Evaluate existing contracts	Evaluate procurement options	Evaluate procurement routes
Need for services	Performance	Outcomes	Advice
Market structure	Efficiency	Attractiveness	EU Part A options
Competition	Demand	'Lotting' strategy	Other
Capacity	Fitness	Single/multi-source	
Innovation			
Interest			

- The key principles of good procurement and procurement strategy are:
  - transparency – including the use of sufficient and appropriate advertising of tenders, transparency in making decisions not to tender, and the declaration and separation of conflicts of interest;
  - proportionality – making procurement processes proportionate to the value, complexity and risk of the services contracted, and critically not excluding potential providers through overly bureaucratic or burdensome procedures;
  - non-discrimination – ensuring consistency of procurement rules, transparency on timescale and criteria for shortlist and award; and
  - equality of treatment – ensuring that all providers and sectors have equal opportunity to compete where appropriate; that financial and due diligence checks apply equally and are proportionate; and that pricing and payment regimes are transparent and fair.

Any willing provider

- The term 'any willing provider' (AWP) describes a set of system rules whereby, for a prescribed range of services, any provider that meets criteria for entering a market, can compete for business within that market, without constraint by a commissioner or payor organisation.
- The PRCC states that, for routine elective care, the opportunity for 'any willing provider' to supply services should not be constrained except under exceptional circumstances.
- Commissioners may choose to create local AWP policies for other services, consistent with their strategy, regional market management activities and procurement strategy.
- AWP processes can be open or managed.
- Providers operating under AWP rules should be awarded a standard NHS contract where one exists.

Further brief guidance on standard NHS contracts, sub-contracts and practice based commissioning is included in paragraphs 4.26 to 4.32.

Annex A of the Guide summarises relevant EU Procurement Directives.

1 Introduction

1.1 The *PCT Procurement Guide for Health Services* is intended to support NHS commissioners in their decisions on **whether and how to procure health services through formal tendering and market-testing exercises**. For the avoidance of doubt, under joint commissioning scenarios, it will only apply if the PCT is a joint signatory to the contract. It will also apply when PCTs delegate commissioning authority, such as to a mental health trust. This Guide deals with services which are covered by Part B of the European Union (EU) Public Procurement Directives and UK regulations (together, the 'procurement rules'). Part B includes health services, which are not subject to the full procurement rules regime, but which nevertheless may require some form of competitive tender to be undertaken. This Guide sets out the policy and regulatory context for procurement and provides advice on how to operate within the requirements of good procurement practice, including issues to consider when developing a procurement strategy.

1.2 This Guide is one of a number of system management 'tools' and guidance outlined in Annex C of the 2008/09 NHS *Operating Framework*, and should be read in that context. It sets out the **criteria** PCTs, as 'contracting authorities', should apply when deciding whether a formal procurement/tendering process is required. It also describes how the general EU procurement **principles** should be applied consistently, objectively and in a transparent manner within the framework of system management rules, to ensure the procurement processes used are defensible under scrutiny, and the outcome represents best value for money as well as being the best for the patient and the population.

1.3 **The Cooperation and Competition Panel, once established, will need to be satisfied that contracting authorities have consulted and complied with the guidance within this document as a basis for the decisions they have made.**

2 Policy context

2.1 There is no general policy requirement for NHS services to be subject to formal procurement processes, and this Guide is not intended to create such a requirement.

2.2 When the Public Services Contracts Regulations 1993[1] came into force they introduced a new regime applying to certain public bodies, with a set of detailed rules relating to the procurement of services. These regulations had very little impact on the NHS as they applied only when a legally enforceable contract was to be awarded. The public provision of healthcare usually involved no such contracts. This is because arrangements between NHS bodies (other than with foundation trusts) are usually 'NHS contracts', which are not enforceable in the courts.

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1 Now superseded by the Public Contracts Regulations 2006, SI 2006/5

2.3 However, as the use of independent and third sector providers for NHS-funded health services has become more common, and foundation trusts have become established (with whom contracts are legally binding), the current procurement regime (as implemented in the UK by the **Public Contracts Regulations 2006**)[2] has become more relevant to the activities of NHS commissioners. There are now a range of circumstances in which a formal procurement process should be followed and may actually be highly desirable in order to achieve the best value for patients and taxpayers.

2.4 The **Commissioning Framework**[3] set out a requirement for commissioners to initiate a systematic programme of service reviews, focusing initially on services where there is concern about quality. An outcome of such a review might be a decision to tender the service that fails to meet standards and fails to improve.

2.5 For routine elective services, the principles of free choice of provider for patients and the opportunity for any willing provider to supply services should not be constrained by commissioners. Other than in exceptional circumstances, there should be no guarantees of volume or payment in any contract given. PCTs, through contracts, give permission for the provider to supply services to their population without any promises regarding income. PCTs should give such contracts only to providers who can demonstrate that they meet national minimum quality criteria, as set out by the Care Quality Commission. It is, in effect, a local approval process for providers with the intention that competition is encouraged within a range of services rather than for them. This means that for providers looking to supply a routine elective service, including those developed through practice based commissioning (PBC), tendering is not required, but in the interests of openness and non-discrimination, consideration ought to be given to advertising to ensure competition.

2.6 **Practice based commissioning guidance** issued in November 2006[4] confirms that the same approach of fostering, not limiting, choice should be extended to the development of enhanced primary care services through PBC. Where the PCT is granting permission for any willing provider to operate in their area rather than purchasing an exclusive service from a single or limited number of providers, then tendering is not required.

2.7 For services developed through PBC, tendering will normally only be required when the intention is to award a contract to a sole provider or providers of service, rather than to grant approval to providers who reach required standards.

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2 www.opsi.gov.uk/si/si2006/uksi_20060005_en.pdf

3 *Health Reform in England, update and commissioning framework,* DH, July 2006, annex, paragraphs 2.31 to 2.33

4 *Practice based commissioning, practical implementation,* DH, November 2006, paragraphs 3.34 to 3.43

2.8 **Principles and rules for Cooperation and Competition**[5] (PRCC), published with the NHS *Operating Framework* 2008/09, include Principle 3: 'Commissioning and procurement should be transparent and non-discriminatory'. Adherence to this principle is necessary in order to provide the best value for money, encourage innovation and to protect the reputation of the NHS. The PRCC make it clear that it is for PCTs as commissioners and public sector contracting authorities who purchase Part B services (the 'contracting authorities'), to decide transparently which services require to be tendered. In doing so, Principle 1 lays on commissioners the requirement to commission services from the providers who are best placed to deliver the needs of their patients and populations. Where a provider, for example a mental health or care trust, has a delegated authority from the PCT to commission services, they must abide by the PRCC and this Guide, whenever exercising that authority. NHS trusts and foundation trusts are also public sector purchasing authorities and will need to comply with the procurement rules (see paragraph 1.1).

2.9 Contracting authorities must comply with the **Public Contracts Regulations 2006**.[6] Clinical services are categorised as Part B, and are therefore exempt from many of the obligations under EU Directives. For example, a formal procurement does not require a contract notice to be placed in the *Official Journal of the European Union* (OJEU), or the full OJEU tendering process to be followed. However, in many cases it would be advisable to follow the OJEU procedure because of the requirement to undertake a sufficient degree of advertising so as to satisfy EU Treaty principles of openness and fairness. The lowest risk way of complying with this requirement and protecting against adverse audit scrutiny is to follow one of the formal procedures laid down in the procurement rules.

2.10 Lastly, each contracting authority should remain up to date with changes in procurement rules as part of the world class commissioning competencies and be aware of the elements of competency 9. This Guide is not intended to be a definitive and exhaustive statement of the relevant law. The law is subject to change and this Guide is no substitute for obtaining appropriate legal advice in individual circumstances at the appropriate time. When contracting authorities are in doubt as to the application of these rules, legal advice should be sought. See Annex A for further information on the background to the procurement rules.

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5 Annex D of the 2008/09 NHS *Operating Framework*.
www.dh.gov.uk/enPublicationsandstatisticsPublications/PublicationsPolicyAndGuidance/DH_081098

6 The current procurement regime (Public Contracts Regulations 2006) is becoming more relevant to the activities of commissioning bodies in the NHS due to: the expansion in the use of the independent and third sectors for the provision of health services; the creation of independent foundation trusts; the deployment of legally binding contracts for the purchasing and performance management of services; certain European case law and views expressed by the Commission

3 EU principles and criteria

This section is a summary of the relevant EU law and landscape that commissioners should take into account when making procurement decisions. It is not exhaustive, but should be used as a reference point to begin with. Specific NHS principles are explored in section 4.

EU principles

3.1 The EU Treaty and Public Procurement Directives require competition as the mechanism by which contracting authorities ensure that the EU principles of equality of treatment, transparency and non-discrimination are met. UK policy, audit requirements and bodies' own constitutions (e.g. Standing Financial Instructions) also require that contracting authorities secure value for money through fair and open tender procedures, when these are appropriate.

3.2 It is for each contracting authority to decide whether a formal tender is required for healthcare services. Consideration should be given as to whether greater competition to deliver better quality is required. If, after a risk assessment, a contracting authority is considering not tendering the contract opportunity, it should perform basic financial and quality assurance checks before entering into a contract, e.g. financial viability, economic standing, clinical capacity and capability/ governance, affordability and value for money. In the absence of a competitive tender process, the contracting authority needs to demonstrate that quality and value for money has been obtained.

Deciding whether to tender

3.3 The following criteria should be considered (not necessarily in this order) by contracting authorities when considering whether to competitively tender.

Table 1: Criteria

Assessment	Consideration
Estimated value of the contract	The greater the value of the contract, the stronger the case for advertising the tender.
Level of market interest and capability	The larger the number of potential providers for the services there are, the stronger the case for advertising the tender. This could override considerations based on the value of the contract.
Government policy on protected services	Where the contracting authority can demonstrate that the service must be provided by a particular provider to protect essential public services, an advertised tender is unlikely to be necessary. (This must not be used to protect providers that are not best placed to deliver the needs of their patients and population.) [7]
Is there a reason that competition is not appropriate in this circumstance?	Do urgency considerations, due to factors beyond the contracting authority's control, preclude an advertised tender? Are the services protected by monopoly rights in accordance with a legal or administrative instrument? Is there only one supplier capable of providing services due to technical reasons or special or exclusive rights?

3.4 The transparency principle imposes an obligation to carry out a sufficient level of advertising,[8] but does not necessarily imply an obligation to conduct a formal tender procedure in full accordance with the procurement rules. Each contracting authority should assess local context and each circumstance, and decide whether a formal procurement is desirable on the grounds of demonstrating best value, market testing, maintaining some element of competitive tension and complying with the public procurement rules. Use of single tender actions and urgency exemptions should be avoided except where robust reasons can be given.

7 PRCC, Principle 1

8 The European Commission has clarified 'sufficiency of advertising' in paragraphs 2.1.1 to 2.1.3 of 'Commission interpretative communication on the Community law applicable to contract awards not or not fully subject to the provisions of the Public Procurement Directives' (http://ec.europa.eu/internal_market/publicprocurement/key-docs_en.htm) whereby the key factor in determining the nature of the advertising and other procedures to be followed is the relevance of the specific contracts to the internal market

EU Directive

3.5 The EU Directive has two levels of application – a full regime for services designated as Part A where the value of the Part A contract exceeds the relevant thresholds,[9] and a lighter regime for other services designated as Part B. The table below illustrates how the regulations apply to Part A and Part B services.

Table 2: Requirements

	Part A	Part B
Sufficient degree of advertising to satisfy principles of transparency, non-discrimination on grounds of nationality, and equality of treatment	X	X
Tender advertised in the Official Journal of the European Union	X	
Compliance with specified minimum timescales for providers to respond to adverts, pre-qualification checks and tenders	X	
Competitive dialogue or negotiated procedure allowed only in specified circumstances	X	
Detailed rules on selection and award criteria; contracts awarded either on the basis of the lowest price or the most economically advantageous offer (but note: award criteria must still be fair and non-discriminatory in the case of Part B contracts)	X	
Provision of feedback to unsuccessful providers and standstill requirement after contract award and prior to contract execution (but note: the 'openness' principle may require that this should happen in practice in Part B contracts)	X	
Issue of contract award notice to European Commission within 48 days of award	X	X
Collation of relevant statistical data	X	X

3.6 To comply with the requirement for transparency, non-discrimination and equality of treatment, contracting authorities may wish to adopt approaches required for Part A services. Each contracting authority should take proportionate and appropriate action to ensure a fair playing field among providers.

9 The Public Contracts Regulations 2006 apply to contracting authorities where the estimated value of the contract is more than the threshold set out in the regulations, currently £90,319. Details of the current thresholds for Part A service EU procurement are published on the Office of Government Commerce website at: www.ogc.gov.uk/procurement_policy_and_application_of_eu_rules_eu_procurement_thresholds_.asp

Court review of procurement procedures – remedies

3.7 Legal action may be taken challenging a contract award by a service provider who believes that (a) there has been a breach of the procurement rules, and (b) it has suffered or will suffer loss as a result. If the challenge is successful, the court may (under the current law) only grant an injunction suspending the award of the contract if the contract has not yet been entered into with the successful bidder. If an injunction cannot be granted, the challenger may claim damages for the loss that it has suffered. These may be based on wasted bid costs or possibly on a proportion of the profits of the contract, where the challenger can show a sufficient degree of probability that it would have won the contract had the rules been applied correctly. When the new Remedies Directive (see paragraph 3.9) is implemented in the UK, the courts will have power in certain circumstances to grant injunctions and overturn contracts even after they have been entered into.

3.8 In addition, an aggrieved tenderer may also bring a claim based on breach of an implied contractual term, where a contracting authority has failed to abide by the tender processes it has published to tenderers or where it has not acted in good faith.

3.9 The Commission has consulted on a Remedies Directive,[10] which is likely to be implemented in the UK within the next 18 months or so. The amended Directive is mainly aimed at Part A services but has implications for Part B services where it would be good practice to adopt the amendments to ensure good governance.

3.10 The Directive details the requirement for a 'standstill period' before concluding a public contract to 'give the tenderers concerned sufficient time to examine the contract award decision and to assess whether it is appropriate to initiate a review procedure'. The Remedies Directive states that the standstill period does not have to apply to Part B services; however it does stipulate that, as a minimum, if a standstill period is not implemented, an effective review procedure must be in place. This would include Part B services and contracts awarded by mini-competition under a multi-supplier framework.

3.11 The main implications are that contracting authorities should ensure that the procurement decisions are documented in a way that can be audited and justified.

Commission enforcement proceedings

3.12 The Commission has the power to bring enforcement action before the European courts against member states that have infringed procurement law and it has indicated that it will only open proceedings in relation to contracts awarded in violation of EU principles of transparency, equality or non-discrimination where this appears appropriate in light of the gravity of the infringement and its cross-border impact.

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10 http://ec.europa.eu/internal_market/publicprocurement/remedies/remedies_en.htm

4 NHS principles and practice

4.1 The following sections cover a simple aid to formulation of a procurement strategy (which, with the EU criteria above, will support the decision whether to procure formally), and a guide to the actions and behaviours that support both the EU procurement principles and NHS PRCC. Finally, there are sections on standard contracts, how to ensure AWP mechanisms stay within the rules, and issues related to the award of PBC contracts.

4.2 Each PCT must ensure that it understands its duties and obligations; the extent to which it is accountable; and the potential risks to the PCT and to the Secretary of State. Standing Financial Instructions must be adhered to in all procurement and contract procedural rules. If in doubt, legal advice should be sought. The Office of Government Commerce (OGC) Gateway review process[11] should be used to provide assurance to contracting authorities that the procurement is conducted in accordance with best practice. Use of the Gateway process is mandatory for high risk and optional for low or medium risk procurements as defined by the OGC risk potential assessment.

Procurement strategy

4.3 PCTs should agree with their boards a procurement strategy for large tenders, including novel, contentious or repercussive tenders. Consideration should also be given to tendering jointly with other PCTs if possible, to utilise the market effectively.

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11 www.dh.gov.uk/gatewayreviews

The following table provides some considerations when developing a procurement strategy – this is neither prescriptive or exhaustive.

Table 3: Considerations

Assess relevant markets	
What is the need?	Are new services required either in terms of new treatments or additional and discrete new provision?
Market structure	Assess local, regional and national markets in terms of where services are provided along current or desired patient pathways (vertical market structure). Assess the number of local and regional provider organisations and understand current market structure (horizontal market structure).
Competition	Assess behaviours that demonstrate competitive tension and responsiveness to patients and commissioner needs. Is there a case for introducing (more) competition to address choice, quality, efficiency or responsiveness?
Capacity	Is there sufficient capacity (facilities, diagnostics and treatment equipment, workforce etc) to provide required services?
Innovation	Assess developments in the market in other regions and international benchmarks.
Interest	Assess market interest in opportunities, transparently and without discrimination, including whether a contract may be of interest to a provider from a member state.
Evaluate existing contracts	
Performance	Analyse current provider's performance – are they meeting expectations and seeking quality improvements? Will a re-tender/new tender have a positive impact on the end user?
Efficiency	Are services being delivered efficiently? Is productivity in line with services delivered elsewhere including internationally?
Demand	Is demand being managed effectively?
Fitness	Are current contracts fit for purpose in light of future need and requirements?

Evaluate procurement options (especially in relation to market structure)	
Outcomes	Review outcomes from previous procurements, particularly for similar services and with regards to the size/structure/number of contracts and contract lots.
Attractiveness	Based on the market assessment and proposed risk-sharing arrangements, determine the scale and attractiveness of the opportunity to providers (existing providers, existing or potential market).
'Lots'	Assess whether the needs of the population would be best served by single or multiple contracts (lots), and approaches to achieving seamless pathways of care.
Multi-source	The multi-sourcing approach offers a number of potential benefits including: • providing scope for continuing to exert a degree of competitive pressure between providers; • access to a wider range of resources and approaches than might otherwise be possible, and to pilot or run with different approaches in parallel; and • continuous improvement.
Single-source	The potential benefits of a single provider approach include: • flexibility in bringing about business change; • potential for servicing the entire requirement at a lower total cost than with multiple providers, through economies of scale; and • reduced contract management overheads.
Evaluate procurement routes	
Advice	Seek legal advice or contact NHS Purchasing and Supply Agency (PASA) for help on the procurement routes.
Mirror Part A	The procurement routes to consider include those used for Part A services: open procedure; restricted procedure; competitive dialogue (where justified). Negotiated procedure should only be used in very exceptional circumstances.
Other	Determine other routes that are proportionate for the scale, complexity and risk associated with the services to be purchased and the market to be managed.

Procurement principles and practice

Transparency

4.4 It is for a contracting authority to decide the most appropriate media in which to advertise contracts. 'Passive' publicity, where a contracting entity simply responds to unsolicited requests from applicants who found out themselves about the

intended award, is not considered adequate. The EU Commission suggests that adequate means of publication include: the internet, national official journals or journals specialising in public procurement announcements, newspapers, or specialist publications, and publication in OJEU, particularly for larger contracts. It is recommended that an appropriate qualification is included in any OJEU contract notice stating that the notice is voluntary and non-mandatory (on the basis of it being a Part B contract) and that the contracting authority will not be bound by the full force of the regulations (OJEU is not compulsory and is one of many routes).

4.5 It is fundamental that adverts are used to ensure competitive procurements. Therefore, the DH is establishing a procurement portal, as outlined in the PRCC. PCTs will be required to advertise their tender and contract award on this portal, for all Part B services. The procurement portal will complement any other adverts PCTs may wish to place, and will maintain PCTs' ability to decide their own procurement route.

4.6 PCTs must gain the consent of their boards and inform SHAs where they decide not to tender a contract for new or significantly changed services (see Table 1). These decisions should be made public via minutes of board meetings. Any breaches of the PRCC may be subject to Cooperation and Competition Panel referral (see paragraph 1.3).

4.7 PCTs must assure themselves that bidders declare any and all potential conflicts of interest (e.g., see standard NHS acute contract clause 53). In some circumstances, a bidder's involvement in previous or parallel projects, its participation in multiple bids, or its participation in the PCT's activities (e.g. as a provider of commissioning or consultancy services) may give rise to a conflict of interest in bidding for certain contracts. The use of contractual mechanisms may be sufficient to mitigate such conflicts of interest. In other cases, it may be appropriate to exclude the bidder from the tender process to ensure equality of treatment between bidders. The bid documentation should clearly state the PCT's policy on managing conflict issues. Legal advice should be sought prior to any decision to exclude bidders on conflict of interest grounds. This decision could be challenged if the bidder can show they were excluded on grounds that are not consistent with the selection criteria.

4.8 The PRCC states: 'All referring clinicians (such as general practitioners and hospital consultants) must tell their patients about any financial or commercial interest in (or are employed by) an organisation to which they plan to refer a patient for treatment or investigation. When treating NHS patients they must also tell the commissioner (GMC Good Medical Practice 2006, paras. 74 –76). This interest must also be declared on NHS Choices.'

4.9 It is good practice to provide feedback to unsuccessful bidders and to allow a standstill period between notifying the contract award decision and executing the contract.

Proportionality

4.10 The procurement process should be proportionate to the value, complexity and risk of the services contracted. When making the decision about how to procure and what degree of advertising is required, the contracting authority should consider the factors outlined in Tables 1 and 3.

4.11 Specifically, the procurement route and pre-qualification criteria will be informed by the services to be purchased. It is for PCTs to decide or define the procurement routes, including any streamlined processes for low value/local services. Best practice guidance is available on the OGC website.[12]

4.12 When designing the procurement process and qualification and evaluation criteria, PCTs should ensure that they are not disproportionately demanding, as this would discriminate against small organisations such as social enterprises and smaller third sector organisations.[13]

4.13 When designing and delivering procurements, PCTs should have regard for the bidding costs providers incur, in particular with reference to wasted costs due to significant delays or material scope changes.

Non-discrimination

4.14 The subject matter and the scope of the contract should be described in tender documents in a non-discriminatory fashion. In particular, care should be taken to use generic or descriptive terms, rather than the trade names of particular products or processes or their manufacturers or suppliers.

4.15 All participants should be told the applicable rules in advance and the PCT must ensure that the rules apply to all providers equally. Timescales for providers to respond to adverts, pre-qualification checks and tenders must be non-discriminatory and reasonable.

4.16 Shortlist criteria must not be discriminatory nor particularly favour one potential provider because of the way the statement of requirement has been developed. The efficacy of the PRCC would be seriously undermined if the PCT were free to reject offers or service providers on arbitrary grounds.

Equality of treatment

4.17 No sector of the provider market (public, private, third sector/social enterprise) should be given any unfair advantage during the procurement process. Procurement practices have a major role to play in ensuring a fair playing field in public service markets.

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12 www.ogc.gov.uk/Resource_Toolkit_procurement_resources.asp

13 See www.thecompact.org.uk/shared_asp_files/GFSR.asp?NodeID=100322 for specific information

4.18 The basic financial and quality assurance checks (financial viability, economic standing, clinical capacity, capability/governance, affordability and value for money) should apply equally to all types of providers. There should be no preferential treatment awarded to a provider purely based on the status in law of the entity. Reference to the appropriate regulatory licensing and inspection regimes is essential.

4.19 All providers must operate under the same set of rules when being asked to respond to any tender specification. No provider should be given a longer time to respond or the opportunity to view proposals of other tenderers before it submits its final bid.

4.20 Pricing and payment regimes must be transparent and fair (see the 'Principles and Rules').

4.21 PCTs should retain an auditable documentation trail around the key decisions, which provides clear accountability and could be subject to review. SHAs will utilise this as part of their performance management toolkit for PCTs.

Any willing provider (AWP)

4.22 The PRCC state the following for routine elective care: 'Under Free Choice the opportunity for "any willing provider" to supply services should not be constrained by the commissioner other than in exceptional circumstances, e.g. concern about aspects of clinical quality. Any restriction must be agreed with the SHA.' As choice is rolled out in other areas, e.g. long-term conditions, PCTs can, if they wish, create local AWP policies, consistent with national policy and regional market management.

4.23 The AWP process for award of contracts can either be open or managed. In an **open process** (such as under Free Choice), PCTs are willing to accept proposals from providers at any time. If the provider meets:

- minimum standards of clinical care;
- the price the NHS will pay; and
- the regulatory standards for IS providers registered with the Healthcare Commission and from April 2010 the registration requirements that will apply to all providers under the Health and Social Care Bill,

then a contract will be awarded to that provider.

4.24 This is likely to be a standard NHS contract (see paragraph 4.26 below). PCTs may decide to review or 'refresh' these arrangements on a periodic basis. In a **managed process**, PCTs award contracts at discrete moments in time for particular purposes; this may result in contracts not being awarded to providers even though they meet minimum standards. This managed process is essentially run as a simplified procurement and may be appropriate to address local issues such as demand for specialist services or to deal with performance issues.

4.25 For the avoidance of doubt, when awarding contracts under AWP, PCTs should do the following.

Table 4: Considerations for AWP

Any willing provider	
Transparency	• Signal intentions transparently to the market • Advertise open and managed processes in the Procurement Portal
Assurance, objectivity, proportionality	• Carry out the same financial and quality assurance checks • In a managed process, objectively set/assess qualification and evaluation criteria proportional to size, complexity and risk of the services procured
Competition, non-discrimination	• Ensure that their actions do not distort competition in the market • Avoid favouring incumbents or types of providers • Negotiate local quality and risk arrangements fairly
Contracts	• Use the most relevant standard NHS contract, or include standard provisions
Conflicts	• Ensure conflicts are declared and managed appropriately
Local policies	• Seek approval of locally generated AWP policies by PCTs from their SHA

Standard NHS contracts

4.26 DH is publishing standard NHS contracts, beginning with acute services.[14] Once introduced, they are mandated for use by PCTs when purchasing services from any type of provider.

4.27 This is to ensure non-discrimination and equality of treatment among providers, as well as ensuring that NHS patient care is underpinned by the same quality, governance and risk management mechanisms, irrespective of location or provider type. Currently, it is envisaged that, effective from 2009, standard contracts will be developed to cover: mental health services; ambulance services; community services; GP-led health centres; and PBC provision.

4.28 In addition, DH is defining a number of standard clauses that will be mandated in all other (non-standard) contracts. When these clauses are published, PCTs will be required to carry out variation procedures at the earliest possible time, and ensure that all new contracts contain the same standard provisions.

14 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081100

Sub-contracts

4.29 PCTs should understand that accountability remains with their boards for the delivery of services to their population under any contractual relationship; the need, if any, to carry out due diligence on major sub-contractors; and the procurement and contractual mechanisms at their disposal to do so.

4.30 When deciding whether to award a contract to a master vendor/prime contractor or to multiple contractors directly, PCTs should consider the potential lack of transparency, and therefore of lack of visibility of actual risks, that this may entail.

Practice based commissioning (PBC)

4.31 The PRCC state: 'PCTs are the only contracting authority for NHS direct patient care.[15] Practice-based commissioners must operate through PCT-let contracts', and 'Commissioners must comply with the PBC accountability framework and tender where a PBC proposal would result in a major services change or the creation of a monopoly'.

4.32 PCTs must have regard for 'Practice based commissioning: Practical Implementation' DH guidance (November 2006), and in particular, 'the criteria for assessing business cases will include consideration of whether formal tendering is required, which it is envisaged will be infrequent'. Consideration should be given, by PCTs using transparent decision-making processes, in particular to the potential conflicts of interest for GPs in providing and commissioning care.

15 An exception to this rule is specialist mental health services where the PCT may choose to delegate responsibility to another NHS body

Annex A – EU Procurement Directive

Public procurement law

1. As a member of the European Union (EU) and a signatory to World Trade Organization (WTO) agreements, the UK is governed by the following legislation as far as public procurement is concerned. The current legislation that forms the basis of mandatory procedures to be adopted for procurement in the public sector in the UK includes:
   - the Treaty of Rome ('the EU Treaty');
   - the Government Procurement Agreement (GPA);
   - Directive 2004/18/EC of the European Parliament and of the Council of Europe 31 March 2004 ('the EU Directive');
   - the Public Contracts Regulations 2006 ('the regulations');
   - Council Directive 89/665/EEC relating to review procedures in the event of infringement of the Public Procurement Directives (the 'Remedies Directive'); and
   - relevant case law of the European Court of Justice.

2. Copies of these documents and other published guidance are available online at www.ogc.gov.uk or http://europa.eu. Details of Department of Health and NHS Purchasing and Supply Agency (PASA) procurement activities are available from www.pasa.nhs.uk and www.dh.gov.uk/en/Procurementandproposals/index.htm. Other key resources are available at:
   - www.ogc.gov.uk/procurement_policy_and_practice_procurement_policy_and_application_of_eu_rules.asp, where you can find a copy of the regulations and Office of Government Commerce (OGC) guidance;
   - www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_072604, which is extant Department of Health guidance on its *Commissioning Framework*, and has a section on contracting; and
   - www.ogc.gov.uk/documents/ProcurementPolicyThresholdProcurement.pdf which contains a link to the OGC's Procurement Policy Notice 03/06. This outlines the Commission's latest position on the law relating to Part B services.

EU Procurement Directive 2004/18/EC

3. The EU Directive has been transposed in the UK by the Regulations (SI 2006/5). The EU Directive and the Regulations implement the general EU principles of non-discrimination, transparency and equality which are applicable to EU member states. The EU procurement rules may be enforced either by the European Commission or directly in the courts by persons, such as unsuccessful bidders, who have been harmed by a breach of the rules.

4. It is the aim of the EU member states to create a single European market devoid of all trading restrictions and barriers in which all businesses have an equal opportunity to compete. The EU regulates and monitors public sector procurement primarily through the EU Directive covering the supply of goods, services and works.

5. In the UK, the Directives apply to all NHS contracting authorities. These legal rules also assure taxpayers and service users that the public purse is being used in a way that seeks best value for money for the contracted services, and guide officers in such matters.

Applicability of public procurement rules

6. The EU Directive (implemented by the UK's 2006 Regulations) has two levels of application – a full regime for services designated as Part A services where the value of the Part A contract (or contracts where the aggregation rules apply) exceeds the relevant thresholds, and a lighter regime for other services designated as Part B services.[16] This categorisation of service types reflects the fact that certain services are regarded by the EU institutions as higher priority for the operation of the EU internal market.

7. Part A services, the fully regulated category, include services such as telecommunications services, financial services, IT services, construction services and consultancy services. Part B services, the partially regulated category, include legal services, educational services and health and social services. Clinical services are, therefore, usually assessed by contracting authorities as Part B services. However, all commissioners should take legal advice as necessary, based on specific circumstances, to determine the correct categorisation.

8. If services are determined to be Part B and the contract value is beneath the level set, then procurement is not obligatory. Contracting authorities should be aware that if the contract value subsequently exceeds the threshold then the Part B requirements will apply. Parties should be certain that the contract will not exceed the threshold before disregarding Part B requirements. If the services are not Part B they will be Part A where the threshold is lower.

9. The fact that Part B services are not subject to a full regime does not automatically mean that they should not be subject to competitive tenders. Competition is the main mechanism by which contracting authorities ensure that the EU principles of equality of treatment, transparency and non-discrimination are met. These principles are considered by the Commission to apply to tenders for both Part A and Part B services.

10. If a contracting authority decides to mirror a Part A procedure, it should clarify that it is not bound by the full force of the regulations by dint of the proposed contract being a Part B classification.

16 Part B services have a current threshold of £139,893 which is subject to change, and should be verified on the OGC website. This refers to total contract value (www.ogc.gov.uk/procurement_policy_and_application_of_eu_rules_eu_procurement_thresholds_.asp)

Interpretation of EU procurement law

11. The Commission issued an interpretative communication on 24 July 2006[17] outlining its views on how the EU general principles of transparency, non-discrimination and equality should apply to:

    - procurements of Part B services, such as health services (which are only partially covered by the procurement regulations); and
    - procurements of contracts falling below the relevant thresholds (to which the procurement regulations do not otherwise apply).

12. This guidance does not create new law; rather it clarifies the Commission's understanding of existing European case law and suggests best practice for contracting authorities to follow when advertising and awarding Part B contracts. While the Commission considers that applying its view of best practice would comply with the general principles of EU law, it notes that compliance may also be achieved by other means.

17 http://ec.europa.eu/internal_market/publicprocurement/key-docs_en.htm

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