



Public Health  
England



Department  
of Health



# HIV, sexual and reproductive health: current issues bulletin

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## **Bulletin 4: Tendering sexual health services**

**Date:** May 2014

This bulletin has been developed by Public Health England with input and support from the Department of Health, the Local Government Association, the Association of Directors of Public Health, NHS England and the English HIV and Sexual Health Commissioners Group. Recommendations and questions for future issues of the bulletin can be submitted to [sexualhealthenquiries@phe.gov.uk](mailto:sexualhealthenquiries@phe.gov.uk).

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## **Purpose of this bulletin**

The Department of Health (DH) has issued a range of guidance and other supporting documentation over the last year to support commissioning of sexual and reproductive health and HIV services following transition. However, there is a recognition that situations continue to arise where further clarity about how to operate under the new arrangements is required. This bulletin is intended to address these issues in a timely manner.

This is the fourth bulletin. The series will focus on 'live' issues and will provide further suggestions for solutions that can be used at local levels.

The bulletin is intended to address queries from all those responsible for commissioning sexual health and HIV services (that is, contraception and reproductive health services, GUM services, HIV testing or treatment services and abortion services), whether they are local authorities (LAs), NHS England and Clinical Commissioning Groups (CCGs). The bulletin is also intended to provide information for provider bodies. Public Health England (PHE) will work with DH, NHS England, the Local Government Association (LGA), the Association of Directors of Public Health (ADPH) and the English HIV and Sexual Health Commissioners Group to provide timely responses.

This bulletin will not be a source of new formal guidance, but will help with the interpretation of existing policy and guidance. Where issues are raised that require a policy response they will be raised with the DH policy team.

### Focus on: Tendering sexual health services

*This edition of the bulletin is primarily aimed at local authority commissioners. It may also provide useful information for providers considering responding to local authority tenders. For commissioners in NHS England and CCGs the bulletin provides valuable information on the links to be made around joining up services on the ground and working collaboratively with local authority commissioners to ensure seamless services for patients. However, NHS commissioners should refer to guidance around procurement and contracting issued by NHS England and Monitor, in particular regarding use of the [NHS Standard Contract](#) and [procurement, choice and competition](#), as well as to the [NHS \(Procurement, Patient Choice and Competition\) \(No2\) Regulations 2013](#).*

### Introduction

Tendering and procurement of services is one part of the commissioning cycle. It is clearly a very important part of that cycle as it determines which organisation is going to be providing what to whom, where and when for a period of time. However, it must not be seen in isolation. The work needed to understand the local need and what configuration of services might best meet that need is a crucial stage in the commissioning cycle, and should not be neglected when undertaking a tendering process.

Likewise, monitoring the performance of a provider against agreed indicators during the lifetime of the contract is essential to ensure that the provider is delivering what was asked for in the tender process and that it meets population needs. Needs and priorities will change overtime, so the part of the commissioning cycle that allows for monitoring and evaluation, feeding into a further assessment of need also needs to be given sufficient time and attention.

Re-tendering a service should not be used in place of performance management of a provider. Commissioners should address any concerns about performance through performance management and other contractual mechanisms.

Tendering is not an end in itself, but a means by which public bodies discharge their duties by helping to drive up quality and innovation, implement changes to models of care, increase efficiencies and obtain value for money.

All public bodies are subject to European Union (EU) procurement law. In many circumstances public bodies will want to take a market testing approach to assure themselves that they are commissioning the service that provides the best value for money given the limited resources available. CCGs and NHS England (but not Local Authorities) are also subject to the NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 ("the 2013 Regulations") when commissioning health care services for the purposes of the NHS. Those commissioners should be fully aware of their obligations under the 2013 Regulations, including in particular the procurement objective in regulation 2 and the general requirements in regulation 3.

NHS England commissions specialised services, including HIV services, to national service specifications using the NHS Standard Contract. Local authorities will wish to liaise with specialised services commissioners within NHS England to ensure that their commissioning and procurement plans for sexual health services are appropriately aligned, and vice versa. In some circumstances a commissioning body may take the decision to redesign services with current providers, but that would be subject to legal requirements as outlined below.

### EU procurement law

***Please note that this section sets out the current position with regards to EU procurement law. Procurement regulations will change significantly later this year. These changes are outlined in the box at the end of this section. Commissioners will need to familiarise themselves with the new regulations later this year.***

The legislation which requires local authorities to arrange for the provision of confidential, open access sexual health services does not set out or limit the way in which local authorities can go about commissioning these services. Local authorities do however need to follow any general legislation on procuring public sector services which may apply to commissioning and procuring sexual health services.

Local authorities are required to comply with the Public Contracts Regulations 2006. Schedule 3 of these Regulations designate public services either as Part A or Part B, and different procurement procedures apply to each. If a contract falls below a certain threshold of value (£172,514 from January 2014), then the procurement is largely exempt from the regulations, although the European Treaty principles (see below) still apply to even sub-threshold procurements. A contract cannot be split into a number of smaller parts each of which does not exceed the threshold.

Authorities must usually conduct tenders for Part A services and advertise the requirement in the Official Journal of the European Union (OJEU). Tenders must be conducted and contracts awarded in accordance with the systems set out in the regulations.

The Regulations state that health services fall within Part B services. Procurement of part B services does not have to follow the detailed process which apply to Part A. Part B services must, however, comply with certain parts of the Public Contracts Regulations, most importantly the requirement to comply with the European treaty principles of equality, non-discrimination and transparency (CCGs and NHS England are also subject to the similar general requirements of transparency and equal treatment in regulation 3 of the 2013 Regulations). Only under very limited circumstances can authorities comply with these principles without appropriate advertising of the requirement and intending to seek bids from all suitable providers who express an interest in providing that requirement. The subsequent tender process must also comply with the EU treaty principles.

While the Public Contract Regulations do not prescribe a specific process some European and domestic case law has developed which clarifies the application of the treaty principles. Commissioners may wish to use the more prescriptive Part A process or parts of it, but there is no requirement for them to do so as long as they are sufficiently transparent. The Public Contract Regulations impose a number of other requirements on commissioners procuring Part B services. This includes an obligation to publish a contract award notice in the OJEU within 48 days of contracts being signed.

Section 135 of the Local Government Act 1972 requires each local authority to make standing orders covering its contracting and procurement procedures. These must include provision for securing competition in the awards of contracts, as well as the exemptions that are allowed to normal procurement processes.

**Local authorities will therefore need to adhere to their own standing orders when considering procurement of sexual health services. While each local authority has its own standing orders for procurement which may cover circumstances which are specific to the local authority in question, all standing orders will set out the need to comply with the law and to secure best value.**

This is a general overview of procurement procedures, but all commissioners should seek their own advice, including procurement and legal advice, to ensure that any individual procurement exercise they undertake is compliant with applicable laws and regulations. Further useful information can be found on the EU's website on [procurement](#).

### **Forthcoming changes to EU procurement rules**

Changes to the EU procurement rules will take effect from October this year. These changes will include abolishing the distinction between Part A and Part B services. Instead of the Part A and Part B distinction, there will be a move to a 'light touch' regime for social services, including health related services, with a higher threshold (likely to be 500,000 Euros, around £415,000) before the full provisions of the procurement rules apply. It is recommended that commissioners fully familiarise themselves with these changes before they come into force, as they will apply to all new procurement exercises undertaken after new regulations come into force later this year.

To support the implementation of these changes the Cabinet Office is developing training which will be rolled out in May. The LGA are supporting this training and are developing 'train the trainers' events.

For more information on these changes and the training please visit:

<https://www.gov.uk/transposing-eu-procurement-directives>

### General approach to tendering

General principles such as transparency, non-discrimination and fairness apply to the tendering process. Authorities must be objective and treat all tenderers equally to ensure that all providers are given a fair and equal chance of winning the contract. Below are some general factors that authorities need to take into account before embarking on a tendering process:

- the specification used in the tender process must be informed by a local assessment of need. The Department of Health have published [a template service specification](#) for local authority commissioned sexual health service which includes references to current service standards. The NHS England service specification for HIV treatment and care service can be found [here](#)
- it is important to allow sufficient time for retendering. Whilst the formal procurement stage may only take a specified number of weeks or months if everything runs on time and according to plan; the work involved in getting the specification right prior to beginning the formal procurement process, and the time required post contract award to mobilise the service can mean that the entire process can take well over a year, if not significantly longer. See Appendix A for an example procurement timeline. Commissioners should provide adequate staffing and resources to procurements not only during the formal procurement, but also before (to ensure the specification and requirement is right) and after (to manage provider performance)
- commissioners will be aware of the corporate processes they need to follow within their own organisation, for example, contract award may need to go to local authority cabinet for ratification. You must build in the timescales for these corporate processes into any procurement project plan / timetable. Where more than one local authority is involved in a tender process the separate procedures for each authority will need to be followed
- commissioners should not under-estimate the need to have enough time to get the service specification right for the local circumstances. The detail of the specification is best informed by a process of needs assessment, public consultation and clinical engagement. As these will be localised services, consideration of local (not standard) requirements is key. It goes to the heart of the recent changes to commissioning that local commissioners are best placed to decide the needs of the local population. Tender specifications should reflect this
- getting the service specification right includes ensuring that quality measures incentivise the provider. Be careful to avoid measures that create perverse incentives. For example, simply requiring an increase in attendances could result in a high level of repeat attendances whilst not improving access to the service; or increases in attendances from those living close to the clinic, but very low attendance from other areas that the service is intended to provide for.

An annual equity audit is a good way of assessing how effective the service is at meeting the needs of the local population. Any measures included need to be ones for which data can be collected but should not place an undue burden on the provider. Any undue burden on the provider is ultimately likely to be reflected by paying the provider a higher price for that service

- evaluation criteria and proper weighting to those criteria is crucial for choosing the right provider who will deliver the best value for money as this will determine which bidder is successful. As with the service specification, commissioners should spend the time to get the evaluation criteria right and ensure they focus on the right aspects of the service. Think carefully about what aspects of price and quality you want to focus on. What are the most important things the provider simply must deliver on? Which aspects of the requirement are “nice to have” but not absolutely essential for the service? What will the balance in weighting between price and quality be? Commissioners need to communicate all of this evaluation and weighting information clearly and transparently in any procurement documentation
- unsuccessful bidders may want feedback about why they were not selected, so ensure that criteria are clear and unambiguous and that you record in detail how bidders have or have not met the criteria. If commissioners have recorded fairly and transparently how bidders have performed and can supply some of this information to unsuccessful bidders upon request. This should lower the risk of any legal challenge at the outcome of your procurement
- commissioners may want to consider the use of open days / information events for potential providers to ensure that they have a good understanding of the local need, what the vision is for the service, and to allow potential bidders to ask questions. As the purpose of tendering a service is to get the best value for money service for the local population, any approach that increases potential bidders’ understanding of the local need and what services are needed should increase the quality of the bids. Time spent early on in the process can save time further down the line. For example a very clear requirement and specification will reduce the need to clarify unclear points with bidders later on, which could delay the procurement
- commissioners may want to consider the use of patient/public representatives on evaluation panels, in line with their own organisational policy. This is particularly important when commissioning services for young people to help ensure the service is ‘young people friendly’. As with any member of the evaluation panel who is bringing particular expertise, the commissioner will need to be clear whether the patient/public representative is a full panel member, or being asked to comment on/score particular elements of the bids

- expert advice may well be required on key aspects of the specification, evaluation criteria and evaluation process. For example, premises/estates, clinical, microbiology, information governance, IT. To enable commissioners to involve appropriate clinical expertise and avoid any potential conflicts of interest, the British Association for Sexual Health and HIV and the Faculty of Sexual and Reproductive Health have compiled a list of their members who would be willing to offer local authorities expert clinical input into sexual health contracting processes. However, local authorities should note that they will most probably need to pay a charge for using these services, as the clinicians concerned will need to arrange cover for any time they spend on external contracting.

Any local authority wishing to make use of this facility should contact: British Association for Sexual Health and HIV, Secretariat: [admin@bashh.org](mailto:admin@bashh.org); Faculty of Sexual and Reproductive Health, Administration Office: [mail@fsrh.org](mailto:mail@fsrh.org) Commissioners will need to be mindful of how this process is managed, and ensure it is transparent both with regards to the specification and the procurement process, in order to avoid challenge

- retendering services will take time and resource for both commissioners and current and potential service providers. You must take this into account in the planning process and spend time at the start identifying exactly what is needed. Due to the time and resource involved in redesigning service provision, the length of contract being awarded should be commensurate with the complexity of the service being tendered. A service requiring significant redesign is unlikely to be attractive to potential providers if the contract length is unduly short
- it is absolutely essential that the commissioner considers the inter-relationships of the services they commission with services commissioned by other bodies and plan in detail with other commissioners how to deal with these inter-relationships going forward. This is particularly pertinent when a local authority is re-commissioning a level 3 GUM service that may well also provide HIV treatment and care services (often by the same clinician); or where NHS England is working on reconfiguration of HIV treatment and care services which are delivered by the same provider that delivers level 3 GUM services
- tenders will also need to take account of linkages to local abortion services. The Department of Health is exploring with relevant partners an update of its standard service specification for abortion services. In the meantime commissioners are encouraged to review the contract and specification in use locally
- commissioners also need to work with the Local Education and Training Board (LETB) with regards to training provision (see below for more detail). These situations are likely to be complex, and no one solution or approach will be applicable across the board

- **given the complexity of the inter-relationships, it is essential that the conversations on how to address any potential implications start early on in the tendering process. This may well involve some detailed service mapping to understand the inter-relationships in sufficient detail to inform solutions. It is best practice for tendering bodies to notify one another formally of any intentions to retender or reconfigure services, and then agree between themselves how best to proceed. Use of section 75 agreements to support collaborative commissioning is an option that local areas may wish to consider in these circumstances**

### **Important elements to consider when re-tendering**

As the market develops, it is increasingly important to specify all the factors that bidders must address in their tender; included within the financial envelope; or taken into consideration as part of the service mobilisation. Commissioners should detail the key aspects of the services needed so that bidders explicitly understand the service required. This will avoid problems later in the process.

The list below includes some of the key aspects we are aware of and questions to think about. However, this should not be taken as an exhaustive list.

- premises – Where do you want the service to be located? Do you want to specify the general location or the specific building? Who owns the building the current service uses? Will it still be available going forward? If so, on what terms? How long a lease do you want the provider to take out, or is that at their risk? Does the financial envelope include premise costs? Do you need tenders to include provisional guarantees of premises? Do you need bidders to detail how they will secure premises?
- assets – Who owns the assets and is responsible for maintenance and insurance cover, if required, (such as examination couches, medical equipment, photocopiers, furniture, IT systems and phones) that the current provider uses? Will the assets be available when the new contract is let? If so, on what terms? If the service model has changed, are the current IT systems fit for purpose? The Public Health Services [template contract](#) may be helpful in this circumstance. It states that ‘The Provider must provide and maintain at its own cost (unless otherwise agreed in writing) all Equipment necessary for the supply of the Services in accordance with any required Consents and must ensure that all Equipment is fit for the purpose of providing the applicable Services.’ Commissioners should check the terms of their existing contract

- medicines supply and pathology – Is it clear in the tender documentation as to whether the costs of these, and other similar services, are included in the financial envelope or not? Do you want assurance that bidders have arrangements in place for these services? Have you included quality indicators for pathology services? E.g. Turnaround times? Ability to provide CTAD data?
- patient records – You need to specify arrangements for the transfer of patient records as appropriate between previous and new providers. You must fully consider any data protection, information management or security issues associated with any such transfer. Have you considered how the new provider will access old notes, for example where a patient has recurrent infections, or complex contraceptive needs? If the SRH and HIV treatment and care service are provided by different providers will they have different patient management systems or will they share one? One area has found it useful for the system to be shared. For example, if an HIV positive woman attending for contraceptive provision does not declare they are HIV positive, this information may not be available if each part of the service has a different patient management system, whereas it would be available if the system were shared
- training and education – What arrangements do you want to include for the ongoing training of the medical and nursing workforce? This provision is the responsibility of the LETB (mentioned above) and as such the LETB need to be involved in partnership arrangements when commissioning, prior to the tender stage. Have you explicitly described in the tender documentation what you want this training to cover e.g. Diploma, Letters of Competence, STIF training? Who is eligible to receive this training? In order to maintain a pool of trained and experienced clinicians to undertake, for example, Long Acting Reversible Contraception (LARC) procedures, there is a need to continue to provide training for staff and trainees from a variety of settings and providers. By narrowing access to training too much, you may reduce the pool of qualified staff to undertake this work. Training and education provision will need to be costed, including any additional consultation time required when working with a trainee. Commissioners may wish to be explicit, or ask providers to be explicit, about whether trainees will be charged for training
- links to other services – Be as explicit and detailed as possible about how you expect relationships to work, or the information you want from bidders on how they see the relationships working. In particular, think about the links and pathways needed for those testing positive for HIV who therefore require treatment and care. Do you know what plans NHS England have for HIV treatment and care services locally and how that may impact on any care pathways? Are there specific arrangements in place, for example with termination providers, for young women to be referred for dedicated support to prevent repeat unintended pregnancies?

- TUPE refers to the Transfer of Undertakings (Protection of Employment) Regulations 2006, and is designed to protect employees' terms and conditions of employment when either a business or undertaking is transferred to a new employer

TUPE is a complex legal area and commissioners must take detailed legal or HR advice on any such issues. The obligations of the commissioner are limited as TUPE requires the transferor (incumbent provider) to supply 'employee liability information' to the transferee (i.e. new provider organisation). (There may be circumstances where the commissioner is outsourcing a service that it currently provides in which case the commissioning body will have obligations as the incumbent provider)

Contracts should allow the commissioner to request employee liability information in good time before the contract end date and contain a warranty from service providers as to the accuracy of any employee information they provide. The more information bidders have about the staff they may inherit, the better able they are to price their bids

- key performance indicators (KPIs) – Consider what mechanisms you can build into the contract to incentivise quality. For example, one area has developed an expected contract value for a three year contract for integrated sexual health services. This expected value is the result of a series of agreements based on a combination of basic price, inflation uplift, annual efficiencies and stability premiums

The commissioner has then subtracted 2 sums from the contract value which are retained. One is a payment for complying with the full 'minimum standard', and a further sum for achievement of specified quality improvement standards. As such quality incentivisation is captured in the overall pricing framework

- clinical governance – have you specified the requirements; if these are reliant on other local providers e.g. level 3, are you aware of what the plans are for these services? Will they still be able to provide clinical governance support? For further information on clinical governance refer to [Sexual health: clinical governance](#) document

### Useful links

Commissioners will use a variety of procurement portals to advertise tenders. NHS bodies use [Supply2Health](#). This website also provides resources for both commissioners and bidders in relation to procurement. Local authorities may use Supply2Health, [Tenders Electronic](#) and [Contracts Finders](#).

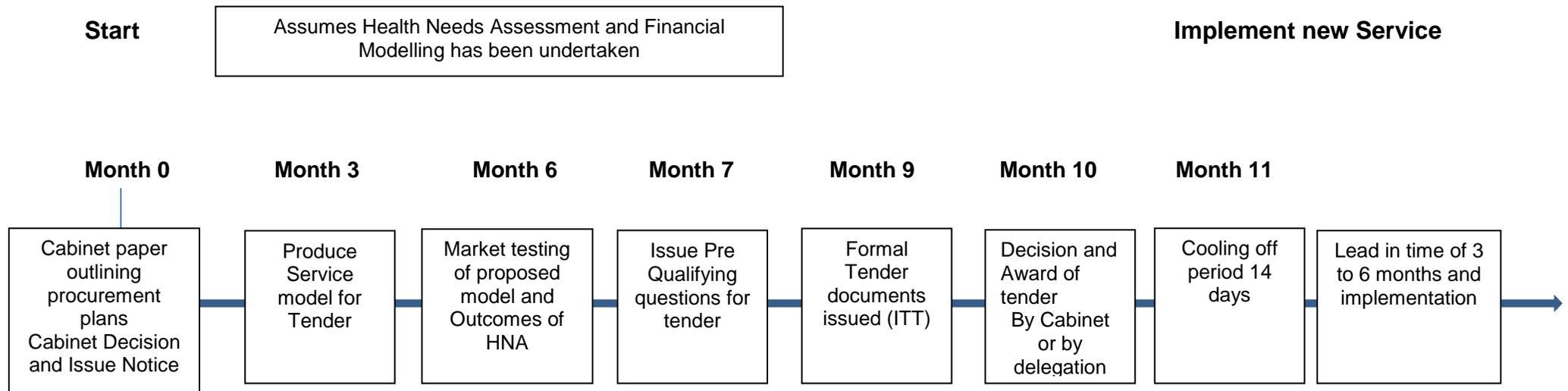
Useful LGA documents include the [LGA guide to Commissioning better public services](#) and [A councillor's guide to procurement](#). Examples from across local government from the [LGA productivity programme](#).

The [Commissioning Academy](#) brings together commissioners from different parts of the public sector to learn from the example of the most successful commissioning organisations. It will develop a cadre of professionals who are progressive in their outlook on how the public sector uses the resources available.

### **Future editions of the bulletin**

This bulletin is for you, and can only work if it is responding to the issues that are currently concerning you. Each monthly edition will therefore focus on a 'live' issue, or issues. These issues will be identified by assessing the questions raised on the commissioners' group forum; questions that have come direct to PHE, LGA or DH, and questions that have been raised through [our dedicated inbox](#).

## Appendix A: Example sexual health procurement timeline



**Work with Key Stakeholders to develop a service model, include independent clinical advice**

Notes: The above timeline is not based on any recognised best practice and individual authorities may follow different procurement timelines and approaches. It is an example to illustrate some of the key stages and the likely timescales for a full and complex procurement