COMMERCIAL MEDICINES UNIT

Best practice for the provision of nutrition supply services including feeds, pumps, consumables, home delivery and associated support services.

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Introduction

The National Enteral Feeds Advisory Group was convened in 2000 by the NHS Purchasing and Supply Agency to support its role in providing appropriate and effective guidance and strategic advice to the NHS in England on all matters relating to the purchasing and supply of enteral tube feeds, oral nutritional supplements (ONS) and associated products and services. The Group is facilitated and chaired by the Commercial Medicines Unit (formerly the Pharmaceutical Directorate of the NHS Purchasing and Supply Agency), Department of Health.

The British Specialist Nutrition Association (BSNA) Ltd is the trade association representing the manufacturers of products designed to meet the nutritional needs of individuals at different life stages or with specific health requirements. The UK Medical Nutrition Executive (MNE) is a specific member group of the BSNA. The member companies of the MNE are Abbott Nutrition, Fresenius Kabi, Mead Johnson Nutrition, Nestle Health Science, Nualtra and Nutricia Advanced Medical Nutrition.

This best practice document has been developed and approved by the National Enteral Feeds Advisory Group and is supported by the Medical Nutrition Executive.

Tendering for nutrition supply services can be considered a complex and significant undertaking, involving collaboration from a wide range and diversity of stakeholders. This document is intended to support procurement groups / clinicians throughout the process and aims to define and encourage best practice with regard to the procurement of nutrition supply services across the whole health economy. The document outlines the twelve key steps to be followed in order to drive forward a best practice agenda for successful procurement - Figure 1.

It is the intention that the document be followed / adhered to in its entirety. If procurement groups / clinicians choose only to use the sections / points that they feel will be of advantage to their particular tendering exercise, it must be realised that this approach may have serious ongoing financial consequences.

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The NHS in England currently has approximately 45,000 home patients being supported on enteral feeding. The feed market is worth approximately £353.5 million per annum – data produced by NHS Prescription Services 2015/16. An additional 10% of that value of feed products is supplied via the non FP10 route and these figures are therefore not captured by NHS Prescription Services.
The market is considered discrete and specialist with only a limited number of suppliers. Although all companies providing products and services in England have offices, distribution and storage in the UK, the majority of feeds are made in the EU, including some in the UK. Certain suppliers source a small volume of feed from China and the USA. It is therefore essential that supply chain issues are addressed in the tender documents to ensure contingency plans are appropriate for the volume of contracted business.

UK Suppliers (March 2017)

Company	Products and services provided
Abbott Laboratories Ltd www.abbottnutrition.co.uk	Adult and paediatric nutrition products (enteral feeds, oral nutritional supplements), enteral feeding pumps and consumables, home delivery and associated support services.
Fresenius Kabi Ltd www.fresenius-kabi.co.uk	
Nutricia Advanced Medical Nutrition * www.nutricia.co.uk	
Nestle Health Science www.nestlehealthscience.co.uk	Adult and paediatric oral nutritional supplements and specialist feeds
AYMES International Ltd www.aymes.com	Adult oral nutritional supplements
Nualtra Ltd www.nualtra.com Foodlink	
B Braun Medical Ltd www.bbraun.co.uk	
Nutricia Metabolics * www.nutricia.com/products	Adult and paediatric specialised feeds and products
Vitaflo www.vitaflo.co.uk	Adult and paediatric specialised nutrition products
SMA Nutrition www.smanutrition.co.uk	Specialised infant formulas
Mead Johnson www.meadjohnson.com	
Danone Nutricia Early Life Nutrition * www.eln.nutricia.co.uk	
Covidien www.covidien.com	Feeding pumps, consumables

N.B. * Companies within the Danone Group.

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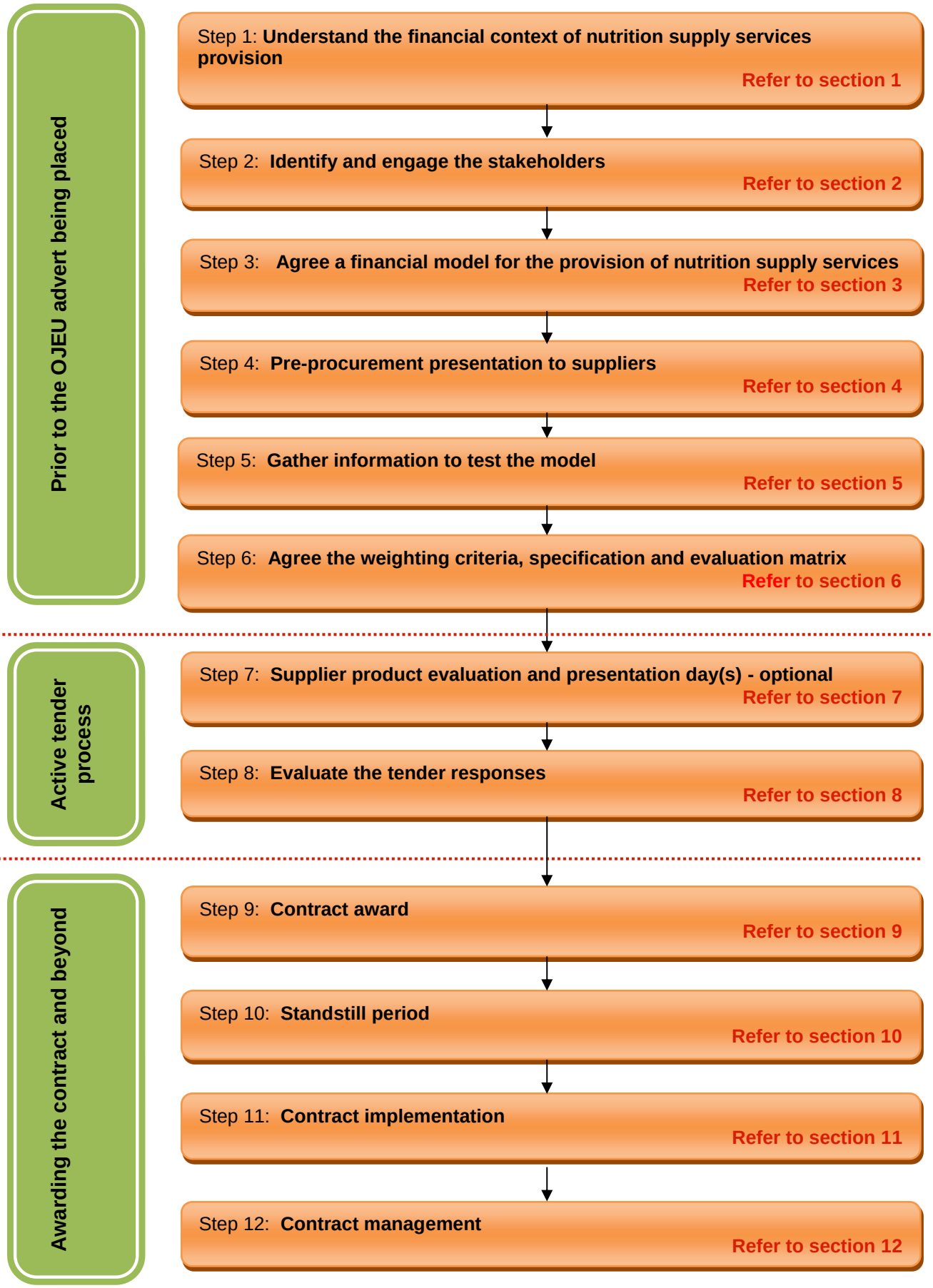
Figure 1: 12 Best practice steps for the successful procurement of nutrition supply services



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Section 1: Understand the financial context of nutrition supply services provision.

Golden Rules

- **Ensure that all relevant stakeholders fully understand the financial context of the contract that must be applied to the proposed tender exercise**
- **Agree and ensure a whole health economy approach**

1.1 The following products and services are covered by the contract:

- Secondary care: Feeds (which may include tube feeds, specialist feeds and oral nutritional supplements), enteral feeding pumps and associated consumables (e.g. plastics and possibly ancillaries).

- Primary care: Enteral feeding pumps, associated consumables (e.g. plastics and possibly ancillaries) home delivery and associated support services – as outlined in paragraph 1.2 below.

  Feeds (which may include tube feeds, specialist feeds and oral nutritional supplements) in primary care do not form part of the contract if prescribed via the FP10 route. The feed only becomes part of the contract if the tender requires the feed to be procured via the non FP10 route – see Section 3.

  Note: The inclusion, within the tender documents, of requests to procure the feed in primary care via the non FP10 route has been challenged on occasions. If offers for this route are requested and a challenge is received, Trusts are advised to seek their own legal advice.

  BSNA members may have differing views regarding the procurement of feed via the non FP10 route. Pre market engagement is therefore essential if considering this option.

1.2 The service requirements of the tender usually include:

- A homecare delivery service which delivers to patient's homes and alternative venues e.g. special schools, on a once or twice monthly basis
- Service for patients travelling away from home – UK and International
- Company patient co-ordinators to manage stock control
- Company nursing services
- Help lines for patients and health care professionals which may include cover outside normal office hours
- Ongoing staff and patient training
- Feeding pumps for secondary and primary care. Some home patients may request more than one pump
- Maintenance of feeding pumps according to manufacturer's recommendation
- Literature associated with the service provision
- Multi-lingual literature and support
- Electronic patient registration / ordering / reporting systems

Outside these requirements, requests are frequently made by provider services and commissioning organisations for additional services including:

- IT / monitoring systems

- Salaried posts including travel allowance and on-costs
- Funding for HCP education and sponsorship of training and development

Currently these service requirements are usually provided at no specified cost to provider services and commissioning organisations. However, participating organisations should be very aware that these services are not low cost for the suppliers to provide and therefore that cost must be recouped elsewhere i.e. through the FP10 cost of the products.

Requests for suppliers to fund NHS posts within a tender for nutritional supply services, whilst possibly temporarily relieving pressure on the Trust's staffing budget, leads to increases in the FP10 prices of the products and so ultimately to a greater cost for the NHS as a whole. A further consequence of such requests and the subsequent financial implications is resulting, in some instances, in one or possibly more companies deciding not to submit a bid for the tender.

Although the supplier is funding these posts, the NHS Trust is assuming employment related liabilities by employing these individuals. If the supplier's funding of the post were to terminate, the NHS Trust is left with these employment related liabilities for the duration of the individual's employment. If the NHS Trust no longer requires the post for whatever reason, the NHS may need to hold a redundancy process which could incur redundancy payments.

1.3 The financial value of the contract in the acute sector has become relatively small as, currently, feeds and plastics are supplied for a nominal amount. In the community, whilst plastics are also supplied for a nominal amount, the FP10 value of the feed has continued to grow. This complex procurement model has led to inequality in the distribution of cost across primary and secondary care. It is essential that the relevant stakeholders from all provider services and commissioning organisations are involved with the procurement process and have a clear understanding of the costs and benefits of the contract. A whole health economy approach must be considered.

1.4 It is also essential that all stakeholders are aware of the potential costs to the NHS (i.e. equipment, maintenance, deliveries, training and company staffing) that are included within the specification as these represent substantial investment by suppliers. A fair and transparent contract must be implemented to ensure one sector is not benefiting significantly more than another.

1.5 The main component of a nutrition supply services contract is the service specification. Historically, the service element of the contract and the 'loss leading' on the product has been financed by the value of the FP10 tube feed in primary care. However, due to increasing demands for and / or offers of higher service levels it is now increasingly necessary for the value of the oral nutritional supplements in primary care to subsidise these demands.

1.6 If a company is awarded the tube feed business in secondary care, the patient will usually be discharged on that feed, especially when the same company has been awarded the pumps and home delivery service. Once the patient is at home however, the duty of care passes from the Trust to the GP, the feed is prescribed via the FP10 route and, whilst the feed prescribed is usually the same product that was prescribed in the hospital, that feed is not part of the contract.

1.7 Patients who are discharged from hospital with a supply of oral nutritional supplements may request further supplies from their GP. Oral nutritional supplements prescribed on FP10 are not part of the contract and there is no commitment for the GP to prescribe the same product.

1.8 However, there has been an 'assumption' by the suppliers that there would be a 'follow through' of feed products into primary care and this 'assumption' may have been used to forecast the 'budget' when bidding for the contract. **This assumption cannot be made.** Contracts awarded for feed products to be used in secondary care cannot influence prescribing in primary care.

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1.9 Increasingly, commissioning organisations and provider services are looking to improve malnutrition management whilst realising cost savings or cost avoidance. This may mean managing the demand for ONS through appropriate prescribing policies – see Appendix 1. Participating organisations need to have a clear understanding of the tube feed and oral nutritional supplement usage and spend cross the locality. It is vital that suppliers are made aware of any local prescribing guidelines that may be in place ahead of the tender process as changes to policy post award of the contract can undermine the financial modelling done by suppliers in order to offer prices – see Section 4.

1.10 Before commencing a procurement procedure, contracting authorities may conduct pre market engagement by way of publishing, in the Official Journal of the European Union (OJEU), a Prior Information Notice (PIN). A PIN is a method for providing the market place with early notification of intent to award a contract and can lead to early supplier discussions which may help inform the development of the specification.

1.11 It is important to note that due to rises in prices, as well as the increase in ONS demand management initiatives, which have the potential to lead to a decrease in the use of ONS, suppliers are unlikely to maintain the nominal charges currently being made. Provider services and commissioning organisations will need to be prepared to either increase budgets or further control the use of these products and services.

Section 2: Identify and engage the stakeholders

Golden Rules

- **Identify all participating provider services and commissioning organisations – written confirmation of involvement must be obtained prior to publication of the tender in OJEU**
- **Identify the awarding authority from provider or commissioning services – written agreement must be obtained from all participants**
- **Framework (no commitment) agreements are unsuitable for the provision of nutrition supply services, unless the framework is only to be used as a vehicle to run mini competitions for individual Trusts or a consortia of Trusts**
- **The optimum number of home tube fed patients used to determine the level of contracting should not exceed 700**

2.1 The procurement of essential products and services must be an integrated process across all local NHS stakeholders to ensure the best possible quality and productivity outcomes. Prior to the onset of the tender process an initial scoping meeting should be held for all relevant stakeholders to agree all aspects of the proposed procurement process – as outlined in sections 2.2 to 2.16.

2.2 Identify all participating provider services and commissioning organisations. Written confirmation of each organisation's commitment to the tender process must be obtained prior to the commencement of the procurement with the publication of the OJEU notice. It is essential that all beneficiaries of the contract are clearly identified at the OJEU stage: depending upon budgetary responsibility, this may or may not include Clinical Commissioning Groups (CCG's). Additional contracting authorities cannot be added at a later date.

2.3 Identify the 'lead' authority in managing the procurement and who will be designated as the awarding authority in the OJEU adverts should be identified. Written acceptance of the 'awarding authority' should be obtained from all participating organisations.

2.4 Each participating organisation should follow internal financial instructions in seeking written agreement to be part of the tender process.

2.5 It is strongly recommended that home tube fed patient numbers should be used to determine the level of contracting and that the ideal home patient number should not exceed 700. If the tender is to be issued by a consortia and the number of home patients exceeds the recommended number, the consortia should consider tendering on behalf of 'clusters' of organisations within the group.

2.6 To ensure patient safety and appropriate clinical controls where services in addition to the actual provision of the feed itself are requested, framework (no commitment) agreements are not considered suitable for the procurement process, unless the framework is only to be used as a vehicle to run mini competitions. Suppliers will need realistic / identifiable volumes of business to support the whole supply chain and patient care process. As direct award frameworks do not guarantee volume commitment, suppliers may not offer best price.

2.7 If, however Trusts still make a decision be part of a framework agreement, clinicians should ensure that the proposed specification meets the requirements of their service. The service specification for the mini competition should be within, but cannot exceed, the scope of the framework specification.

2.8 Establish the current contract timescales and service provision. Identify future service provision (in general terms).

2.9 Agree the award option(s) to be included within the tender documentation in multi-organisation projects - for example: exclusive contract award only; facility to award by groups of participating organisations but not necessarily all participating organisations; facility to award by individual organisations; facility to split the award i.e. product ranges, service, etc. by its different elements. Offer documents must make clear what is expected of the bidder and price schedules must reflect, with appropriate, accurate data, the award option(s) included within the tender documentation. Each award option must include clearly defined criteria / sub criteria and weighting relevant and specific to that award.

2.10 Models which involve splitting the products and service provision between different suppliers, for example across different feed categories or different patient groups, require detailed specification. Extra consideration needs to be given to areas of product and / or service overlap to ensure clarity is provided regarding supplier expectations.

2.11 Agree the geographical area to be covered, including any cross-boundary issues.

2.12 Agree the period of the contract – a period of three years with the option to extend for a further period of up to two years is recommended.

2.13 Agree the timescales to be incorporated into the project. **At least 18 months should be allowed from the start of the process to the start of the new contract (and at least 24 months if organisations are considering changing their procurement model).** This period may need to be extended depending upon:

- The number of organisations and stakeholders involved and their availability for attending meetings
- The complexity of the service provision and the time required to gain agreement on the specification and evaluation criteria
- The authorisation procedures required by each of the participating organisations at the various stages of the process and the timescales involved
- The lead time for the organisations post-adjudication authorisation period to be completed
- A period of at least four months (for the possible change over to a new supplier) should be allowed after the contract award. Contracting authorities must ensure that timetables take this issue into account
- Where the number of home tube fed patients exceeds 700 patients, consideration should be given to allowing additional time for change-over. Extra care should be taken to ensure that all key stakeholders are sufficiently engaged in the process due to the added complexities involved
- Sufficient key staff from the participating organisations must be available to support the change-over as required
- Suppliers are not obligated to extend contracts under their current terms beyond the original term of the contract (with extensions). It is important to note that if organisations are not ready to implement the new service by the contract start date, suppliers may revert to list price until the situation is resolved

2.14 Identify and agree the financial and budgetary criteria that are to be applied to the contract for its full duration. This will be particularly relevant if consideration is to be given to taking the supply of products off the FP10 prescription route.

2.15 Identify the budget holders for each element of the contract – within all participating provider services and commissioning organisations. Identify the budget holders if there are any non-NHS elements included within the contract e.g. care homes, private hospitals.

2.16 Agree the project team / sub-group structure, membership and task allocation to be set up for each stage of the process under the direction of Nutrition and Dietetics facilitated by the procurement department. Consideration will need to be given to the representation of the various stakeholders and this may depend upon local circumstances – Table 1.

2.17 Patient participation and involvement in the process is considered important and every attempt should be made to consult with users and define 'expert patients' and / or a public governor of a Foundation Trust, who can be involved throughout the tender exercise.

Recommendations for patient involvement can be found on the PINNT (Patients on Intravenous and Nasogastric Nutrition Therapy) website www.pinnt.co.uk.

Table 1: Suggested representation of the tender sub-group

- Define and agree the terms of reference for the sub-group.
- The sub-group will be responsible for allocating tasks and timescales for each stage of the tender process.
- Confirm clear communication pathways between both group members and the participating organisations. It is the responsibility of each member of the group throughout the tender process to cascade information to and from the organisations and professions that they represent.
- It is suggested that 2-3 representatives from each participating organisation be nominated to the tender sub-group.

Participating Organisation: _____	
Representative from:	**Name & contact details**
Adult and paediatric dietetics	
Adult and paediatric nursing	
Adult and paediatric medical i.e. GP or consultant	
Adult and paediatric patients / carers	
Trust Caldicott Guardians / Information Governance	
Infection control / Quality and Patient Safety Teams	
Medicines management / Pharmacy	
Community bedded services	
Medical engineering department	
Finance department	
Budget holders	
Procurement department	

Section 3: Agree a financial model for the provision of nutrition supply services

Golden Rules

- **Ensure robust financial modelling and a feasibility study has been carried out when considering different procurement models**
- **Ensure all key stakeholders are clear about the financial and clinical risks of all models and written agreement is obtained from all key stakeholders**

The On FP10 Model

The following products are covered by the contract:

- Secondary care: Feeds (which may include tube feeds, specialist feeds and oral nutritional supplements), enteral feeding pumps and associated consumables (e.g. plastics and possibly ancillaries)

- Primary care: Enteral feeding pumps, associated consumables (e.g. plastics and possibly ancillaries) home delivery and associated support services.

- **Feeds: (which may include tube feeds, specialist feeds and oral nutritional supplements) in primary care do not form part of the contract if prescribed via the FP10 route.**

3.1 Although tube feeds and / or ONS for patients in the community cannot be deemed to be part of the contract (if dispensed using an FP10), it has to be recognised that the bulk of the spend will be incurred by primary care. It is essential that relevant stakeholders from both provider services and commissioning organisations are part of the procurement process and involved in all aspects of prescription and financial management.

3.2 It is essential that all relevant stakeholders are aware of the potential clinical / financial implications of the proposed model and written consent is obtained from **all** budget holders (- see Section 2).

3.3 Prescription management must be taken into consideration. The patient **must** be discharged with sufficient supply of feed on TTOs (to take out) in accordance with local policy / recommendation (7 - 14 days' supply of product) to ensure that the initial delivery is only made on receipt of the FP10.

3.4 There is no legal requirement for a GP to issue an FP10 retrospectively for products that have already been supplied. The Invitation to Tender (ITT) should state that products will only be supplied on receipt of the relevant FP10.

3.5 It is essential to good contract governance to have processes in place within provider services and commissioning organisations / medicines management teams to monitor the issue of FP10s, feed delivery, ePACT /supplier data information by:

- Linking discharge and supply of TTOs
- Clarifying who generates the first prescription
- Wherever possible avoid requesting repeat prescriptions
- Prescriptions submitted to the home delivery company must be used in sequence

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- Improving accountability back to GPs for prescriptions issued
- Consideration should be given to the use of electronic prescriptions. Companies should be able to demonstrate their ability to receive electronic prescriptions as required as the system develops
- Ensuring that prescriptions for cancelled / failed deliveries are not presented to NHS Prescription Services

3.6 Participating organisations need to have a clear understanding of the tube feed and supplement usage across the locality. Partnership working with medicines management will enable provider services to identify usage by GP practice. Levels of ONS and home enteral tube feeds and associated costs need to be determined.

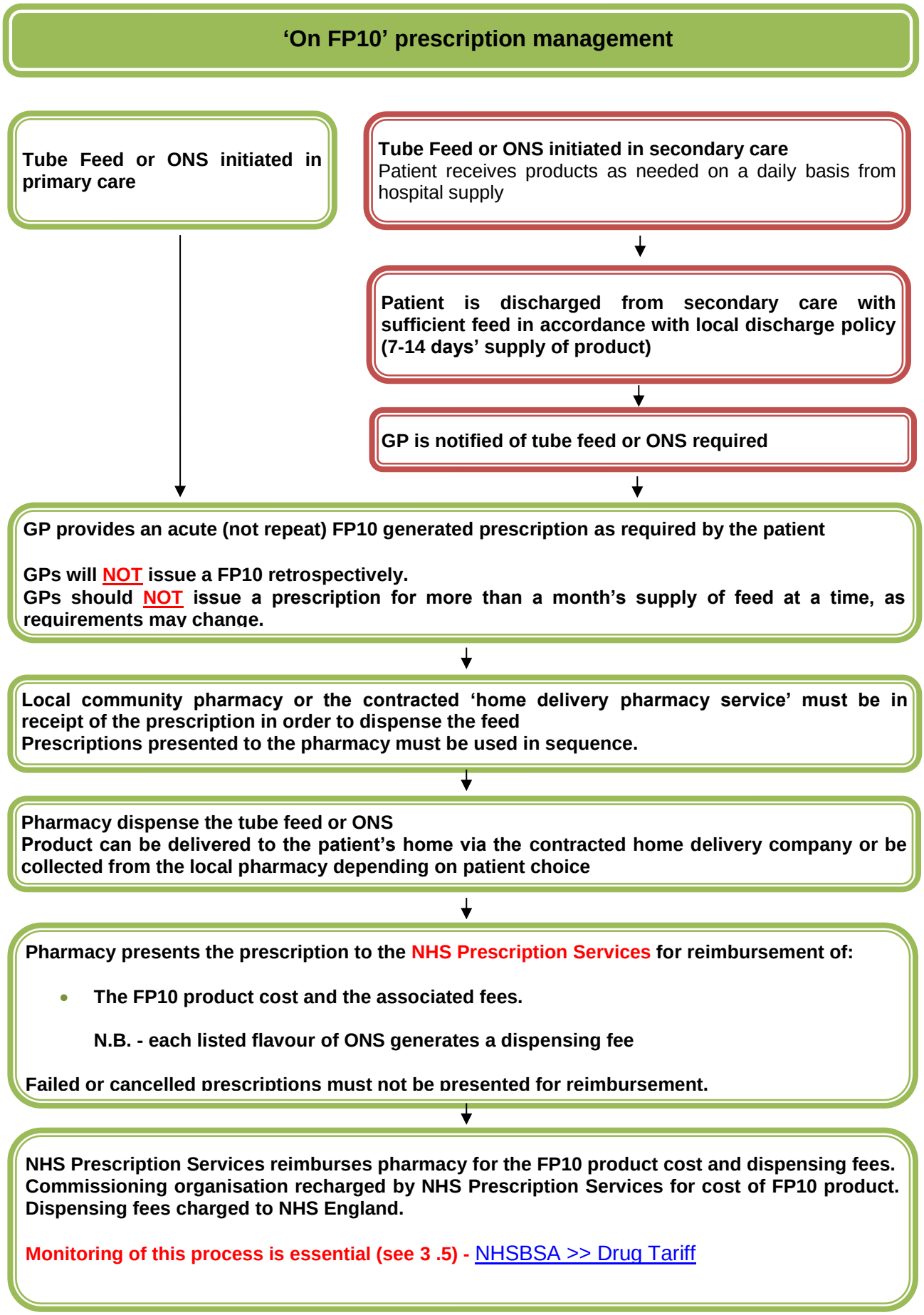
3.7 Usage of products must be audited to determine prescribing trends and profiles.

3.8 Robust nutrition support guidelines/protocols must be developed with medicine management and other key stakeholders. These guidelines / protocols may include care pathways for the use of ONS locally.

3.9 Local training programmes should be established and uptake monitored.

3.10 Sufficient clinical staff should be available to review patients receiving both tube feeds and ONS. This includes both dietetic and nursing review. However, clinical provision varies widely across the country and also between patients depending on their age and location.

Figure 2: 'On FP 10' prescription management



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The Off FP10 Model

The inclusion, within the tender documents, of requests to procure the feed in primary care via the non FP10 route has been challenged on occasions. If offers for this route are requested and a challenge is received, Trusts are advised to seek their own legal advice.

BSNA members may have differing views regarding the procurement of feed via the non FP10 route. Pre market engagement is therefore essential if considering this option.

The following products are covered by the contract:

- Secondary care: Feeds (which may include tube feeds, specialist feeds and/or oral nutritional supplements), enteral feeding pumps and associated consumables (e.g. plastics and possibly ancillaries).

- Primary care: Feeds (which may include tube feeds, specialist feeds and oral nutritional supplements), enteral feeding pumps, associated consumables (e.g. plastics and possibly ancillaries) home delivery and associated support services**.**

3.11 The off FP10 model transfers the budgetary responsibility for tube feeds and / or oral nutritional supplements to a unified budget which can be managed by either provider services and/or commissioning organisations.

3.12 Consideration must be given to any budgetary cost pressures that arise due to volume growth. A decision must be made as to where the responsibility for budget overspends will reside.

3.13 When supplying nutritional products via the non FP10 route, consideration must be given to the design and implementation of the alternative supply system. Alternative routes can result in a more integrated care pathway, improvements in patient care and reduced waste. Such systems are not without risk and a poorly planned and implemented system of supply can result in increased costs and patients being unable to access the products that they require. Robust systems of record keeping and financial control should mitigate these risks.

3.14 Written commitment is needed from Chief Executives / Directors of Finance (or delegated officers) of all provider services and commissioning organisations involved in the tendering exercise prior to publication of the OJEU notice.

3.15 All current budgets / budget holders must be identified and agreement reached as to how the unified budget will be managed. Compensation arrangements may need to be agreed, as costs could increase in some health sectors even though costs to the wider health community are reduced.

3.16 Consultation must be undertaken with all potential stakeholders e.g. GPs, community pharmacies, patients and relevant community services.

3.17 Services need to have a clear understanding of the tube feed and supplement usage across the locality. Partnership working with CCG Medicines Management will enable provider services to identify usage by GP practice. Levels of home enteral tube feeds and oral nutritional supplements and associated costs need to be determined.

3.18 If the intention is to remove tube feeds to an off FP10 system of supply, consideration must be given to oral nutritional supplements that are administered via a tube.

3.19 Usage data for feeds, plastics, ancillaries must be accurate. The CCG will have access to ePACT data. The data will give details of all the nutritional products that GPs have prescribed and will require careful interpretation.

3.20 There may already be in existence some local alternative supply arrangements not using FP10 prescriptions. Such supply arrangements must be identified and considered and data from these sources should also be taken into account.

3.21 There must be sufficient staff (dietetic and administration) to manage the workload. A robust system to replace the mechanics of the FP10 route must be established.

3.22 Products issued against a FP10 prescription will be subjected to a check by a pharmacist. If products are supplied via the non FP10 route it is most likely that there will be no pharmacist check before dispatch. Adequate processes must be in place in non FP10 routes to ensure that the patient receives the correct product.

3.23 Any alternate system to the FP10 prescription must be able to accommodate the needs of all patients.

3.24 Consideration will have to be given to patients transferring in from or managed by neighbouring acute and community Trusts.

3.25 Protocols must be agreed to ensure that the prescribing of feeds is compliant with local governance arrangements and these must be ratified by the appropriate local committees.

3.26 Any bespoke data for this service that contains patient identifiable information (PID), must be subjected to local Information Governance scrutiny.

3.27 Advice should be sought on the governance arrangements for sharing PID with third parties such as product suppliers and sub-contractors.

3.28 A robust database and IT support is essential to ensure that all prescribing is recorded and auditable. A system must be in place to record the spend on products as EPACT data will not record any off FP10 expenditure. Usage of products must be audited to determine prescribing trends and profiles.

3.29 Hidden costs e.g. stationery, postage, dispensing fees must be considered.

3.30 Agreement must have been reached on these issues and a formal signing up process undertaken by all provider services and commissioning organisations before the procurement exercise can commence. The complexity of the new service model and the necessary detailed planning needed should be recognised.

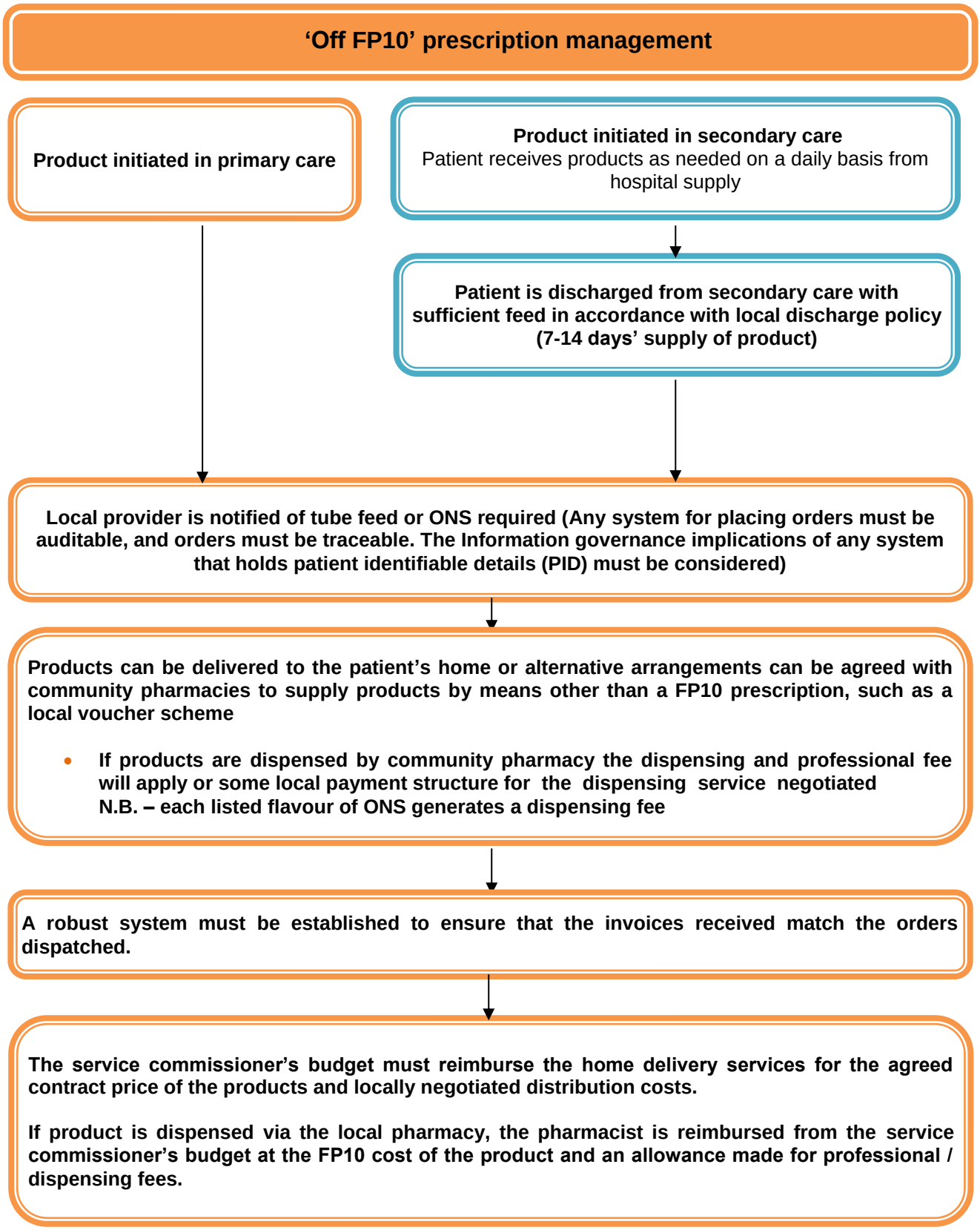
3.31 Robust nutrition support guidelines/protocols must be developed with medicine management and other key stakeholders. These guidelines / protocols may include care pathways for the use of all products that are to be supplied via the non FP10 route.

3.32 Local training programmes should be established and uptake monitored.

3.33 Services must work in partnership with medicines management, audit and information, communication and technology teams to identify all patients on oral nutritional supplements and to track patient pathways for effective use of resources. Responsibilities for monitoring patients on oral nutritional supplements and agreeing when product usage should be stopped need to be determined.

3.34 Sufficient clinical staff should be available to review patients receiving both enteral feeds and oral nutritional supplements. This includes both dietetic and nursing review (company or local staff). However, clinical provision varies widely across the country and also between patients depending on their age and location. Failure to provide adequate clinical and administration staff to support the Off FP10 model, results not only in poor quality care (and associated costs to the whole health economy), but also results in an inability to adequately monitor the changing need for products. This may result in increasing expenditure that accompanies inappropriate use of products. Delays in reviewing patients may also give rise to a dual system with GPs continuing to initiate ONS prescription prior to assessment by the local service. As provider services and / or commissioning organisations are responsible for the 'nutrition prescribing budget' in the off FP10 model, there could be a danger of unmanaged overspend.

Figure 3: 'Off FP10' prescription management



Considerations of both the 'On FP10' and 'Off FP10' models

3.35 Historically, most of the services highlighted in plain red boxes in Figure 4, page 23, have been provided at no specified cost. However, provider services and commissioning organisations should be very aware that these services are not low cost for the suppliers to provide and therefore that cost must be recouped elsewhere i.e. through the FP10 cost of the products.

3.36 Although these services have historically been provided as part of a nutrition supply services contract, it is not always necessary for this to continue. Many of these services are not essential for enteral feeding or could be provided in different ways.

3.37 Service for patients travelling away from home – UK and International: Provider services and commissioning organisations may wish to consider whether delivery services (i.e. where the supplier delivers the enteral feeds / plastics to the patient's travel destinations) should be paid for as part of a NHS contract. Conversely, as most patients will require at least 1 litre of enteral feed per day (weighing over 1 kilogram), it would be troublesome for patients to transport their own enteral feeds. It should be noted that the extent of service that a company will be able to provide in the patient's travel destination will not be comparable to that provided within their area of residence, for example, the provision of nursing service will not extend to the travel destination.

3.38 Enteral feeding ancillaries: provider services and commissioning organisations should be aware that the third party prices offered by the enteral feed suppliers reflect the fact that companies have to purchase and distribute these products. Procuring organisations may choose to purchase their ancillaries elsewhere but will then require a mechanism for delivering them to the patient's home. From a patient perspective, it may be more convenient to receive their ancillaries as part of their monthly enteral feeding delivery. Ancillaries used in the acute setting would not normally be expected to fall within the scope of contract provision by the appointed home care supplier.

3.39 Staff: Historically, provider services and commissioning organisations have requested certain numbers of whole time equivalent (WTE) supplier-employed nurses as part of contracts. In addition, many provider services have requested sums of money to fund salaried posts. Procuring organisations need to consider local commissioning and skills gaps to define the level of service required to support the contract. Any services requested must compliment local skills and services. Nursing support provided by Industry must work in partnership with local nursing services to deliver locally agreed protocols with clear lines of accountability.

3.40 Expressing staff needs in terms of number of WTE nurses or in terms of sums of money is not considered good practice. Where nursing support is required it is advisable to state the level of service required in relation to patient outcomes. Provider services and commissioning organisations should consider the feasibility of re-skilling their local acute and community nurses to carry out the nursing functions which company nurses have been increasingly providing.

3.41 Where company staffing support is requested as part of the contract, it should be for patient-focused tasks only and expressed by the clinical outcomes needed. Company staffing support must be directly involved in delivering the contract.

3.42 It is important to understand that although staff and funding for staff is provided to the contract at a nominal charge, these services are not low cost for the suppliers to deliver and therefore the cost must be recouped elsewhere i.e. through the FP10 cost of the products.

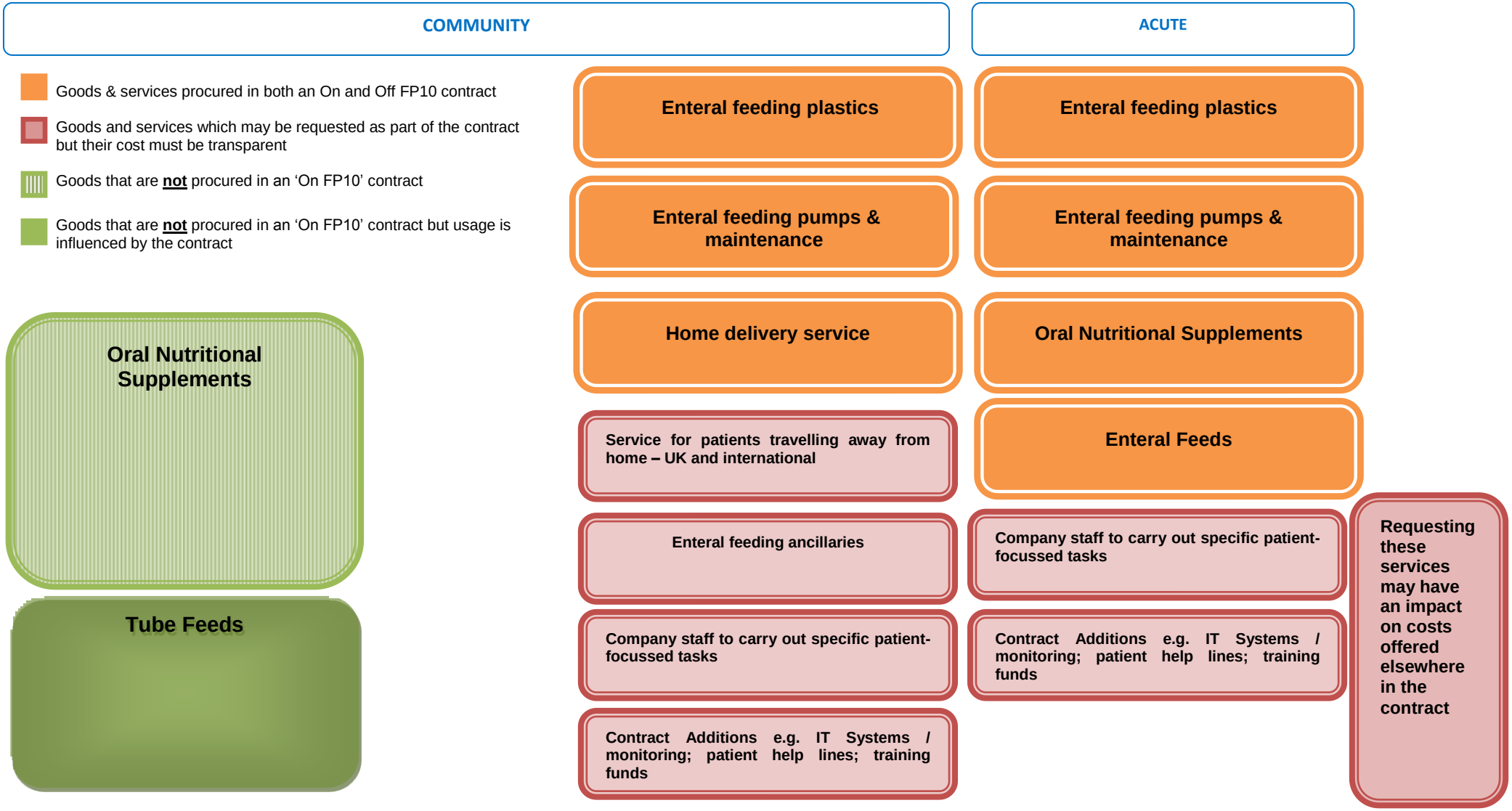
3.43 Requests for suppliers to fund NHS posts within a tender for nutritional supply services, whilst possibly temporarily relieving pressure on the Trust's staffing budget, leads to increases in the FP10 prices of the products and so ultimately to a greater cost for the NHS as a whole. A further consequence of such requests and the subsequent financial implications is resulting, in some instances, in one or possibly more companies deciding not to submit a bid for the tender.

Although the supplier is funding these posts, the NHS Trust is assuming employment related liabilities by employing these individuals. If the supplier's funding of the post were to terminate, the NHS Trust is left with these employment related liabilities for the duration of the individual's employment. If the NHS Trust no longer requires the post for whatever reason, the NHS may need to hold a redundancy process which could incur redundancy payments.

3.44 Incorporating Industry in the design or delivery of local services i.e. delivering training or screening programmes must be carefully considered due to the potential for conflict of interest and impact on local prescribing practice. If this approach is implemented, strict criteria and local policy must be adhered to.

Figure 4 – Suggested nutrition supply services procurement model for either 'On FP10' or 'Off FP10' contracts

Transparent pricing structure across all sectors



Section 4: Pre-procurement presentation to suppliers

Golden Rules

- **Prior to the issue of the OJEU advert meet with suppliers to present the proposed financial and service model of the future contract**

4.1 Prior to the issue of the OJEU advertisement, it is recommended that all the suppliers who may respond to the ITT be invited to meet with representatives of the tender sub-group group in order that Industry may be made aware of the proposed financial and service model of the future contract.

4.2 There is no requirement for provider services and commissioning organisations to be specific about patient numbers or finances at this meeting.

4.3 An agenda should be issued before the meeting detailing the key stakeholders, which parts of the meetings will be open to all suppliers, which will be confidential and the issues to be discussed. A suggested format for the meeting could be:

4.3.1 Group session

- Provider services and commissioning organisations to give an overview of the planned model and seek supplier feedback before the tender documents are issued
- Provider services and commissioning organisations to issue the procurement programme (with timelines) to the suppliers
- Open questions and answer session

4.3.2 Individual sessions

- An opportunity for each company to meet individually with the tender sub-group (allocate 15 to 20 minutes for each supplier). Care must be exercised to ensure that all suppliers are treated equally and that any one supplier is not inadvertently given more information than others
- Provider services and commissioning organisations to learn of planned / recent innovations in products and / or services

4.4 Following this meeting and having reviewed the feedback from suppliers, the tender sub-group are able, should they wish, to amend their procurement plans.

Section 5: Gather Information to test the model

Golden Rules

- **Identify the budget holders within all participating organisations for each element of the contract**
- **All data required for the specification as detailed in Table 2 must be accurate**
- **All tendered volumes must be supported by the previous 12 months historical actual data at pack level**
- **Company health care professional services should be defined by patient focused responsibilities and specified outcomes**
- **The sharing of a draft specification and usage data prior to the formal issue of the ITT is recommended**

5.1 Obtaining accurate current data in the pre-tender process is vital as volume data may guide the choice of procurement model and prevent later financial risk to provider services, commissioning organisations and to suppliers – see Section 3. It is essential that volume data is not estimated and that out of date volume data should not be used. It is important to note failure to provide accurate data can have a significant impact on the tender timescale. Volume data must be included within the ITT on issue of the document. Data provided 3 or 4 weeks post issue of the tender may necessitate extending the period to allow sufficient time for suppliers to compile a bid.

5.2 All tendered volumes must be supported by the previous 12 months historical actual usage data at pack level e.g. 500ml, 1000ml, and 1500ml etc., supplied by each budget holder. Without quality usage data, broken down to pack size per group of feed, the correct number of giving sets / reservoirs used by primary and secondary care, financial analysis cannot take place and true benefits cannot be assessed in terms of savings – see Table 2.

5.3 A decision should be made on the range of feeds to be included in the tender. Inclusion of highly specialised categories / products, not generally supplied by all the bidders, will limit competition and may lead to problems with evaluation of the bids.

5.4 Volume data can be provided by the suppliers but provider services and commissioning organisations need to ensure that all suppliers are contacted in order to capture any products purchased (locally) in addition to existing contract items. It is recommended that data obtained from all sources should be verified with the internal ordering systems of the provider services and commissioning organisations involved in the tender exercise.

5.5 Suppliers invest great resource in calculating their tender offering based on the volume data provided in the service specification and cannot accurately bid for the business if they are given incorrect or incomplete information. If volume data released in the service specification is incorrect then the lead organisation (provider or commissioning) may be responsible for ensuring the stated volume of business to any new supplier. Suppliers may reserve the right to subsequently modify their prices if data is inaccurate at the time of the tender submission.

5.6 In addition to current usage data, provider services and commissioning organisations will need to consider any planned service or policy changes or developments that are scheduled to occur at any stage over the life of the contract e.g. hospitals bed numbers increasing or decreasing, potential organisational mergers, opening or closing of specialist units – particularly those with a high need for artificial nutrition, infection control policies demanding single use of syringes etc. An attempt should be made to quantify the effect of these changes on volume data.

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5.7 Establish existing current contract timescales: existing contracts cannot be terminated early for expediency. However, subject to any procurement or contractual issues, existing contracts may be extended to allow the procurement process to take place and guidance from individual organisation procurement departments should be sought.

5.8 Establish current contract service provision and identify proposed changes.

5.9 Where company health care professional services are requested, suppliers should not be asked to provide a specified number of posts. It must be explicit what patient focused responsibilities will be undertaken by company staff and to whom they will be accountable. These responsibilities should focus on supporting patients and achieving specific patient outcomes.

5.10 It is strongly recommended that home tube fed patient numbers should be used to determine the level of contracting and that the ideal home patient number should not exceed 700. If the tender is to be issued by a consortia and the number of home patients exceeds the recommended number, the consortia should consider tendering on behalf of 'clusters' of organisations within the group.

5.11 Cost of change – a realistic assessment needs to be evaluated financially and considered by the tender sub - group. Costs incurred cannot be a deterrent as all suppliers must be treated equally but it is a factor to be considered as a potential write off against the first year savings achieved.

5.12 Companies would be expected to deliver training under the supervision of the provider services and commissioning organisations' staff. Numbers of staff to be trained and their locations must be provided in order that suppliers can submit an implementation plan.

5.13 Risk analysis at national level shows considerable concern over specialist feeds and vulnerable patients. The percentage number of patients that cannot adapt to regimen changes for clinical, social or valid personal reasons and need to therefore stay on existing systems must be considered at this stage and built into the specification document. The provider service and commissioning organisations will need to identify and work with these patients and suppliers to develop a transition process wherever possible.

5.14 Not all of the home tube fed patients will transfer to the new supplier for clinical, social or valid personal reasons. The percentage of home patients who are unlikely to transfer must be estimated. Some home patients may not require feed or may wish to use the local community pharmacy for their feed, using the company home delivery service for plastics and / or ancillaries only. This number of patients should also be identified in the specification. Where patients are not transferring to the new supplier, consideration needs to be given to the service levels that will be available for those patients under the new contract – see Table 2.

5.15 In order to avoid clarification questions and challenges on data, the sharing of a draft specification and usage data prior to the formal issue of the actual ITT is recommended. If clarification questions are received, they should be directed to an appropriate member of the stakeholder group.

5.16 An OJEU advert cannot be published until as much information as possible has been gathered. Details cannot be added later if they were not included within the scope of the OJEU advert.

Table 2: Data required for the specification

Each organisation involved in the tendering process should collate the data below: the volumes must be supported by the previous 12 months historical usage data

Feeding pumps	• Current pumps: free on loan, purchased, rented • Name(s) of current pump supplier • Responsibility for maintenance and repair of pumps - medical engineering department, supplier, third party • Number of standard pumps required • Number of portable pumps required
Plastics	• Number, type and current cost of standard giving sets • Number, type and current cost of gravity feeding sets • Number, type and current cost of extension giving sets • Number, type and current cost of portable giving sets • Number, type and current cost of reservoirs • Number, type and current cost of ancillaries (i.e. syringes; PEG ends; connectors etc.) * • Number and type of feeding tubes** • Ensure all stakeholder groups are using the same language to refer to plastics, as different suppliers and organisations may use differing terminology
Enteral feeds and ONS	• Number, type, current cost and pack size of all adult tube feeds • Number, type, current cost and pack size of all paediatric tube feeds • Number, type, current cost and pack size of all adult ONS • Number, type, current cost and pack size of all paediatric ONS • Number, type, current cost of other products – thickeners, modular feeds**
Patients	• Number of adult community patients, ideally providing information on distribution by care setting • Number of paediatric home patients • Number of home patients who are likely to remain with the current contractor (as a percentage) • Number of home patients who are bolus fed • Number of home patients who receive plastics only • Delivery arrangements – are home patients registered with the home delivery company or are the community pharmacists providing the feeds • Service for patients travelling away from home (discussed at local level)
Professional services	• Training patients and carers on pump use in agreed settings • Nursing support to meet patient outcomes • Enteral feeding training programme for staff • Patient helpline
Financial	• Requirements for the new contract – being aware of any planned services or policy changes that may affect future needs • Financial information for all products used, prices currently paid, budget holders, budgetary arrangements • Delivery arrangements within hospitals – direct from company or using local wholesaler

*** May or may not be part of the contract**

NB: At this stage:

- "Type" refers to the brand name of the product. It is for Trust use only to help in the internal identification of products currently being used**.**
- **Generic descriptions only must be given in the offer schedules.**
    - "Current" cost is for the use of the tendering organisation only.

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Section 6: Agree the weighting criteria, specification and evaluation matrix

Golden Rules

- **The OJEU notice should make it clear when the awarding authority is acting as a central purchasing body on behalf of other public sector organisations**
- **All evaluation criteria, including sub-criteria, must be clear. The awarding authority must use criteria linked to the subject matter of the contract**
- **The pricing element of the tender should represent no more than 20% of the evaluation weighting**

6.1 When developing the specification, consideration must be given to a wide range of factors. Decisions must then be taken on the relative importance of each factor.

6.2 An evaluation table must be developed to reflect the specification and scoring criteria / weighting for each section /sub section / 'lot' agreed. Provider services and commissioning organisations should note that it is not possible to introduce revised scoring criteria / weighting once these have been advertised in OJEU or included within the ITT.

6.3 As the contract is primarily a service contract, it is recommended that the pricing element should be no more than 20% of the evaluation weighting although it is recognised that this can be governed by local economics. It is essential however that quality should always outweigh price.

6.4 When adapting the standard specification for local use, the following areas will need to be included:

- The participating provider services, commissioning organisations
- Period of the contract
- An outline of the way the service is provided
- Accurate, detailed data to support what is required as part of the contract.

6.5 Development of performance measures for post-contract monitoring should be considered alongside the specification, addressing such issues as:

- Accuracy and timelines of delivery
- Notification of any problems to provider services and commissioning organisations
- Provision of identified support services
- Prescription and financial management
- Patient experience

6.6 Key performance indicators (KPIs) must be identified which reflect the contract specification as well as monitoring aspects of service providers both in acute and community settings. Choosing the right KPIs relies upon a good understanding of what is important to the local Trust and care should be taken to ensure that KPIs are relevant to the enteral feed service requirement and that the expectations are realistically achievable within the parameters available. Between four and eight measures are likely to be key for most Trusts. Extensive lists of KPIs are unnecessarily burdensome adding to the costs of servicing without enhancing contract performance.

For those wishing to include 'service credits' to ensure unforeseen costs for poor supplier performance are borne by the supplier the following should be considered. To enforce this term

the credit must relate specifically to the poor performance and be realistic in terms of amount. There must be a genuine pre-estimate of loss incurred in the event that the supplier fails to meet the measureable KPIs. They must not be seen to be a "penalty" imposed upon the supplier otherwise they will be unenforceable in the courts. Examples should be included to ensure clarity is established prior to the contract being awarded.

6.7 The relevant terms and conditions that need to be included are:

- NHS Conditions of Contract for the Purchase of Goods
- NHS Conditions of Contract for the Supply of Services
- https://www.gov.uk/government/publications/nhs-standard-terms-and-conditions-of-contract-for-the-purchase-of-goods-and-supply-of-services
- NHS Conditions of Contract for the Supply and Installation of Equipment
- NHS Conditions of Contract for the Maintenance of Equipment.
- http://webarchive.nationalarchives.gov.uk/20091106150013/http://www.pasa.nhs.uk/PASAWeb/Guidance/TermsandconditionsofcontractMaintermsandconditionsofcontract.htm

6.8 Consideration must be given as to whether the tender process is subject to public procurement law. The areas to be addressed are:

- Recommend use of the restricted tender procedure (if at EU level)
- Timescales
- Details to be provided for the OJEU advert including evaluation criteria/sub criteria
- Supplier responses and pre-selection
- Invitation to tender / specification requirements
- Award evaluation criteria / sub criteria and scoring matrix
- Offer evaluation processes
- Publishing the results of the process and the award notice (at EU level)

6.9 The OJEU notice should make it clear when the awarding authority is acting as a central purchasing body on behalf of other public sector organisations. A generic description of these organisations can be used but classes of contracting authority must be defined so as to enable immediate identification of the contracting authorities concerned. If further Trusts wish to participate in the contract at a later date, these Trusts must be named on the OJEU notice and the relevant information / data included within the documentation.

6.10 A comprehensive set of tender documents must be prepared. Each set of tender documents should include:

- Date for issue of tenders;
- Closing date for receipt of tenders
- Covering invitation to offer letter
- Terms of the offer
- Terms and conditions of contract
- Specification
- **Offer schedule for completion by the bidders**
- Form of offer.

6.11 Tender submissions must be returned to the awarding authority in accordance with the terms and conditions of the ITT.

Regulation 53 of the Public Contracts Regulations 2015 states that "Contracting authorities shall, by means of the internet, offer unrestricted and full direct access free of charge to the **procurement document** from the date of the publication in the Official Journal of a notice sent in accordance with Regulation 51 or the date on which an invitation to confirm interest is sent."

"**Procurement documents**" are defined in the Regulations and would include the contract specification, payment mechanism, any key performance indicators, the invitation to tender documentation, scoring/evaluation methodology and tender submission requirements.

Section 7: Supplier product evaluation and presentation day(s) - optional

Golden Rules

- **Agree the format, timing and content of the day(s)**
- **Use the opportunity for fact finding and supplementing company information**
- **Do not use as a decision tool in the evaluation process**

7.1 Provider services and commissioning organisations may wish to set up a supplier product evaluation and presentation day(s) as part of the tendering process – pre-offer or at the adjudication stage.

7.2 A presentation and product evaluation day(s) should be built into the tender timetable at the very start of the process.

7.3 If possible, a suitable location should be provided that allows for privacy for companies and the Trust staff / patients who visit.

7.4 Companies should be given details of the proposed presentations and product evaluation day(s) at least 28 days prior to the event(s).

7.5 Presentations are not intended to be prescriptive but should form the basis of the service required to meet local needs. The same agenda, with details of the presentation topics required, should be sent to each company.

7.6 Presentations can be very subjective and should be used only as an opportunity for fact finding and supplementing the written information submitted in the company's offer. Presentations should not be used as a decision tool, i.e. be 'scored' as part of the evaluation process.

7.7 The event(s) should be formally recorded.

7.8 For those provider services and commissioning organisations wishing to hold a presentation and product evaluation day(s), the factors in Table 3 should be considered.

Table 3: Suggested plan for supplier product evaluation & presentation day(s)

Events	Requirements
Session 1: approximate duration - 3 hours	
Product evaluations Consider running in part over lunch break to allow clinicians to attend to review products. Suppliers are usually asked to exhibit the following: • Full range of adult, paediatric and specialist tube feeds with supporting literature • Sip feeds and puddings with supporting literature • Range of sip feeds and puddings available for tasting. (together with the wherewithal to taste and an appropriate means of disposal after tasting) • Most commonly used feeding pump and / or a portable pump with instruction and patient manuals • The facility to set-up and operate the feeding pumps • A range of giving sets with supporting information. • Literature, DVD, etc.	**Attendees** • Patients • Clinicians • Tender sub-group. **Venue** • Room large enough for all suppliers, their products and all attendees. **Equipment** • Tables for product displays and space for posters. • Suppliers should have sufficient room to conduct discussions with HPCs discreetly from other suppliers. Information shared may be commercially sensitive. • Ensure suppliers are aware of Wi-Fi availability.
Session 2: can be held on the same or an alternative day to session 1	
Supplier Presentations Allow approximately 1 hour per company. Time should be allowed for changeover and set up time: • Set up / take down - 10minutes • Presentation - 25 to 30 minutes • Questions - 15 to 20 minutes. Not all companies will tender for 'the full service' but should be given the opportunity to present on the topics that are relevant to their offer. Specialist companies who may not wish to make a presentation could be invited to attend the product day (see Session 1) Suppliers should be asked to present on specific topics dependant on the specification of each particular tender. Suggestions for presentation topics can be found on page 30. N.B. This is not an exhaustive list.	**Attendees** Up to five representatives from each supplier. Tender sub-group identified in Table 1. This group should consist of the same membership for all presentations to ensure consistency. **Venue** • One room large enough for attendees and equipment and one smaller waiting room for suppliers. • Ensure suppliers are aware of Wi-Fi availability. **Equipment** Screen and the facility for PowerPoint presentations.

Suggested presentation topics

Acute

- Delivery timescales, systems and charges
- Stock control and re-credit arrangements
- Liaison with staff
- Emergency deliveries (speed/charges)
- Invoicing and reporting
- Monitoring procedures
- Advice and timing regarding hazard notices
- Advice regarding unavailability of product
- Key company contacts
- Confidentiality procedures
- Clinical trials
- Off-contract purchasing
- Electronic communication capability
- Complaints procedures
- DBS checks.

Community

- Named co-ordinator, training and workload
- Registration system, paperwork, flexibility
- Prescription management
- Deliveries – times, frequency, flexibility – am/pm, deliveries, ancillaries, competitor feeds
- Financial management – failed/cancelled deliveries
- DBS checked named drivers with appropriate training and compliant with HR policy
- Stock levels, stock control procedures, handling unused stock – stock control procedures/physical stock checks
- Invoicing and reporting – at individual primary care level
- Liaison with dietitian/notification of change in supply
- Patient liaison
- Service for patients travelling away from home
- Emergency delivery requests of feed/pump – response times
- Monitoring procedures – guidance/ training
- Advice and timing regarding hazard notices
- Advice regarding unavailability of product
- Key company contacts
- Confidentiality procedures
- Clinical trials
- Off-contract purchasing
- Electronic communication capability
- Complaints procedures
- Liaison with community pharmacists**.**

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Support to patients / carers

- Pump training – speed of response, where trained, by whom, liaison with dietitian
- Training package offered, including at company change over
- Helpline details
- Service satisfaction
- Holiday service
- Emergency arrangements
- Supporting literature: adults/paediatric
- Availability of interpreters.

Support for hospital and community staff

- Training offered, including at company change over
- Complaint procedure.
- Other e.g. literature searches etc.

Support from company nurses

- Details of their training programme including updates, indemnity, insurance cover
- Compliance with recognised guidelines
- Notification of absence cover
- Management of clinical risk/governance
- Out of hour's service.

Support from industry representatives

- Details of training programme provided
- Arrangements for training updates
- Compliance with recognised guidelines
- Notification of absence cover for industry representatives
- Number of representatives dedicated to contract and geographical areas covered
- Out of hour's service.

Case study

- A case study devised by the tender sub-group (preferably taken from 'real' experience) and given to the companies on the day – e.g. half an hour before their presentation time.

Company Developments

- New products (available within the next six months)
- Service developments.

Implementation / exit plan for new contract

Section 8: Evaluate the tender responses

Golden Rules

- **The evaluation weightings published in the initial OJEU papers must be adhered to throughout the award process**
- **All evaluation criteria must be clear and related to the subject matter of the contract**
- **Award criteria must contain both qualitative and quantitative criteria**

8.1 Whilst the specification is the most important part of a public contract once it has been awarded, evaluation is the most important part of the procurement process and often forms the basis of a challenge. The manner in which UK public sector bodies are able to procure goods, services or works is determined by EU directives, which is implemented in the UK via the Public Contract Regulations 2015. The following key principles of the EU procurement regime apply to all aspects of the procurement process, including selection of bidders and evaluation of tenders including those which fall below the relevant thresholds in the 2015 Regulations:

- **Transparency:** this is not simply about disclosure and openness but also the removal of discretion and subjectivity. Evaluation must be based on objective criteria that are known to bidders in advance
- **Fairness:** evaluation criteria and the evidence required from bidders must be actual and demonstrably related to the subject matter of the contract and applied proportionately to the stated objectives
- **Equal treatment (or non-discrimination):** all bidders and potential bidders must be given the same opportunity, based on the same information and criteria, and evaluated in a non-discriminatory manner

8.2 As the evaluation process is a key component that is potentially open to challenge, provider services and commissioning organisations must be able to demonstrate that all tender responses are handled with fairness and equity.

8.3 The evaluation panel should be made up of the tender sub-group / relevant key stakeholders from within the participating provider services and commissioning organisations. Where using a panel to evaluate bids, each member of the panel should be fully briefed about the evaluation methodology that is being used and ideally consider the tenders separately before coming together to moderate their scores. This approach ensures that the risk of potential bias is reduced as far as possible. As with all public sector decision-making, due process must be followed.

8.4 The evaluation panel must use scoring matrix tender award criteria and this must relate back to the OJEU advertisement – see Section 6.

8.5 Provider services and commissioning organisations should note that it is not possible to introduce revised scoring criteria / weighting once these have been advertised in OJEU and /or included within the ITT. Ideally the evaluation process should have been previously tested to identify any potential problems. Once the evaluation criteria are set, they must be adhered to. No adjustment of the criteria or their weightings is permitted unless the procurement is rolled back to the stage at which the evaluation criteria should have been set in the first place and the procurement process re-started which in itself potentially carries legal and reputational risk.

8.6 The authority should treat all bidder responses in a confidential manner during and after the procurement process. This is subject to any obligation that the authority has under the Freedom of Information Act 2000.

8.7 Evaluation is an area that is seeing an increasing number of challenges in the courts. Bidders can potentially claim not only their wasted tender costs but also potential loss of profit for the contract. As a result of this increased risk to the public body, it is vital that a clear audit trail of the entire decision-making process throughout the evaluation process is maintained together with copies of all tenders submitted.

Section 9: Contract award

Golden Rules

- **The award recommendation must be "signed off" by all participating organisations**
- **All stakeholders who have been involved in the tender process must be advised of the outcome**

9.1 The award recommendation must be made in accordance with public procurement law, standing orders and / or standing financial instructions of the participating provider services and commissioning organisations and, in addition, comply with the authorities corporate governance procedures.

9.2 The outcome of the evaluation must be communicated to all bidders in the form of an acceptance letter to the preferred supplier and rejection letters to unsuccessful suppliers. Under the 2015 Regulations, contracting authorities must issue an award decision notice (a standstill letter) to tenderers as soon as possible after the decision has been made. Tenderers are defined as those companies which submitted an offer and have not been "definitively excluded". Tenderers which have been definitively excluded need not therefore be sent an award decision notice. An exclusion is definite if the tenderer has been notified of it and one of the following applies (i) the exclusion has been held in proceedings to be lawful and (ii) proceeding to challenge the exclusion would be out of time even assuming the grant of the maximum extension. Similar notice must also be sent to candidates (that is, operators which applied to be included among the operators to be selected to tender but were rejected) unless they have been previously informed of their rejection and the reasons for it. The notice to candidates will not include the relative advantages of the successful tender, as the candidate will not have submitted an offer. The award decision notice to tenderers must include:

- The award criteria
- The reasons for the decision, including the characteristics and relative advantages of the successful tender (subject to commercial confidentiality and intellectual property)
- The scores obtained by the recipient and the operator to be awarded the contract
- The successful operator's name
- A precise statement of when the standstill period is expected to end
- Any reasons for non-compliance with the technical specification

9.3 The relevant procedures must be met by each participating organisation to adopt the award recommendation. The awarding authority must receive written acceptance of the award recommendation from each participating organisation.

9.4 All stakeholders who have been involved in the tender process must be advised of the outcome.

9.5 Key stakeholders must be made aware of and trained to carry out their individual roles and responsibilities in all aspects of contract management.

Section 10: Standstill period

Golden Rule

- **Contracting authorities must not enter into a contract before the end of the standstill period**
- **All suppliers must be treated equally and not be discriminated against**

10.1 In order to enable unsuccessful bidders to consider whether they have a potential claim before the contract is signed, the Public Contracts Regulations 2015 provides for a standstill after the contracting authority announces its intention to award the contract to the successful bidder. Contracting authorities must not enter into the contract before the end of the standstill period. The provision upfront of the appropriate feedback within the standstill period is designed to allow those suppliers sufficient time for them to judge whether to legally challenge the procurement process.

10.2 The standstill period ends at midnight at the end of the tenth day after the date on which the contracting authority sends a compliant award decision notice to all the relevant operators (by fax or e-mail) .Where the standstill letter is sent by means other than fax or e-mail, the period ends at the latest by midnight at the end of the 15th day after the sending date (or earlier, if more than ten days after the date on which the last economic operator received the notice have elapsed). The standstill must always end on a working day.

10.3 Provided that the contracting authority has met the requirements of the 2015 Regulations in relation to the standstill letter (see paragraph 9.2) there is no obligation on the authority to conduct a formal face to face meeting with the rejected supplier. However, it is often in the interests of the contracting authority to meet a bidder and listen to any concerns they may have. It is also advisable to keep a detailed record of the debrief.

10.4 If effective competition for tendering is to be maintained, suppliers that are unsuccessful in the tender process must be treated with equal consideration as the successful suppliers. It must be appreciated that tenders require a significant resource investment from the suppliers.

10.5 Regulation 92 of the 2015 Regulations limits the time within which proceedings may be started. Provided that the proceedings do not seek a declaration of ineffectiveness, the proceedings must be started within 30 days beginning with the date when the economic operator first knew or ought to have known that grounds for starting the proceedings had arisen. However the Court may extend the time limit where it considers that there is a good reason for doing so.

10.6 A follow up letter should be made to the preferred supplier at the end of the standstill period to update them of the outcome of the standstill period.

Section 11: Contract implementation

Golden Rules

- **Meetings must be held with key stakeholders and the successful supplier as soon as possible after the contract award**
- **A fully comprehensive and realistic implementation plan must be agreed by all stakeholders**
- **Good communication between all stakeholders is essential**

11.1 Implementing a new nutrition supply and services contract, especially where there is a change of supplier, is complex and time consuming. Adequate time must be given to planning the implementation for both bedded services and for patients in their own homes – see Checklists 1 and 2.

11.2 A period of at least four months should be allowed after the contract award for the implementation of the new contract. Suppliers are not obligated to extend contracts under their current terms beyond the original term of the contract (with extensions). It is important to note that if organisations are not ready to implement the new service by the contract start date, suppliers may revert to list prices until the situation is resolved.

11.3 Companies would be expected to deliver training under the supervision of the provider services and commissioning organisations staff.

11.4 Regular (recommended weekly) meetings should be scheduled with key stakeholders and the successful supplier as soon as possible after the contract conclusion to implement the exit plan with the incumbent and the implementation plan with the new supplier:

- The logistical plan for implementation
- The communications strategy, which is vital to ensure all staff and patients are aware of the planned change
- The service level specification – memorandum of understanding
- The responsibilities of both the outgoing and incoming suppliers (if appropriate)
- The responsibilities / resource required from Trust staff
- Timescales that are realistic and appropriate to allow for the return of all patient data from the current supplier and for the transfer of that data to the new supplier
- Agreed relevant KPIs

11.5 Ensure that key stakeholders are aware of their individual roles and responsibilities in all aspects of contract management. Confirm and implement training where necessary.

11.6 Agree the frequency of service level review meetings and complaints procedures.

11.7 Ensure that all meetings are recorded and that any issues are actioned and monitored.

Checklist 1: Checklist for changing supplier – provider services

Task	Lead person and timescale
Liaise with outgoing supplier to implement exit plan regarding process / timing of equipment uplift.	
Liaise with incoming supplier to implement plan for changeover process and training schedule.	
Communicate changes to key stakeholders - Table 1.	
Liaison between all provider services, commissioning organisations and suppliers to confirm communication pathways.	
Identify training needs for all relevant staff. Clinical governance and / or the training department are likely to want copies of the records of staff trained.	
Liaise with procurement department regarding ordering / purchase of new stock.	
A risk assessment of the changeover process must be carried out.	
Revise documentation – ordering systems, feeding regimen charts, enteral feeding guidance documents.	
Confirm feed / pumps / consumables and ancillary requirements.	
Confirm systems for maintenance / service of pumps, emergency out of hour's replacement.	
Confirm funding / invoicing arrangements.	

Checklist 2: Checklist for changing supplier – patients in their own homes

Task	Lead person and timescale
Liaise with outgoing supplier regarding the transfer of patient data. Trusts should obtain the patient data from the current contractor. The data should include name, address, GP details, feeding and equipment requirements and delivery details. Once checked and confirmed, this data can then be passed to the new contactor to facilitate change over.	
Identify key personnel from commissioning organisations to the homecare provider.	
Confirm key contact / supplier details, e.g. homecare nurse, patient services.	
Confirm communication pathways between provider services, commissioning organisations, current home patients / carers and the homecare provider.	
Confirm existing supplier responsibilities (if applicable) and the responsibilities of the new homecare provider.	
Ensure that the homecare provider's patient management system meets the needs of the contract and agree the details and frequency of the reports that the trust will require.	
Confirm appropriate documentation for all elements of the homecare provision.	
Confirm nursing protocols, referral and on-going care pathways and a plan of all training requirements.	
Confirm patient information, current prescriptions, current delivery schedule, (if applicable) special delivery requirements/ venues /arrangements.	
Confirm tube feed / ONS for bolus if appropriate/ pumps / consumables and ancillary requirements.	
Confirm systems for maintenance / service of pumps, emergency out of hour's replacement.	
Confirm funding / invoicing arrangements.	

Section 12: Contract management

Golden Rules

- **All relevant stakeholders should be represented at the contract management meetings**
- **Contract management should occur on an agreed basis to ensure local key performance indicators (KPI's) are met**
- **All KPI's should be monitored in accordance with the contract**
- **Where KPI's are not met a written corrective action plan should be agreed by all stake holders in accordance with the terms of the contract**

12.1 Following the award of the contract, it is essential that the supplier's performance of the contract is continually assessed against the terms and conditions of the contract in order to ensure that risk and delivery is properly managed.

12.2 Ensure that all the relevant stakeholders in the provider services and commissioning organisations are aware of the new contractual and monitoring arrangements – see Table 1.

12.3 KPIs will have been identified which reflect the contract specification as well as monitoring aspects of service providers both in acute and community settings. Care should be taken to ensure that KPIs continue to be relevant to the enteral feed service requirement and that the expectations are realistically achievable within the parameters available. Extensive lists of KPIs are unnecessarily burdensome adding to the costs of servicing without enhancing contract performance.

12.4 The frequency, format and content of the contract review meetings should be agreed by the relevant stakeholders and the supplier.

12.5 All relevant stakeholders must be advised of the contractual and management arrangements and key stakeholders must be made aware of and trained to carry out their roles and responsibilities.

12.6 Ensure that key stakeholders are aware of and trained to carry out their individual roles and responsibilities in all aspects of contract management:

- If provider services are ordering products (feeds and / or plastics) via a local wholesaler, ensure that contract prices are set up for items from the main supplier and likewise for any items being supplied by secondary contracts.
- Ensure that commissioning organisations staff are made aware that patient endorsed delivery notes have been requested (if detailed within the specification) and are trained in procedures to 'recover' missing notes.
- Ensure that provider services and commissioning organisation staff responsible for invoices are fully aware of the prices/procedures in order to confidently 'sign off' the invoice.

12.7 Reports must be provided covering agreed KPIs.

12.8 Over the contract period continual evidence must be provided by the supplier detailing full compliance (trusts need to utilise this performance measurement process to determine the need for fall-back/contingency measures).

12.9 Formal meetings must be minuted in accordance with Trust policy.

12.10 A decision to possibly take up existing extension options should be discussed and mutually agreed at least nine months prior to the end of the initial contract period.

Glossary

Term	Description
Ancillaries	One of the groups of products which are used to deliver enteral feeds to tube fed patients, including: syringes, gastrostomies, naso-gastric tubes; extension sets for balloon gastrostomies.
Bolus feeding	Bolus feeding is intended to mimic mealtimes and / or snacks to allow patients to optimise a physiological response, allowing the patient to feel that they have had a 'meal'. A bolus is a specific amount of tube feed or ONS which is administered via the feeding tube at set times during the day. Bolus feeds can be delivered via gravity: either via a syringe attached to the feeding tube or via gravity giving sets. Pumps may also be used.
Clinical Commissioning Group (CCG)	A membership organisation, made up of group of GP practices, which is responsible for commissioning most health and care services for patients in their locality. They do not commission primary care for specialised services.
CCG and prescribing costs	A CCG holds a budget on behalf of its members (practices) for all medicines, appliances and products prescribed on FP10 prescriptions by its members. This will include nutritional products. CCGs actively manage prescribing quality and costs using formularies, guidelines pathways, product substitution and waste management programmes.
Consumables	The umbrella term for both ancillaries and plastics. This term does not include the tube feeds or ONS which may be used during tube feeding.
Enteral feeding	In this document, the term enteral feeding is used to describe the process of providing full or partial nutrition (using enteral feeds) to a person via their feeding tube.
OJEU	"OJEU" stands for the Official Journal of the European Union. This is the publication in which all tenders from the public sector the total value of which are above a certain financial threshold must be published according to EU legislation. The initial advertisement can be responded to by any legitimate provider operating within the geography of the EU.
ONS (Oral nutritional supplements)	Powdered or liquid products that contain energy, protein, vitamins, minerals and trace elements. The products are intended to be taken orally, however ready to drink liquid ONS can be given via an enteral feeding tube. The products are designed for people who cannot meet their full nutritional requirements from food.
Plastics	One of the groups of products which are used to deliver enteral feeds to tube fed patients, including giving sets and reservoirs into which enteral feeds are decanted.
Tube feeds	The products are not designed to be taken orally, but instead should be given via a feeding tube. The products are designed for people who cannot meet their full nutritional requirements orally. For some patients, these products are the only nutrition they will receive.

Appendix 1

Understanding oral nutritional supplement (ONS) demand management initiatives and appropriate prescribing

Due to increasing awareness of the financial and clinical impact of malnutrition, many provider services and commissioning organisations now focus on improving the identification and management of adult malnutrition. It is essential that a whole health economy approach is taken into account when considering strategies to improve the identification and treatment of those at risk of malnutrition whilst reducing inappropriate prescribing of ONS thus improving cost and quality simultaneously.

A consistent integrated approach to local ONS prescribing is required to ensure patients receive quality, cost effective care. It should be noted that solely focusing on reducing ONS expenditure can result in malnutrition not always being addressed in its entirety, sometimes leading to false economy.

Central to improving care is ensuring that patients are systematically assessed prior to receiving ONS. A food first approach should be considered as first line intervention when it is deemed to be clinically appropriate. ONS should only be used when they are deemed to be clinically indicated.

Adult ONS have been shown to have beneficial effects in terms of clinical outcome in patients who are malnourished or at risk of malnutrition. However, data from audits carried out nationally have highlighted between 30-75% of adult prescriptions for ONS were deemed inappropriate when compared with dietetic judgement and ACBS prescribing indications, resulting in significant waste and unnecessary healthcare costs.

Malnutrition management strategies which have been shown to facilitate improvements in both the quality of the management of malnutrition and ONS prescribing practice should be implemented.

These include:

- Local demand management initiatives that are underpinned by robust clinical, economic, patient reported experience and patient reported outcome measures
- Change in culture and practice by all professionals involved in malnutrition identification and management across all health and social care sectors including dietitians, General Practitioners (GPs) medical staff, nursing staff, carers, voluntary workers and Allied Health Professionals (AHP's)
- Malnutrition management pathways between primary and secondary care to ensure effective and efficient care throughout the whole patient journey
- Appropriate ONS prescribing initiatives implemented in secondary care especially relating to the discharge process
- Training and education in identifying and managing malnutrition embedded in acute, community and social services, as specified by local policy
- Medicines management led multi-professional prescribing strategies including GP incentive schemes, education programmes and formularies
- Strategies in place to assess, review and support patients receiving ONS
- Education, training and intervention in day care centres, nursing and care homes

References

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