tfc tendering for care
30 Gritstone Road, Matlock, Derbyshire, DE4 3GB
tel. 01629 57501
fax. 01629 584972
info@tenderingforcare.com
www.tenderingforcare.com

Draft Public Contracts Regulations 2015
Consultation Response

Tendering for Care – is a membership organisation which provides a wide range of support activities for just over 300 providers of health and social care providers tendering for public sector contracts in England, Wales and Scotland. The size of the organisations vary from the smallest with an annual turnover of £1m to the biggest who have a turnover of over £200m. Membership includes sole traders, small, medium and large companies and charities across the size range.

We have worked with our membership to produce a considered response to six of the questions asked in the consultation document which could potentially affect our membership.

1. General
The Consultation document asks for general comments in addition to the questions asked. Our Members have raised the following general points which we feel should be taken into account in the drafting of the final version of the Regulations.

a) The majority of contracts sought by our Members are likely to fall above the Threshold identified in draft Regulation 74 as follows:

Public contracts for social and other specific services [listed] in Schedule 3 shall be awarded in accordance with this Section, [where the value of the contracts is equal to or greater than the threshold indicated in regulation 5(1)(d).]

A high proportion of Health and Social care procurement is purchased using the restricted "framework" system. In this system it is clear that admission into a "framework" is no guarantee of being awarded the final "contract. It is not clear whether Regulation 74 as drafted will apply to the value of the framework as a whole or to the final contracts to be awarded. In the latter case the actual value of individual contracts during the call-off for contracts under a framework.

The same is true for individual contracts awarded using a "LOT" approach where the value of the LOTs may vary considerably.

We are aware of the Government's intention to limit Regulation, and where possible to transfer into guidelines. However, guidelines can and are frequently ignored. This question is so fundamental to the tendering for Health and Social care contracts which, if left in guidelines could result in a considerable degree of confusion

Our Members request that these matters are clarified in the Regulations themselves.

b) It is a mantra employed throughout the draft Regulations that the Draft Regulations are as designed to employ a high degree of flexibility. Our Members understand why lobby groups acting on behalf of Local Authorities and healthcare purchasers in particular should want maximum flexibility. It is also true that many Health and Social Care providers work across numerous Local Authorities and, as a result of the trend for integration, across NHS bodies also. This bias toward "flexibility" and lack of clear Regulatory requirements in far too many areas has the distinct possibility of resulting chaos in Health and Social Care tendering for contracts above the Regulation 74 threshold.

Whilst flexibility is well and good many providers will be forced to face increased costs when meeting the requirements of different purchasers from different Local Authorities and NHS bodies. What is needed to enable effective tendering and competition is certainty which mere guidelines cannot erase. At the very least a mandatory standard model Pre-Qualification Questionnaire would be helpful. Our Members report that far too often purchasers want different things during the selection phase, sometime the PQQ has similar demands as those employed in an open tendering procedure.

The Directive allows the Government to mandate the procedures to be employed in Social care tendering. Article 76 of the Directive states:
Member States shall put in place national rules for the award of contracts subject to this Chapter in order to ensure contracting authorities comply with the principles of transparency and equal treatment of economic operators. Member States are free to determine the procedural rules applicable as long as such rules allow contracting authorities to take into account the specificities of the services in question.

Indeed this wording appears to imply the expectation that such procedures will be mandated by National Governments. A failure to do so across the UK will, our Members say certainly lead to confusion and increased costs for the large, cross authority providers as they struggle to comply with a myriad of different sets of requirements and procedures..

Our Members request that the Regulations stipulate the national rules for the award of contracts classified as being above the threshold under Regulation 74

c) A recent Hackett Group study has quantified the waste arising from tendering in the USA. This amounts to a staggering $1.5billion and wasting 32.2million man-hours. Ultimately this feeds through to a cost on the public purse. Although no similar study had been undertaken in the UK there is no reason to doubt that the cost to the overall economy is proportionally similar. Currently the trend in numbers of tenders submitted in health and Social Care exercises is increasing. 40/50 tenders are not unusual, 80/100 not infrequent and number of 129 tenders for a framework of six providers has been reported. Somebody ultimately has to pay for these costs. This is a huge, hidden drain on already strained resources at a time of implied austerity. It is probably the case that these costs are factored into the rate paid per hour in the ultimate contract resulting in poorer services than planned in the specification and higher than necessary costs.

Additional costs also arise where there is a lack of clarity in the procurement process. This results in excessive questioning during the clarification phase of the tendering process. There are numerous examples of 130/150 questions being asked during this phase. As drafted Regulation 76 has the potential to result in a high degrees of uncertainty as providers seek to clarify both the tendering process and the requirement.

76.—(1) Contracting authorities shall determine the procedures that are to be applied in connection with the award of contracts subject to this Section, and may take into account the specificities of the services in question.
(2) Those procedures shall be at least sufficient to [ensure compliance] with the principles of transparency and equal treatment of economic operators.

Our Members request that the Regulations should provide the certainty which guideline would not by mandating the systems to be used for the procurement of contracts under draft Regulation 74 and further, that a mandatory requirement should be in place for purchasers using the Regulation to provide a technical specification for the services to be purchased.

Together these proposed mandatory requirements would have the effect of at least maintaining tendering costs at their current level, and avoid the inevitable increase which the removal of these factors would bring as providers spend excessive tie attempting to define requirements as part of tendering exercises.

d) There is a general assumption throughout the draft Regulations that public purchasers will obey the rules. Although this is largely true, it is not always the case. As far as Health and Social Care tendering is concerned, the Part B classification has meant that Treaty requirements for tenderers to be treated fairly, transparently and equally have, in many cases been breached. Indeed during 2013, TfC alone dealt with 32 cases of this kind. All were resolved without going to court. However the resolution in every case was a re-tendering exercise. In all of these cases clear mandatory rules and procedures would have saved time and money for both purchasers and providers. This contributes to the hidden costs of procurement which ultimately has to be met from contract costs, limiting the cash available for purchasers to buy services and in many cases resulting in the delivery of poor quality services. Given the experience of the past nine years, simply continuing with no mandatory Regulation or trusting in guidance rather than Regulation it is difficult to see how this situation will improve, indeed the more lax regime which does not require purchasers to act in a “transparent” way has the potential to make the situation worse with more costly challenges.

Our Members request the requirement for purchasers to act in a “transparent” manner during a tender exercise to be instated for contracts falling under draft Regulation 74; and for clear procedures to be mandated under article 76 of the Directive for those contracts which fall above the threshold defined in draft Regulation 74.

e) There is general concern, particularly amongst our smaller members, regarding the possibility of a 30 day minimum between advertisement and tender submission. Many providers of residential care are very small companies usually with ne or at most two Directors. These providers find it very, very difficult to prepare tenders alongside their everyday work. The 10 days allowed for tender preparation following expression interest in a PIN would be an impossibility for these providers. Many of these providers are managed by very experienced former nurses who provide the cosy, family style settings which older people in particular want. This commitment generally extends to the provision of one-to-one care well beyond the hours purchased. If Local and health Authorities believe that the time scale which appears throughout the draft Regulations (30 days) is acceptable and implement this in their tendering exercises, this will result in the loss of man y excellent providers who offer an excellent homely service non institutional and cost effective service.

If the Government is serious about the aim of enabling an increased engagement in tendering for public contracts by very small providers then it will use its powers under Article 76 of the EU Directive to mandate and increased time limit from advertisement to deadline for tender submission specifically for social care providers.

Our Members request that the Regulations mandate a minimum of 54 days from advertisement to tender submission for all services covered by draft Regulation 74.

2) Responses to six consultation Questions.

We have responded to six of the consultation questions which have the potential to effect health and Social Care Providers tendering for public sector contracts. Whilst we are aware that under the Regulations as drafted there are currently no mandatory procedures for services which fall within Annex XIV. Neither do the other Regulations apply.

a) Question 3 Reserved Contracts for Sheltered Workshops
We welcome comments on whether the draft regulation implements this flexibility in an effective way. We also welcome suggestions on the key issues to be considered in providing guidance on the terms discussed above.

Whilst our Members recognised that the draft Relation derives from the Directive, they noted that very few tender had been published in the UK under the current Regulation 7. Whilst there are a number of situations across the country to which this draft Regulation might apply, in particular in the fields of Learning Disability, Mental Health and addiction recovery, and some very good work is being undertaken, the threshold of 50% employees with a disability is a barrier to the overall success of the business. It was thought that 30% might be a more realistic figure.

Concerns were raised regarding the use of the terms “disabled persons” and “disadvantaged persons”. Whilst it was recognised that these are to be defined in guidance, it was felt that these definitions are so fundamental to the services to which the draft Regulation applies. Attention was drawn to potential linkages with the Social value Act which should be highlighted. Reference was also made to a possible link to the “Rooney Rule” which has been adopted by some providers with regard to disabled employees. It was felt that tis generally worked better than the establishment of individual enterprises for people with disabilities which had the potential for ghettisation. Our Members generally disliked the notion of sheltered workshops for people with disabilities on principle. They cited examples of the employment of people with known disabilities and others where such disabilities are not known. Reference was made to recent cases before the EAT which dealt with this point.

b) Questions 8/9 Division of contracts into lots / SME access
We invite comments as to whether the proposed approach to the two policy choices is appropriate bearing in mind policy goals and stakeholder views to date, or whether there are clear arguments to the contrary.
We invite comments as to whether the intended approach to explaining the combined lots provisions, i.e. providing an explanation in supporting guidance, is appropriate.

Our Members understand that the policy argument for encouraging the division of tenders into LOTS is to increase the participation of smaller companies. Over the past year there has been a considerable increase in the number of tenders which are divided into LOTS. The effect has been counter-productive in that it has found to make tendering more difficult for smaller organisations rather than easier as intended.

Reasons include:
i) Tendering for more than one LOT has increased the workload to such an extent that this became impracticable. The approach had therefore the effect of excluding small providers rather than including them;
ii) With regard to purchasers having the option to accept tenders for combinations of LOTS in a number of cases there were concerns and indeed challenges regarding the unfair application of evaluation procedures when comparing the scoring of tenders for one LOT against tenders for combinations of LOTS.
iii) Where a purchaser allows LOTS to be combined there is a concomitant requirement for increasing economies of scale, depending upon the number of LOTS which are combined. This has a negative effect upon small providers tendering for just one or two LOTS compared with larger organisations with the capacity to tender for more. The number of LOTS available can also be disproportionate. One example is a single tender divided into LOTS for 29 separate services, with the maximum to be awarded being seven.

If the intention is to give access to small or very small providers, then other options are available. These are “Request for Quote” a system which has been used extensively ad effectively over the past three years by Gloucestershire for Learning Disability and mental health services. This system is not mentioned in the draft Regulations. It would be useful if this could be mandated as a real alternative. A second option is to provide more information regarding possibilities which allow small providers to “shelter” under a lead provider in a consortium style of arrangement. These options could be both mandated as available with detailed explanations within the proposed guidance.

c) Question 12 Conflicts of interests, exclusion and related matters
We invite comments as to whether the proposed approach set out above is appropriate bearing in mind policy goals and stakeholder views to date, or whether there are clear arguments to the contrary. We also invite comments on whether the mandatory exclusion offences in English law are correctly identified.

Although not a requirement under the current Public Contracts Regulations, Regulation 23 has been adopted almost exclusively for Part B tendering over the past nine years. This and specific questions regarding conflict of interest are standard and well understood by our Members. Their corporate structures make it extremely unlikely that there would be contravention on a widespread scale.

However the issues of exclusion arising from some situations do cause difficulties. These are exclusively under the discretionary exclusions. For example: criminal convictions resulting from contravention of health and Safety Legislation initiated by the HSE; action by the EAT. Currently such exclusions are not time limited, so such a limit is welcomed. It is accepted that a balance has to be drawn, but our members feel that five years in the absence of self-cleaning is too long perhaps 3 years is more realistic which would enable an excluded provider to respond when a contract is re-tendered from which they have been excluded. It is recognised that improvements would be necessary.

A major issue for larger providers operating across a number of Local Authorities is the absence of guidance, direction or legislation on proportionality for exclusion issues. For example a large provider providing services in tens if not hundreds of locations can find currently find itself excluded for a seemingly high organisation-wide number of H&S breach or EAT outcome issues. However when focussing on the actual incident rate or risk profile I one particular authority the performance can be as good, if not better, than a provider providing a service within a single Local Authority area. This is because the large provider must respond as a whole, rather than with regard to the single Authority which is the subject of the competition. The large provider therefore finds an good/excellent service excluded die to the performance of the whole. There would be considerable merit in greater definition in guidance as to how this may be addressed in order to help large providers compete more fairly and on an equal basis at local level.

It would be helpful if the quality and standard of self-cleaning required for re-admission to tendering could be mandated. As it stands this can mean different things of varying quality to different purchasers and providers. Our Members feel that providers should be given a consistent level of clarity as to what exactly is required of them.

There are particular difficulties for providers tendering for NHS contracts. Draft Regulation 118 (1) limits the application of the draft Regulations until 18th April 2016.

This means that the time limitations and self-cleaning options do not apply to providers tendering for NHS contracts until that date. Our members feel that this implies a degree of unfairness to providers in this position. They will be required to disclose non-time limited contraventions of current Regulation 23(4) whilst this is not the case for other sectors. In order to achieve fairness it is felt that the option to self-clean could be mandated for all, including NHS contracts from the date of implementation of the new Regulations under the law.

NHS procurement is already problematic, given that this falls under the current Part B regime. The “light touch” approach adopted by Part B is frequently and routinely ignored. Tenderers are typically asked to respond to 20/30 questions at each award stage each answer requiring up to 500 words. Indeed there are several examples of tenders requiring 80 such questions resulting a response amounting to 40,000 words. Given that a typical master’s degree requires a dissertation of 20,000 words, this is by any measure excessive. The lack of certainty with regard to the tendering processes to be used applies to a considerable extent to tenders in this area. To allow this situation to continue amounts to a costly drain on scarce NHS resources both directly in terms of the cost of tender appraisal; and indirectly in term of the cost of tender preparation being passed on in the tender price. It is therefore important that limitations are mandated as a matter of urgency in order to limit these excessive practices which have been adopted by Clinical Commissioning Groups, Commissioning Support Units and NHS Trusts.

d) Questions 13/14 Sub-contracting
We welcome comments, particularly on whether these draft regulations achieve the objective of implementing the requirements of the Directive in a minimalistic fashion. We welcome comments on the type of supporting materials needed and key issues to be addressed

Sub-contracting has been an approach which is widely used across the Health and Social Care sectors. The approach provides a shelter for providers who are new to the market or are smaller and thus value support from the main contractor in a wide variety of areas which includes payroll, training, performance management, etc.

The flexibility and minimalist approach is welcomed for this type of tendering, in particular question a) in the consultation document. Our members question the intervention of the purchaser in the approval of sub-contractors (question b)) this seems to contravene the principles of the sub-contracting process. This is predicated on the contractor accepting total responsibility and liability for contractual compliance. If the contractor is able to evidence capability and capacity to ensure that compliance, it is hard to see a role for the purchaser in the sub-contracting relationship. Of course safeguards to this effect must be in place. But the contract is with the contractor.

Contractual failure at any point is the contractor’s liability and should be dealt with as such. It is also often hard to see where the public sector appraisal process demonstrates a knowledge and understanding of the business world sufficient to enable and adequate appraisal of an effective sub-contracting relationship. In the view of our Members the fact that a contract is to be sub-contracted is irrelevant. It is the overall offer which should be appraised with its attendant risk and contract management systems. It could be that with careful and effective management a provider which would not pass tender appraisal would provide a valuable and effective service if efficiently managed by an experienced contractor. This option should be available without interference.

A number of our larger Members were very concerned regarding question c). It was felt that the option for sub-contractors to be paid directly had serious implications for the subcontracting relationship. It was also questioned as to whether or not this might contravene contract law. Returning to the principle set out above, the question was asked how a contractor could accept liability for contract delivery if sub-contractors had a separate relationship with regard to payment with the contract purchaser. Many felt that it would not be possible to accept the risks and loss of control for the delivery of contractual outcomes which would be integral with an arrangement of this kind.

Our Members were clear as to the type of supporting material required. They feel that a wide range of case studies which set out options and how these could be implemented in practice would be essential for them to consider sub-contractual arrangements under the new Regulations. They also felt that they would need guidance as to how this process would relate to general contract law and guidance as to exactly how they might be able to mitigate the inherent risks which they would face in participating in such a process. This would also be true for smaller providers who might undertake sub-contracting arrangements and as a result might have a lot to lose, financial and otherwise.

e) Questions 16/17 Light Touch Regime

We welcome comments, particularly on whether these draft regulations achieve the objective of implementing the requirements of the Directive in a minimalistic fashion. We envisage that a minimalistic regulatory approach would need to be supported with relevant training aids, policy instructions or guidance, and welcome inputs on the type of supporting materials needed and key issues to be addressed.

In our response to the Stakeholder Discussion Paper we made the following "general" comment which it is worth repeating as follows:

General comment

In many places across the country all is not well with procurement in the Health and Social Care sectors. Despite attempts by government to reduce red tape and administrative burdens, the lack of compliance with competition law by purchasers is extensive. It may be appropriate for Monitor to investigate procurement across health and social care; take a view and issue inform strong guidance for purchasing authorities a part of the transposition process. Some examples which have arisen over recent months across three or more individual purchasers:

- *CCGs encouraging providers to collaborate in contravention of Chapter 1 of the Competition Act 1998;*
- *The use of scoring scheme which are not clear or transparent; and more importantly, do not set out the objective criteria upon which judgements have been made;*
- *The continued widespread use of "interviews" as part of the award phase, frequently unscored, but used to "adjust" scores awarded;*
- *CCGs encouraging breaches of conflict of interest requirements as part of the tendering process;*
- *Despite moves towards integration, CCGs working in isolation, failing to learn from lessons derived from processes previously employed by social care providers;*
- *General ignorance by of the "pressetext" requirements regarding re-tendering.*

Some will want to argue that the Government should use the opportunity offered by the transposition process to lighten the Regulations regarding tending and competition, making the re-introduction of grants possible. The overwhelming majority of TfC members with whom the options have been discussed and which include a full cross section of the sector not only would not welcome such a step, but would see this as retrograde.

If anything our Membership wants clear mandatory egulation which enables them to compete equally, with Government ensuring that the requirement for compliance with purchasing systems which are fair and transparent within the law are fully met.

This response remains unchanged. Draft Regulation 76 (5) uses the term "*reasonable and proportionate*" which leaves scope for significant legal uncertainty which is unfavourable to both provider and purchaser. Providers will wish to take costly action in order to define these terms through case law. There is already action in the courts regarding the use of the term "reasonable" in contract law. So there is no reason to doubt that similar arguments will be pursued with regard to procurement law, thereby increasing costs for tax payer and providers. The term proportionate can have very different meaning in an industry where typically very small providers compete with NHS Trusts and national bodies such as Care UK. In mandating procurement requirements it is important that Government recognises the benefits of the diversity of providers across the Health and Social Care sectors. This should be supported through a tighter definition of these terms a on this. In addition there are questions which need to be answered in the Regulations. At the very least: What does the Government mean by "reasonable and proportionate"? How is this defined in law? These terms are subjective and in the eye of the beholder. For example for the majority of small providers a 10 day period from advertisement to deadline is not reasonable or proportionate.

There is no evidence that over the past nine years purchasers of Health and Social Care services have respected the ethos of the "light touch" Part B services. Indeed the opposite is the case with 20% of tenders published in the OJEU. Complex and onerous tendering processes are announced on a weekly basis, each requiring a considerable cost in terms of man-hours and direct cost to participate. As long as the Government adopts a minimalist approach to Light Touch this will continue with attendant time and money spent on challenging processes which do not appear to comply with the basic principles of fairness and equal treatment. In mandating procurement requirements it is important that Government recognises the benefits of the diversity of providers across the Health and Social Care sectors. There are numerous policy claims of opening up procurement to small providers. However, without the confidence that small business will be treated fairly if they devote valuable time and money to tendering they will continue to choose not to participate, thereby reducing diversity and minimising choice for the ultimate users of services. Where tenders are advertised is not the problem. Mandating this is of limited value. Rather it is the lack of certainty through a clear and regulated set of procurement processes which limits participation.

Our Members, who have experienced the vagaries of the current systems have asked for the minimalist approach to be balanced with mandatory requirements which will address the current uncertainties which incorporate extensive direct and indirect costs. If the procurement function is to fulfil its key mission: to contribute to the management of ever increasing health and social care budgets; then it must be given the tools necessary to achieve that end in the form of Regulatory certainty in terms of processes which offer clear options for tendering procedures to be followed.

Our members have asked for templates for example for Pre-Qualification Questionnaires. It is accepted and recognised that this element of the tender process is an essential element across the sectors as this confirms regulatory compliance in a number of other key areas. Indeed the Cabinet Office has published Procurement Policy Note 08/14 which includes a model PPQ. Whilst the core elements used by public purchasers generally comply, the technical section is all too often expanded by up to 20 detailed questions which may require 500 word answers. A response requiring up to 10,000 words.

It is for this reason based on years of hard experience that our member have little confidence in the proposed guidance (is this not what PPNs are after all?) and are asking the government to mandate the procures which can be used in health and Social Care procurement together with mandatory limitation on the number and size of responses required. Is it any wonder that providers have little confidence in proposals to publish guidance as set out in the draft Regulations?

The PPN states:
On 11 February 2011, the Prime Minister and the Minister for the Cabinet Office announced a series of measures to make it easier for SMEs to compete for government contracts, including:
a. The elimination of the use of PQQs for all Central Government procurements under the EU threshold;
b. The standardisation of the PQQ, with the objective of ensuring cross -Government adoption of a shortened/less onerous PQQ template.

This Policy requirement has not been realised across the country at Local Authority and NHS levels. The transposition process provides the opportunity for Government, at a stroke, to address the iniquities which exist in Health and Social Care procurement and in addition reduce the waste in terms of manpower and money which will continue to exist if these matters are not rectified.

Our Members are also oncerned that Light Touch might mean a reduced accountability by providers. There should be a mandatory requirement for all contract awards to be verified by an appropriate check of evidence so that light touch does not mean a “watering down” of the requirements of the tendering process. Without this there is a risk that fly by night providers will adopt the approach of just stating what the purchaser wants to hear, being awarded contracts and then when the failure to confirm capacity becomes clear, failing to deliver as required by the contract. The risks here are considerable. There have already been examples of service failures in learning disability services (Winterbourne View) and children’s services (Rotherham). Effective procurement based on a clear mandatory base is the guardian which can prevent these event recurring in the future.

f) Question 18 Remedies and Standstill
We seek stakeholders’ comments on, but strictly limited to, whether the proposed drafting achieves our objective of sewing the existing remedies rules into the new procurement rules framework in a satisfactory way.

We have noted the wording of the question and the limitations which are placed on answers.

However our members respond that this is a continuation of the responses to Questions 16/17. Evaluation and feedback are essential phases in any learning exercise. For this reason the requirements of the Remedied Directive should be mandatory for services classified as over the threshold under draft Regulation 74.

Experience has shown that it is necessary to hold public sector purchasers to account for their decisions, and this is no less true for providers of health and Social Care services. There is no logical reason why over the threshold draft Regulation 74 services should not be subject to a mandatory 10 day standstill period and that tenderers should be denied the ability to challenge unsound decisions.

Indeed it could be argued that for these services above all others where the lives, way of living and comfort of children and vulnerable adults are at risk, the purchasers should be legally required to account for their selection of provider(s).To fail to provide this right, where a poor decision can result in vulnerable elderly being removed from their home, is to fail the most vulnerable in society who are utterly dependent upon a fair and open process which results in the securing of the best possible care and living standards available. If this ability to challenge and hold purchasers publicly to account is not available, what is the point of procurement for services for this group of people?

Janet Roberts FRSA, CIPS Affiliate
15th October 2014