Procurement guidance

The provision of nutrition supply services including feeds, pumps, consumables and a home delivery service
The National Enteral Feeding Advisory Group

The National Enteral Feeding Advisory Group was convened 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 feeds and associated products.

This guidance document has been vetted and approved by the National Enteral Feeding Advisory Group, which is facilitated and chaired by NHS Commercial Medicines Unit (formerly the Pharmaceutical Directorate of the NHS Purchasing and Supply Agency). Representation has been made to this project by a wide range of stakeholders: dietitians, suppliers, patient groups, pharmaceutical advisors, prescribing officers, nutrition nurses and procurement specialists. Legal advice to supplement this document has been obtained from Mills & Reeve.

The guidance will be reviewed on a six monthly basis, next review date March 2012.

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The provision of nutrition supply services including feeds, pumps, consumables and a home delivery service

Guidance document

First steps and market overview
September 2011

Market overview

The NHS in England currently has approximately 35,000 patients being supported on enteral feeding in their own homes, care homes and in hospital settings. Combined with the oral nutritional supplements (sip feeds) the market is worth upwards of £165 million p.a. and growing at an average rate of 10 percent per annum. As enteral feeding and oral nutritional supplements are well utilised in this country for both adults and paediatrics, the UK market is second only in Europe to Germany in terms of value.

The market is considered discrete and specialist world wide with only a limited number of providers, and unfortunately signals of a monopoly/duopoly are emerging in the United Kingdom. In the UK the major suppliers in terms of volume are currently:

Abbott Laboratories Ltd  www.abbottnutritionuk.com
Fresenius Kabi Ltd  www.fresenius-kabi.com
Nestle Healthcare Nutrition  www.nestlenutrition.co.uk
(integrating Novartis Consumer Health)
Nutricia Clinical Care  www.nutricia-clinical-care.co.uk
Scientific Hospital Supplies  www.shs-nutrition.com provides highly specialist feeds only.

There is one further supplier who will bid in this market: this is for feeding pumps, plastic consumables and possibly a home delivery service, and that is:

Covidien  www.covidien.com
(formally Tyco Healthcare)

Although all these companies have offices, distribution and storage in the UK all feeds are made outside the UK in Europe and the USA, so supply chain issues need to be addressed in the tender documents to ensure contingency plans are appropriate for the volume of business that any particular trust/group of trusts/primary care trust contract for.

The main feature of an enteral feed tender is the service specification. Therefore the stakeholder process should be clinically led by either a dietitian or clinician, and it is recommended, due to the potential financial value, there should be trust board director sponsorship from the outset. Some patients, once established on enteral nutrition via a feeding pump or bolus system, are unlikely to come off this regimen. It will then become potentially their sole source of nutrition.

In the NHS, usage in the acute sector in terms of financial value is becoming relatively smaller and smaller as the FP10 primary care trust value grows. This Whole Health
Economy principle needs to be fully appreciated when establishing the stakeholder group and requests for discounts.

Key issues

NHS CMU in conjunction with the National Enteral Feeding Advisory Group considers the following to be key points to assess before the OJEU advert is placed. Local agreement must have been reached on these issues and a formal signing up process undertaken by all participating trusts/primary care trusts before any procurement exercise can commence (note this could take up to six months):

- A stakeholder group should be established, with local procurement facilitating but a clinical lead is required – patient participation and involvement in the process is considered important and every attempt should be made to consult with users and define ‘expert patients’ who can input throughout the tender exercise. Recommendations for patient involvement can be found on the PINNT (Patients on Intravenous and Nasogastric Nutrition Therapy) Patients’ website www.pinnt.co.uk.

- Many contracts are still unnecessarily complicated and prolonged, because key issues are not addressed and agreed before the project commences.

The suggestion of a time line is based upon the following three key principles:

(i) Several months before commencement of the full tender exercise and OJEU advertisement, a pre-brief should be held with all suppliers in the market with representatives of local stakeholder group alongside the local procurement specialist. Local procurement should facilitate this briefing, local finance should provide detailed costings, and the dietitian should provide clinical advice/updates.

(ii) The tender timetable itself allows 12 -18 months from the placing of the OJEU advert to the award of the contract.

(iii) A period of three months (for the possible change over to a new supplier) should be allowed after the contract award and built into the timetable. Trusts should be aware that if trusts are not ready to change over by the contract start date, suppliers may revert to list prices until the situation is resolved.

- 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 and need to therefore stay on existing systems must be considered at this stage and built into the specification document. The trust will need to identify and work with these patients and suppliers to develop a transition process wherever possible.

- Cost of change – a realistic assessment needs to be evaluated financially and considered by the stakeholder group. The National Enteral Feeding Advisory Group considered the cost of change per 100 home patients to be approximately £1,350 - £1,500 – Appendix III.

- There will also be change over costs incurred in the hospital/care unit that need to be considered. Training of staff will generally be covered by the company where it is offered in response to a transparent tender process but processes, systems and guidance documentation will need to be altered to take into account the new clinical systems. Companies would be expected to deliver training of staff under the supervision of Trust staff. The National Enteral Feeding Advisory Group considered
the cost of change for 1200 beds on two sites to be approximately £3,000 – Appendix III.

These costs need not be a deterrent but it is a factor to be considered as a potential write off against the first year savings achieved.

NB It is worth noting the value to be added to the implementation of the contract if GPs’ administration staff is considered/trained during any change of contract in case they should have to utilise new products/procedures.

- **Size of the contract** – **NHS CMU recommends strongly that home patient numbers should be used to determine the level of contracting and that the ideal home patient numbers should not exceed 500.** Evidence shows this number of patients will generate an optimum model for contracts in the short, medium and long term. Costs can be contained and savings achieved on economies of scale. Any larger volume of patients could prove unmanageable to the market place, and is unlikely to attract further savings for the *whole health economy.*

- **Due to the high service level requirement compared with the actual provision of the feed itself, framework (no commitment) agreements are not considered suitable in this market. Suppliers will need realistic/identifiable volumes of business to support the whole supply chain and patient care process. Frameworks are liable to produce artificially higher prices to insure against lack of commitment by trusts.**

- **Accurate usage information is crucial to producing a document of value. Tenders processed through the OJEU process need to be evaluated thoroughly and results defined. Without quality usage data broken down to pack size per group of feed and the correct number of giving sets/reservoirs used by both acute and home patients, financial analysis cannot take place and true benefits cannot be tracked in terms of savings. Suppliers cannot accurately bid for the business if they are given misleading or incomplete information. To date, approximately 30 percent of all tenders issued by the NHS have lacked the quality of detail required, therefore placing the correct contract award at serious risk.**

- **The form of specification needs to be considered in terms of:**
  - feed for home patients following the FP10 route or coming off the FP10* route
  - is a dual/split award likely?
  - is the contract for enteral tube feeds and/or oral nutritional supplements?
  - is nursing support required and if so, full details of the service required need to be specifically provided?
  - the cost of ancillaries associated with delivery to home patients.

* Reference:  
*The challenges of innovation in the organisation of home enteral tube feeding*  
P. Howard and N. Bowen © Blackwell Science Ltd 2001 *J. Hum Nutr Dietet 14. pp 3-11*

If the feed for home patients is to remain on the FP10 route, **prescription management must be taken into consideration.** The patient should be discharged with a sufficient supply of TTOs (accordance with local trust policy/minimum recommendation 14 days) to ensure that the initial delivery is only made on the receipt of the FP10.
NB There is no requirement for a GP to issue an FP10 retrospectively unless it is to cover a supply of drugs required in an emergency.

Although feed for patients when at home cannot be deemed to be inherently part of the contract (if the feed has remained on the FP10 route), it has to be recognised that the bulk of the spend will be picked up by the primary care trusts. Therefore primary care trusts involved in the procurement exercise must be fully aware and involved in all aspects of prescription and financial management.

**Warning – this is an area that is often left unchecked possibly leading to significant financial loss to the NHS.**

**Therefore it is essential to have processes in place within the primary care trusts to monitor the issue of prescription/feed delivery/ePACT data/supplier information – Appendix I and II.**

- Understand feed and supplement usage across the locality. Work with pharmaceutical advisors to identify usage by GP practice. Determine levels of sips and home enteral tube feeds and associated costs.
- Audit usage of products at local level and identify trends and profiles.
- Establish clear nutrition support guidelines/protocols with pharmaceutical advisers and other stakeholders. Include flowcharts for use of enteral/sip feed products.
- Establish local training programmes and monitor uptake.
- Work with pharmaceutical advisers, audit and information, communication and technology teams to pilot tagging patients on oral nutritional supplements and tracking patient pathway for effective use of resources. Establish responsibilities for monitoring patients on oral nutritional supplements and agreeing when product usage should be stopped.
- Establish agreed pathways for audit usage in care homes and usage of oral nutritional supplements.

If the feed for home patients is to be taken off the FP10 route, the following points must be recognised and taken into consideration in order for a safe, efficient and robust system to be put into place.

- Written commitment is needed from Chief Executives/Directors of Finance of all the acute/primary care/community/mental health trusts involved in the tendering exercise.
- Written agreement for any savings made to be re-invested in the service must be obtained: growth in the existing service must also be taken into account.
- GP’s, other prescribers, community pharmacists must be in agreement.
- All current budgets/budget holders must be identified and agreement reached as to how the unified budget will be managed.
- Usage data for feeds, plastics, ancillaries must be accurate. Accurate community data (broken down to pack size) must be available. ePACT data is not sufficiently accurate for this purpose.
• There must be sufficient staff (Dietetic and administration) to manage the extra workload i.e. replacing the mechanics of the FP10 route.

• Protocols must be agreed to ensure the ‘prescribing’ of feeds is within a legally binding framework.

• A robust database and IT support is essential to replace the mechanism of the FP10 route. A system must be in place to record the spend on products as ePACT delivery data will be lost.

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

**Agreement must have been reached on these issues and a formal signing up process undertaken by all acute, primary care/community/mental health trusts before the procurement exercise can commence. It should be noted that due to the complexity of the new service this can take up to two years.**

Once the contract has been awarded, it is essential that procedures are put in place to ensure continuous review of contract performance. **All** stakeholders must be advised of the contractual and monitoring arrangements and key stakeholders must be made aware of and trained to carry out their roles and responsibilities.

**Oral Nutritional Supplement Demand Management / Appropriate Prescribing**

ONS demand management is a multifactorial issue. There is clear evidence for potential cost savings on ONS prescribing by having in place specific Demand Management Dietitians. As many Trusts do not implement the NICE Guidelines (32) for Nutrition Support (2006) failure to implement appropriate procedures results in a continual increase in expenditure. Financial cost savings from appropriate prescribing can be measured however, additional cost savings associated with improved nutrition should also be taken into account (e.g. reduced frequency and length of hospital stay, reduced GP visits and improved wound healing). Potential cost savings and improvements in patient care are achievable with the implementation of ONS demand management initiatives/guidelines and appropriate prescribing of the products. Such initiatives/guidelines will ensure cost and quality improvements are achieved not only from appropriate ONS prescribing but also from the prevention and treatment of malnutrition.

In order to use resources effectively and direct those resources appropriately, the following points must be recognised and taken into consideration:

• Close partnership working across secondary/primary care interface is essential to ensure any management system is of maximum benefit to all health care sectors.

• The management of malnutrition and use of oral nutritional supplements should consist of a targeted approach which is proactive rather than reactive. A strategic, multi-organisational, sustainable approach is required.

• Financial investment in the service is essential. This will ensure that continuous improvements in the identification and appropriate treatment of malnutrition are made and sustained, thus resulting in improvements in health outcomes. This should be adopted as an integral part of patient care in order to provide a high quality service as well as value for money.

• Ensure NICE Guidelines 32 for Nutrition Support (2006) are implemented in both the Acute and Primary Care setting.

• Food and Nutritional Policy is in place within care and residential homes.

• Organisational wide malnutrition screening programme as per NICE guidance (2006) is in place in Acute, Community and Mental Health Trusts.
• Structured training for health professionals and appropriate voluntary sector staff on malnutrition screening
• Regular auditing of prescribing practices of healthcare professionals in all sectors
• Implement agreed local appropriate prescribing guidelines
• Monitor and review processes in place to measure clinical effectiveness.

Discounts and whole health economy

NHS CMU is aware of the requirement to secure best value on all commodity purchasing which is occurring within health economies by supply confederations and other consortia purchasing organisations. Examples of whole health economy purchasing have included attempts by confederations and consortia to link hospital and primary care trust commodity procurement with the products (either medical or non medical) which are dispensed by community pharmacists under the prescription route (‘the FP10’).

This is an area of serious concern to all suppliers and the legal advice needs to be considered thoroughly to avoid risk of challenge. If trusts are going to ask for discounts they must be in a position to evaluate the tender responses effectively and accurately. For the community FP10 figures considerable work will be required (possibly by the dietitians) to identify usage so percent discount off FP10 value can be based against an established product price. Detailed (i.e. by pack size) community feed usage must be available in order to evaluate; ePACT (electronic prescribing analysis and cost) data is not sufficiently accurate for this purpose. Company data should be used in conjunction with trust/primary care trust data. FP10 prices are not ‘fixed’ and could in theory rise several times during the length of the contract. Suppliers products although similar in composition, may vary greatly in price across the pack size range making in effect the potential for a 10 percent discount to be worth less than a 5 percent offer. Discounts may be sought as advice below.

Mills & Reeve advice

Given the requirement by all health economies to secure best value across all purchasing including primary care trusts effectively managing their drugs budgets, NHS CMU has taken legal advice from a Competition Act specialist to determine the extent to which certain practices of suppliers could result in a Competition Act challenge against NHS procuring authorities. The issue is whether NHS procuring authorities may accept discounts or rebates offered by suppliers, which are calculated by reference to the FP10 costs of the same products as those procured. Advice has been received that although any such rebate is calculated by reference to FP10 costs, which are not part of the contract, the rebates are in fact given on the contract price payable under the contract, and as such the rebates are directly connected with the subject matter of the contracts. As a result, any such rebate arrangements would not constitute a breach of the Competition Act 1998. The advice given is that NHS bodies would not be committing an abuse of any dominant position by accepting the discounts on offer and such arrangements could not be said to amount in any other respect to an abuse on the part of the NHS bodies. Accordingly, there is no reason why NHS bodies should not accept such discounts, subject to the guidance below.

The policy and legal guidance is as follows:

i) Where benchmarking for commodity purchasing on a whole health economy basis requires a consideration of FP10 costs and the drug tariff, care must be taken to identify how the FP10 costs will be used to gauge value for money contract award.
Where suppliers offer rebates or discounts calculated against FP10 prices, procuring authorities may accept such rebates or discounts without breaching the Competition Act 1998.

However, in order to comply with EU procurement regulations, procuring authorities, in attempting to secure the benefit of such discounts, cannot accept any offer if it relates to something outside the scope of what was asked for in the tender. Procuring authorities should therefore include a request for discounts in the tender documentation in order to be able to accept, within the procurement rules, any such discounts offered.

A request for discounts in the tender documentation need only be broadly worded, for example stating that the procuring authority is interested in looking at discounts or rebates on products procured and their related community supply.

NHS CMU is aware that in response to including a request for discounts as outlined above, some suppliers might offer discounts calculated by reference to the FP10 costs of their other products, being different products to those procured. NHS CMU has taken legal advice that such discounts cannot be accepted as this would be a breach of the EU procurement regulations. Discounts on the price of products procured may only be accepted if calculated by reference to the FP10 costs of the same product. The FP10 costs of other products are not related to the subject matter of the contract for the purposes of the procurement rules. As a result, acceptance of such discounts could be challenged as failure to make the award by reference to the stated and allowed criteria, as well as potentially breaching the principles of equal treatment and non-discrimination. In addition, such discounts are likely to constitute inducements which will be contrary to the terms and conditions of contract for the procurement in question. For example, where a discount calculated by reference to the FP10 costs of sip feeds is offered against a contract for tube feeds only, such a discount would not be acceptable. Where the contract is for both tube feeds and sip feeds, however, it is possible to accept a discount calculated by reference to the FP10 costs of either type of product.

In addition to discounts calculated by reference to the FP10 costs of products different to those procured, any other discounts offered on or calculated by reference to any products different to those procured cannot be accepted, for the same reasons.

Mills & Reeve advice – ‘Split’ awards:

The same applies where discounts are offered by suppliers who are part of a ‘split’ award. If, where there is a split award, a supplier is successful only in respect of certain products, that supplier cannot offer the contracting authorities discounts on their other products (i.e. the products for which they were unsuccessful). As the contracting authorities are contracting under the procurement regulations it will be a breach for them to accept such discounts from suppliers. For example, if a supplier is successful for two out of ten products, that supplier cannot, as part of its contract awarded for those two products, offer discounts related to the other eight products for which it has not been awarded a contract. Acceptance of such discounts by the contracting authorities will be a breach of the procurement rules.

Please also note that if contracting for primary care trusts, GPs cannot be influenced in their prescribing habits. They will always be free ethically to choose the feed product that is most suitable for their patient. So offers cannot be sought solely for increased volume on the primary care trusts award. Discounts may be asked for but cannot effectively be related.
to growth. Procuring authorities must not suggest they can attempt to influence GP prescribing.

Mills & Reeve advice – influencing GP prescribing

Where acceptance of discounts is permitted by competition law and the procurement rules, there is a further issue to consider. Procuring authorities must not suggest that they will attempt to influence GP prescribing as this may itself give rise to separate problems regarding limiting GPs’ freedom of choice. NHS CMU is aware that for certain commodities the suppliers who are awarded the contract for hospital and primary care trust supply will benefit from a follow on increase in their market share of those products when dispensed via FP10, due to patients requesting the same brand from their GP as they received in hospital. For other commodities this follow on benefit does not flow from the award of the hospital and primary care trust contract. In the latter case it is particularly important that suppliers are made aware that, if discounts are accepted, they are accepted only on the basis that procuring authorities cannot and will not attempt to influence GPs’ choice. Procuring authorities may only pass on information about drugs savings. This means that discounts calculated by reference to the FP10 costs of such products can only be accepted if it is possible to do so without limiting GPs’ freedom of choice.

Sponsorship for funded clinical/non clinical posts

Currently the NHS through this active tendering process is demanding sponsorship for the funding of clinical/non clinical posts from a few discrete suppliers in the region of £1 million p.a. Sponsorship can be requested, but trusts should be aware that this cost may appear elsewhere in the offer or during the term of the arrangement – as FP10 prices do go up!

A few points to note:

- sponsorship cannot be accepted if it is not asked for in the specification
- sponsorship should not be considered as part of the evaluation protocol
- sponsorship should not be declared as a saving by the trusts
- where sponsorship is sought, it must be in conjunction with DH guidance on Commercial Sponsorship – ethical standards for the NHS’ November 2000, and 1993 HSG (93)5 Standards of Business Conduct for NHS staff.

Evaluation of additional offers

NHS CMU’s view, supported by the National Enteral Feeding Advisory Group, is that additional offers should not be considered at all during the evaluation meetings/process. There will be intense scrutiny applied to the evaluation process and as such these additional offers cannot be compared on a like for like basis: therefore additional offers should not be included.

Evaluation of abnormally low offers

NHS CMU is aware of the increasing use by companies of abnormally low offers and has sought legal advice.

Mills & Reeve advice - abnormally low offers

In competition law terms, as long as a supplier is not dominant it may sell at prices as low as it wishes: even prices which clearly incur a loss. This would only be objectionable in respect of a dominant supplier who is using these low prices to push others out of the market, in which case the discounts would not be acceptable.
There are, however, procurement problems with these discounts, which are set out below. First just to note that other than the procurement concerns there is no other objection to what they are doing. Although it may seem morally wrong there is no legal basis to stop a non-dominant supplier selling at low prices, even if it is selling the products of a competitor. After all, their competitor would still make a sale to that supplier and their product would still be getting used so ultimately there is little complaint that could be made by that competitor. It would of course be a problem if a supplier tried to sell its competitor’s products as its own but as long as it is clear whose products they are there can again be no objection to this course of action.

Procurement: abnormally low offers

The procurement regulations make provision for dealing with abnormally low offers. There is no strict definition of what constitutes an abnormally low offer but it seems likely that an offer which appears to give the bidder no reasonable opportunity of making a profit could be considered abnormally low. Where an abnormally low offer is submitted, it is possible for the procuring authority to reject that bid but only via the following process.

• Firstly, there is a duty on the procuring authority to seek an explanation from the bidder for the low offer. This must be requested in writing.

• The offer must then be examined in light of that explanation.

• The procurement rules list certain matters which the authority can take into account in considering whether to reject an abnormally low offer. These are the economics of the manufacturing process (i.e. there may be exceptionally low costs involved for a particular manufacturer), the technical solutions chosen, any exceptionally favourable conditions available to the tenderer for the supply of the goods and the originality of the supplies proposed by the tender.

• The result should be that one of the above criteria would be met if the tender was correctly priced, in which case the price would therefore be objectively justifiable.

• Where there is a justifiable reason for a low offer, the authority will not be able to reject it.

Where the low offer does not fulfil these criteria, the authority will have discretion to accept or reject it. This comes down to a question of the risk involved for the authority. If the low prices were accepted, would there be an unacceptable risk of non-performance of the contract by the supplier? If the authority feels that the prices simply are not sustainable for the duration of the contract, it will be possible to reject the offer. If there is a risk either that the supplier will not perform because it cannot afford to, or that it will have to ask for a price increase, then arguably it would not be the most economically advantageous tender. These questions are very relevant in the case of such discounts. Would the supplier really be able to supply at this rate throughout the contract term? In particular can the supplier really promise to obtain and sell a competitor’s product at that price for the whole term of the contract?

Whenever contracting authorities are concerned about particularly low offers, they should consider whether those offers are justifiable and sustainable (in line with the guidance above) and consider whether the offer should be rejected as abnormally low. However, it is important to note that this is something which can only be considered on a case by case basis, considering the facts in question. It would not
be possible to have a rule, for instance for all tenders priced below a certain level to be automatically rejected as abnormally low. The decision cannot be made in advance or in relation to tenders generally. Any which are thought to be unsustainable should be subject to the procuring authority seeking an explanation from the tenderer so that they can consider the risk involved in awarding the contract to that supplier and whether it really is the most economically advantageous to the authority.

Guidance from NHS Commercial Medicines Unit

NHS Commercial Medicines Unit (NHS CMU) has only one full time member of staff assigned to enteral feeds and that is Lesley Taylor who can be contacted on lesley.taylor@cmu.nhs.uk or 01254 879568. Lesley is more than happy to attend initial scoping meetings and provide the national overview in terms of benchmarking, latest legal advice and general commercial considerations and whole health economy issues.

NHS CMU can then assist with the development of the specification and validation and evaluation of the usage information, having a full understanding of the local requirement. However this guidance document, approved by the National Enteral Feeding Advisory Group, supported by legal advice from Mills & Reeves and designed for use in conjunction with the NHS CMU contract specification and evaluation table, is the composite offering from NHS CMU.

If confederations or local trusts wish to use other tools or advice then NHS CMU support will be withdrawn.

To obtain the full specification, evaluation and evaluation table please email Lesley Taylor lesley.taylor@cmu.nhs.uk
Guidance for trusts on the provision of nutrition supply services including feeds, pumps, consumables and a home delivery service

Contents

1  The overall process  15
2  The review and decision policy for enteral feeding and the parameters of the project  17
3  Information gathering and analysis  21
4  The tender process  25
5  Adjudication  28
6  Contract award  29
7  Monitoring and evaluation of performance  31
   Appendix I  33
   Appendix II  34
   Appendix III  35
The procurement cycle

1 The overall process

The enteral feeds procurement cycle comprises six stages as follows:

1.1 The review and decision policy for the provision of nutrition supply services and the parameters for the project

1.1.1 Overall scope of the project.
1.1.2 Timescales to be incorporated within the project.
1.1.3 Financial foundation upon which the service is to be based.
1.1.4 Consultation/authorisation and formal signing up process to be set up (especially if it is to be a multi-trust/confederation/collaborative hub process).

1.2 Information gathering and analysis

1.2.1 Current contract details and service provision.
1.2.2 Involvement of NHS Commercial Medicines Unit.
1.2.3 Potential changes in the new contract.

1.3 The tender process

1.3.1 Development of weighting criteria, specification, evaluation table.
1.3.2 Terms and conditions of contract.
1.3.3 OJEU procedures.
1.3.4 Pre-offer discussions/presentations.
1.3.5 Tender documentation.
1.3.6 Return of tenders and their scheduling.

1.4 Adjudication

1.4.1 Representation in the adjudication process.
1.4.2 Evaluation/adjudication criteria and scoring systems.
1.4.3 Presentations.
1.5  **Contract award**

1.5.1  Authorisation processes.

1.5.2  Communication strategy.

1.5.3  Preparation of contract documentation.

1.5.4  Implementation of the new contract.

1.5.5  Debrief of unsuccessful bidders.

1.6  **Monitoring and evaluation of performance**

1.6.1  Continuous review of the contract performance.

1.6.2  Performance measurement against tender evaluation criteria.
The procurement cycle

2 The review and decision policy for the provision of nutrition supply services and the parameters for the project

2.1 Overall scope of the project – issues to be included:

2.1.1 The trusts to be involved (acute/primary care/community/mental health trusts) – written confirmation of involvement to be obtained.

NHS CMU recommends strongly that home patient numbers should be used to determine the level of contracting and that the ideal home patient number should not exceed 500.

If the tender is to be issued by a confederation/collaborative hub and the home enteral patients exceeds the recommended number, the stakeholder group should actively consider tendering on behalf of ‘clusters’ of trusts/primary care trusts within the confederation/collaborative hub.

2.1.2 The geographical area to be covered, including any cross-boundary issues.

2.1.3 The ‘lead’ authority in managing the project and being designated as the awarding authority in the OJEU adverts should be identified.

2.1.4 The service to be provided (in general terms).

2.1.5 The award options to be included within the tender documentation in multi-trust projects - for example:

i) exclusive contract award only;

ii) facility to award by groups of participating trusts but not necessarily all participating trusts;

iii) facility to award by individual trusts;

iv) facility to split the award i.e. product, service, etc by its different elements.

2.1.6 The groups of patients to be covered by the service both in the hospital and the community (the ideal home patient number should not exceed 500).

2.1.7 The need to identify the relevant budget holders – within acute/primary care/community/mental health trusts.

2.1.8 Any other financial authorisations required to proceed with the contract.

2.1.9 Specific clinical authorisations required to proceed with the contract (e.g. adult/paediatric).

2.1.10 Any additional justification (apart from the legal requirements) /cost benefit of undertaking the project.

2.1.11 Period of the contract – NHS CMU recommend a period of three years with the option to extend for a further period of up to two years.
2.2 The timescales to be incorporated within the project

Points 2.1.1 to 2.1.11 must have been agreed by the stakeholder group and a pre-brief held with all suppliers individually before the issue of the OJEU advert.

Normally at least 12-18 months should be allowed from the start of the process to the start of the new contract. To enable full consideration to be given to all the issues this period may need to be extended depending on:

2.2.1 The number of participants involved and their availability for attending meetings etc.

2.2.2 The complexity of the service provision.

2.2.3 The authorisation procedures required by each of the participants at the various stages of the process and the timescales involved.

2.2.4 The lead time for the trust(s) post-adjudication authorisation procedures to be completed (to include stand still period of ten calendar days to allow for a possible challenge – Alcatel procedure).

2.2.5 The lead in time required to manage any changes of contractor/service provision.

2.3 The financial foundation upon which the service is to be based

The trust/consortia will need to determine at the start of the process 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 the products off the FP10 prescription route (see pages 6, 7 and 18).

2.3.1 Community supply – FP10 or alternative budgetary arrangements and private prescriptions.

2.3.2 The budget holders for each element of the contract – within acute/primary care/community/mental health trusts.

2.3.3 The budget holder if there are any non-NHS elements included within the contract e.g. care homes, private hospitals.

2.3.4 If discounts calculated against FP10 prices are to be requested, the request must be within the specification documents. The request need only be broadly worded, for example stating that the procuring authority is interested in looking at discounts or rebates on products procured and their related community supply – see Discounts and whole health economy (page 6).

Accurate community data (broken down to pack size) must be available. ePACT data is not sufficiently accurate for this purpose.
2.4 Consultation/authorisation and formal signing up process to be set up (especially if it is to be a multi-trust/confederation/collaborative hub process)

2.4.1 The project team/sub-group structure, membership and task allocation to be set up for each stage of the process under the direction of the head(s) of nutrition and dietetics facilitated by the procurement department, with suggested trust board sponsor at initial meeting only.

2.4.2 Consideration will need to be given to:

The representation of all the various stakeholders and trusts in the following disciplines (the representation may depend upon local circumstances):

i) dietitians (adult/paediatric, acute/community);
ii) Nursing staff – general/nutrition nurse specialists/school nurses;
iii) medical staff e.g. care of the elderly;
iv) community staff – clinical/care/nursing homes;
v) community staff – management;
vi) control of infection staff;
vii) pharmacists/pharmaceutical advisers/community pharmacists;
viii) Finance staff;
ix) General managers;
x) budget holders;
xi) medical engineering staff;
xii) Patients and/or carers (PINNT guidance);
xiii) procurement department;
xiv) Catering;
xv) General Practitioner.

2.4.3 The support and advice of NHS CMU. A master specification and an evaluation table have been produced by NHS CMU in conjunction with these guidelines.

2.4.4 Need for consultation with stakeholders outside the project team.

2.4.5 How the consultation process will be managed – focus groups/central meetings/written communication/other.

2.4.6 Guidance to supplier representatives on their access to the members of the project team, sub-groups and relevant trust staff during the contract project.
Issues to be addressed when considering HETF provision ‘off FP10’.

**Patient safety**
Arrangements to ensure clinical competence
Scope of service provision
Product usage – indemnity
Drug-nutrient interactions

**Clinical responsibility**
Problem solving
Indemnity
Medical supervision
Duty of care

**Financial issues**
Reinvestment of savings
Primary care led services
Budget management
Realistic service costs
Contracting process
Future funding
Long-term implications
VAT arrangements
Community pharmacists

**Organisational arrangements**
Data collection
NHS charges

**Note:** accurate usage (product/quantity) information is essential

Based on
The procurement cycle

3 Information gathering and analysis

3.1 Current contract details and service provision

3.1.1 Current contract:
   i) end date of current contract(s) per participating trust(s);

   Existing contracts for the provision of nutrition supply services including feeds, pumps, consumables and a home delivery service should not be terminated early for expediency.

   ii) extensions required to existing contracts.

3.1.2 Feeding pumps:
   i) supplier(s);

   ii) Quantity of standard pumps;

   iii) Quantity of portable pumps;

   iv) free on loan/purchased/rented;

   v) responsibility for maintenance and repair – medical engineering department/supplier/third party;

   vi) indemnity cover.

3.1.3 Plastics:
   i) supplier(s);

   ii) Feeding tube details – naso-gastric, naso duodenal, PEGs (if these are to be included);

   iii) giving set details – standard and/or other;

   iv) reservoir details;

   v) ancillary items – e.g. connectors, PEG ends, syringes, buttons;

   vi) budget holder(s) for plastics/ancillaries – within acute/primary care/community/mental health trusts.

3.1.4 Feeding solutions:
   i) supplier(s);

   ii) contract ranges – tube feeds, sip feeds, specialist feeds, non-ACBS products;

   iii) ‘off contract’ purchases;

   iv) other products – thickeners, modular feeds, etc;
v) budget holder(s) for feeds etc - within acute/primary care/community/mental health trusts.

3.1.5 Community patients:

NHS CMU recommends strongly that home patient numbers should be used to dictate the level of contracting and the ideal home patient numbers should not exceed 500:

i) patient numbers:
   - Adult
   - paediatric
     - children on adult feeds
     - children on paediatric feeds
     (British Artificial Nutrition Survey [BANS] data may provide this information)

ii) whether all existing home patients are to be transferred to the new contractor/the percentage of home patients who are likely to remain with the current contractor;

iii) projected annual growth in patient numbers;

iv) inclusion of care homes;

v) logistics/delivery arrangements – are home patients registered with the home delivery company for the full service or are the community pharmacists providing the feed;

vi) prescription arrangements:
   - If the feed for home patients is to remain on the FP10 route, prescription management must be taken into consideration. The patient should be discharged with a sufficient supply of TTOs (in accordance with local trust policy/minimum recommendation 14 days) to ensure that the initial delivery is only made on the receipt of the FP10.
   
   NB There is no requirement for a GP to issue an FP10 retrospectively unless it is to cover a supply of drugs required in an emergency.

vii) Nursing support for home patients:
   - trust nursing support;
   - company nursing support – need to specify the extent of service used (i.e. from discharge of patient only to a full nursing service).

3.1.6 Hospital patients:

i) patient numbers:
• adult
• paediatric
- children on adult feeds;
- children on paediatric feeds;

ii) support and training for home discharge:

• Although feed for patients when at home cannot be deemed to be inherently part of the contract (if the feed has remained on the FP10 route), it has to be recognised that the bulk of the spend will be picked up by the primary care trusts. Therefore primary care trusts involved in the procurement exercise must be fully aware and involved in all aspects of prescription and financial management.

Warning – this is an area that is often left unchecked possibly leading to significant financial loss to the NHS.

Therefore it is essential to have processes in place within the primary care trusts to monitor the issue of prescription/feed delivery/ePACT data/supplier information.

iii) logistics/delivery arrangements within hospitals:

• direct from company;
• using local wholesaler.

3.1.7 Support services – user satisfaction of both health care professionals and patients:

i) composition of support services e.g. training, professional support, nurses, dietitians, helplines, support for meetings, etc;

ii) adequacy of support services;

iii) appropriateness of support services;

iv) special needs patients e.g. paediatrics, learning difficulties, visually impaired, cultural needs.

3.1.8 Contract values/volumes

Accurate usage information is crucial to producing a document of value. The full evaluation process cannot take place without quality usage data broken down to pack size per group of feed. Suppliers cannot accurately bid for the business if they are provided with incorrect information:

i) volume details per product:

• Adult
• paediatric
- children on adult feeds
- children on paediatric feeds

ii) volume of giving sets, reservoirs, combined reservoir set;

iii) third party ancillaries (if included);

iv) prices being paid currently – items delivered direct from company or via local wholesaler;

v) inclusion of support services in the pricing regimen.

3.1.9 Budgetary arrangements:

i) local recharging arrangements;

ii) ordering/invoicing arrangements e.g. consolidated invoices, patient endorsed delivery notes;

iii) accuracy and timeliness of invoicing arrangements;

iv) allowance in budget for growth in patient numbers;

v) identify budget holder(s) for products, plastics and services within acute/primary care/community/mental health trusts.

3.1.10 Information management e.g. data flexibility – suitable for requirements of acute/primary care/community/mental health trusts.

3.2 Involvement of the NHS Commercial Medicines Unit

3.2.1 As adviser/consultant.

3.2.2 Use of purchasing guide only.

3.3 Potential changes in the new contract

After the information gathering exercise, the project group/sub-groups will need to analyse the information to determine what changes are likely to be needed to enable a new contract specification to be drawn up and effectively monitored.

Each of the headings in the Section 3.1, current contract details and service provision, will need to be analysed and decisions taken about:

3.3.1 how each aspect is to be provided in the future;

3.3.2 the impact of any proposed changes on future service provision.
The procurement cycle

4 The tender process

4.1 Development of weighting criteria, specification, evaluation table

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.

The NHS CMU has a standard sample specification and evaluation table that should be used as a basis for developing a specification to meet local needs – obtainable from lesley.taylor@cmu.nhs.uk.

The evaluation table must be developed in conjunction with the specification and weighting for each section agreed.

NHS CMU strongly recommends that the pricing element should be in the range of 10 percent – 20 percent maximum.

4.1.1 As a guide, the areas that will need to be included within the specification are:

i) the trusts, primary care trusts etc participating in the service,

ii) a general outline of the way the service is to be provided,

iii) period of contract.

All other areas to be included here have already been identified in Section 3.

4.1.2 Development of performance measures for post-contract monitoring.

These need to be considered alongside the specification and should address issues about:

i) accuracy and timeliness of delivery,

ii) notification of any problems to acute/primary care/community/mental health trusts,

iii) provision of identified support services,

iv) prescription and financial management.

Performance measurement must always be considered on a local basis and include acute/primary care/community/mental health trust dimensions.

4.2 Terms and conditions of contract

The relevant terms and conditions that need to be included:

4.2.1 NHS Conditions of Contract for the Purchase of Goods;

4.2.2 NHS Conditions of Contract for the Supply of Services;

4.2.3 NHS Conditions of Contract for the Supply and Installation of Equipment;
4.2.4 NHS Conditions of Contract for the Maintenance of Equipment.

4.3 OJEU procedures

Consideration must be given to whether the tender process is subject to the European Union Supplies and Services Directives on public procurement.

For guidance, the areas that will need to be addressed include:

4.3.1 Financial thresholds – does the total contract value exceed the current EU thresholds;

4.3.2 The contract award procedure is:
   Restricted;

4.3.3 Timescales;

4.3.4 Details to be provided for the OJEU advert including evaluation criteria;

4.3.5 Supplier responses and pre-selection;

4.3.6 Invitation to tender/specification requirements;

4.3.7 Award evaluation criteria and scoring matrix (see Section 5.2);

4.3.8 Offer evaluation processes;

4.3.9 Publishing the results of the process and the award notice.

4.4 Pre-offer discussions/presentations

A decision must be made about whether it is advisable to undertake pre-offer discussions/presentations with the suppliers who are invited to tender. These discussions would be to:

4.4.1 ensure that suppliers invited to submit offers are capable of understanding the requirements of the participants;

4.4.2 reduce or eliminate the need for post-offer clarification;

4.4.3 ensure all bidders have the opportunity to advise on the documentation required to allow them to submit their most competitive supply arrangement.

Separate guidance is issued on the management of supplier presentations.

4.5 Tender documentation

Having gone through all the processes outlined above, the next and crucial stage is to bring together the above into a comprehensive set of tender documents. Each set of tender documents should include:

4.5.1 Date for issue of tenders;

4.5.2 Closing date for receipt of tenders;
4.5.3 Covering invitation to offer letter;
4.5.4 Terms of the offer;
4.5.5 Terms and conditions of contract;
4.5.6 Specifications;
4.5.7 Offer schedule for completion by the bidders;
4.5.8 Form of offer.

4.6 Return of tenders and their scheduling

4.6.1 Tenders must be returned to the awarding trust in accordance with its procedures for the receipt and safe custody of tenders.

4.6.2 Tenders must then be evaluated using the evaluation table.
The procurement cycle

5 Adjudication

5.1 Representation in the adjudication process

5.1.1 Project team representatives (acute/primary care/community/mental health trusts).

5.1.2 Sub–group representatives.

5.1.3 Other interested parties.

5.2 Evaluation/adjudication criteria and scoring systems

A scoring matrix must be used based on tender award criteria to include both qualitative and quantitative criteria. These should be agreed at local level with ‘essential and desirable’ elements being identified and must relate back to the OJEU advertisement (see Section 4.3.7).

The evaluation process is a key component that is potentially open to challenge. Trusts must be able to demonstrate equal treatment.

5.3 Presentations

Consideration will need to be given to deciding whether those making a bid should be asked to make a presentation in support of the bid.

Separate guidance is available on the management of the presentation/product days – Guidance for trusts on presentation/product days for the provision of nutrition supply services including feeds, pumps, consumable and a home delivery service.

Presentations can be very subjective and should be used as an opportunity for fact finding and supplementing companies’ submissions, rather than a major decision tool used in the evaluation process. The event should be formally recorded as questions may be asked by the suppliers during the debriefing process.
The procurement cycle

6 Contract award

6.1 Authorisation processes

   6.1.1 Award recommendation in accordance with EU procedures and trust
         standing orders and/or standing financial instructions and compliance with
         corporate governance procedures.

   6.1.2 Procedures to be met by each participant to adopt the award
         recommendation.

6.2 Communication strategy

   All parties who have been involved in the consultation exercise (Section 2.4.2 and
   7.2.2) must be advised of the outcome of the process.

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

6.3 Preparation of contract documentation

   6.3.1 Contract schedule outlining all aspects of the contract.

   6.3.2 Rejection letters to unsuccessful bidders – after allowance made for 'stand-
         still period' (10 calendar days – Alcatel procedure).

   6.3.3 Distribution of contract schedule.

   6.3.4 Acceptance letter to successful bidder.

6.4 Implementation of the new contract

   6.4.1 Representation.

   6.4.2 Schedule of internal meetings and meetings with the new contractor in
         attendance.

   6.4.3 Key areas:

      i) trust/primary care trust responsibilities e.g. key contacts, list of wards,
         list of home patients;

      ii) outgoing contractor responsibilities;

      iii) incoming contractor responsibilities;

      iv) in discussion with key stakeholders timescales must be identified that
          are realistic and appropriate to allow for the return of all patient data to
          the trust and for the trust to transfer prescription arrangements to the
          new contractor.

   6.4.4 Agree service level specification – memorandum of understanding.
6.5 Debrief of unsuccessful bidders

An approach should be developed which is based on maintaining good communication/relationships with the bidders throughout the procurement process and trying to reach a position where everyone who entered the process feels that they have been treated fairly. If effective competition for tendering is to be maintained companies that lose must be treated with equal consideration as the successful tenderers and honest feedback must be given to help them be successful in the future.

It must be appreciated that tenders cost a significant amount of investment in resource for the supplier.

A debrief under OJEU procedures must be provided/offered:

6.5.1 available to each bidder;

6.5.2 representative(s) of trust(s) must attend;

6.5.3 timings need to be identified;

6.5.4 information to be discussed:
   i) this is totally confidential;
   ii) key points must be noted;

6.5.5 the trusts need to receive some feedback on how the procurement process has been conducted.
The procurement cycle

7 Monitoring and evaluation of performance

7.1 Continuous review of contract performance

7.1.1 Frequency;

7.1.2 Attendees;

7.1.3 Administration;

7.1.4 Content and format.

7.2 Performance measurement against tender evaluation criteria

7.2.1 Key performance indicators must be identified which reflect the contract specification as well as monitoring aspects of service providers both in acute and community settings.

7.2.2 Ensure that all the various stakeholders within the acute/primary care/community/mental health trusts are aware of new contractual arrangements:

i) dietitians (adult/paediatric, acute/community);

ii) nursing staff – general/nutrition nurse specialists/school nurses;

iii) medical staff e.g. care of the elderly;

iv) community staff – clinical/care/nursing homes;

v) community staff – management;

vi) control of infection staff;

vii) pharmacists/pharmaceutical advisers/community pharmacists;

viii) finance staff;

ix) general managers;

x) budget holders;

xi) medical engineering staff;

xii) patients and/or carers (PINNT guidance);

xiii) procurement department;

xiv) Catering;

xv) general practitioner.
7.2.3 Ensure that key stakeholders are aware of and trained to carry out their individual roles and responsibilities in all aspects of contract monitoring.

i) If acute trusts are ordering products via a local wholesaler, ensure that contract prices are being paid for items from the main supplier and likewise for any items being supplied by secondary contracts.

ii) Ensure that primary care trust 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.

iii) Ensure that acute and primary care trust staff dealing with invoices are fully aware of the prices/procedures in order to confidently 'sign off' the invoice.

7.2.4 Reports must be provided covering agreed key performance indicators including financial, qualitative and quantitative issues and should be relevant to both acute/primary care/community/mental health trusts.

7.2.5 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 fallback/contingency measures).

7.2.6 Formal meetings must be recorded for local use.

NHS CMU would be grateful to receive copies of the minutes of review meetings in order to monitor suppliers nationally and identify positive/negative trends.

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**Prescription management**

- Link discharge and supply of TTOs
- Clarify who generates first prescription
- Avoid deliveries occurring without prescriptions
- Ensure prescriptions for cancelled/failed deliveries are not presented to PPA
- Improve accountability back to GPs for prescriptions issued
- Prescriptions submitted to company must be used in sequence
- Ensure on ‘acute’ script to help avoid excess prescription generation

**Enteral feed contracts (home delivery)**

Date of issue: September 2011
Date of next review: March 2012
Financial management

- Access to patient databases
- Identify items which are on FP10 and/or invoice
- Contract prices and process for ensuring these are achieved – i.e. contract prices through wholesaler
- Invoice checking against contract prices
- Proof of delivery notification of failed/cancelled deliveries. Cross reference with reports
- Company reports trust/budget holder specific

Monitor ePACT data

Appendix II
Checklist for changing supplier in an acute trust

Changing from one supplier to another involves considerable planning and training which will have an impact on staff time and the cost of the new contract. Good communication with the outgoing and incoming providers and with Trust staff and staff in surrounding primary care trusts is essential to ensure the changeover takes place as smoothly as possible. Much of the work is usually led / delivered by the Dietetic Department and Nutrition Nurses.

Issues to consider include:

- Liaison with outgoing provider regarding process and timing of uplift of equipment.
- Liaison with incoming provider to plan changeover process and training schedule.
- Liaison with Trust staff – consider who needs to be informed of the change e.g. Trust managers, consultants, matrons, ward managers, Practice and Professional Development / Training department, supplies department, pharmacy, catering, clinical governance.
- Liaison with surrounding primary care trusts to consider implications for their staff and to address their training needs (local primary care trusts may have been included in the tender process).
- Planning of training – the incoming provider can be expected to deliver much of the training but this should be co-ordinated and supervised by Trust staff. Liaison with the Training Department, ward managers and matrons is necessary to identify training needs. Training needs of ward staff, dietitians, nutrition nurses, supplies team, catering or pharmacy staff (depending upon which department is responsible for ordering and issuing stocks within hospital) must be considered.
- Liaison with procurement department and supplies team regarding ordering / purchase of new stock.
- Clinical governance issues – a risk assessment of the changeover process must be carried out. Clinical Governance and/or the Training Department are likely to want copies of the records of staff trained.
- Revision of documentation – ordering systems, feeding regime charts, enteral feeding guidance documents.

Implementation of a new Homecare Service

Implementing a new Homecare Service or changing from one supplier to another involves considerable planning and training. Good communications with the outgoing and incoming providers, Trust staff, patients and carers is essential.

Identify all stakeholders and schedule internal meetings with the new contractors in attendance:

- Confirm service level specification – memorandum of understanding.
- Identify key Trust personnel to the Homecare Provider. Confirm supplier contact details eg patient services, homecare nurse, account manager.
• Confirm communication pathways between the acute/primary care/community/mental health trusts, existing 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 Systems meet the needs of the contract and agree the details and frequency of the reports that the trusts will require.

• Confirm feed/pumps/consumables and ancillary requirements.

• Confirm patient information, current prescriptions, current delivery schedule, (if applicable) special delivery requirements/arrangements.

• Confirm systems for maintenance/service of pumps, emergency out of hours replacement.

• Confirm funding/invoicing arrangements.

• Confirm appropriate documentation for all elements of the Homecare provision.

• Confirm nursing protocols, referral and ongoing care pathways and a plan of all training requirements.

Key performance indicators must be identified which reflect the contract specification as well as monitoring aspects of the service providers. Ensure that key stakeholders are aware of their individual roles and responsibilities in all aspects of contract monitoring. Confirm and implement training where necessary.

Agree the frequency of the service level review meetings and complaints procedures with the company. Ensure that all formal meetings are recorded and that any issues are actioned and monitored.
Guidance for trusts on the presentation/product days for the provision of nutrition supply services including feeds, pumps, consumables and a home delivery service

<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Format</td>
<td>38</td>
</tr>
<tr>
<td>2 Venue</td>
<td>38</td>
</tr>
<tr>
<td>3 Timing</td>
<td>38</td>
</tr>
<tr>
<td>4 Presentation panel</td>
<td>39</td>
</tr>
<tr>
<td>5 Content of product days</td>
<td>39</td>
</tr>
<tr>
<td>6 Content of presentation days</td>
<td>40</td>
</tr>
</tbody>
</table>
Guidance for trusts on the presentation/product days for the provision of nutrition supply services including feeds, pumps, consumables and a home delivery service

These notes are intended as a guide to trusts who wish to set up supplier presentations as part of the tendering process. They are not intended to be prescriptive but should form the basis of the service available to meet local needs. Presentations can be very subjective and should be used as an opportunity for fact finding and supplementing company’s submissions, rather than a major decision tool used in the evaluation process. The event should be formally recorded as questions may be asked by the suppliers during the debriefing process.

The following must be decided:

1 Format

- Presentations and product evaluations - held on same day or separate days for presentations and products.
- Presentation panel only to attend presentations and view products or panel to attend presentations together with a ‘wider audience’ to view products.
- Number of presentations and their objectives:
  - Pre-tender
  - Pre-offer
  - At adjudication stage.

2 Venue

- If presentations and product evaluations are to be held on same day, two rooms are likely to be needed.
- OHP, screen, video and the facility for PowerPoint presentations to be available for use if required.
- Tables for product displays and space for posters.

3 Timing

- Timing is crucial and must be well-managed.
- Product day – companies invited for approximately three hours, all on the same day, possibly over lunchtime.
- Presentation day – companies usually invited all on same day with approximately one hour (total) allowed per company (for presentations and questions).
  Note: time should be allowed for changeover and set up time:
  - Set up/take down 10 minutes
  - Presentations 25 - 30 minutes
  - Questions 15 - 20 minutes.
- Presentations and product day together – panel members to view products and then attend presentations. Other staff can view products during lunch period.
• Companies should be given **at least 28 days** notice of the presentation/product days. The arrangements for such days need to be built into the timetable at the very start of the process.

• Having the presentation and product days on the same day can be very tight for time but the alternative of separate days may not be possible. Each contracting group will have to decide for itself how to manage this process and how many days to allocate to it.

4 **Presentation panel**

The membership is dependent upon each trust but may comprise:

• Dietitians
• Nursing staff - specialist, generalist, community
• Pharmacists/pharmaceutical advisers
• Catering staff
• Consultants
• Medical engineering department
• Finance staff – acute/primary care/community/mental health trusts
• Representatives of trust management e.g. general business managers
• Procurement leads

The presentation panel should consist of the same membership for all company presentations to ensure consistency of evaluation. This is particularly important if the presentations are spread over more than one day.

5 **Content of product days**

This will vary from trust to trust and will need to be determined within the project team. Patients could be invited to attend these events. Where patients do attend, every effort should be made to record their comments.

Companies 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 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, videos, etc.

Specialist companies who may not wish to make a presentation could be invited to attend the product day.
6 Content of presentation days

Companies should be invited to present on specific topics – again this will depend on the particular needs of each individual trust. Not all companies will offer the “full service” but should be given the opportunity to present on the topics that will be relevant to their offer.

Examples of issues frequently covered are:

Hospital service

- Delivery timescales and systems
- Delivery 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
- CRB checks

Community service

- 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
- Drivers, named, training, CRB checks, HR policy
- Stock levels, stock control procedures, handling unused stock – stock control procedures/physical stock checks
- Invoicing and reporting – at individual primary care trust level
- Liaison with dietitian/notification of change in supply
- Patient liaison, holidays
- 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
Support to patients

- 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
- Other e.g., BANS, literature searches etc
- Complaint procedure

Support from company nurses

- Details of their training programme including updates, indemnity, insurance cover
- Compliance with recognised guidelines
- Absence cover
- Number of nurses dedicated to contract and geographical areas covered
- Management of clinical risk/governance

Support from industry representatives

- Details of training programme provided
- Arrangements for training updates
- Compliance with recognised guidelines
- Absence cover for industry representatives
- Number of representatives dedicated to contract and geographical areas covered

Case study

A case study devised by the presentation panel (preferably taken from ‘real’ experience) and given to the companies on the day – e.g. half an hour before their presentation time.

New products (only those available within the next six months) / service developments.

Implementation plan for changeover to new contract.