
The impact of procurement law in the NHS¹

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The abbreviations used in this chapter are:

CCG	Clinical Commissioning Group
DoH	Department of Health
GP	General Practitioner
NHS Act	National Health Service Act 2006 (as amended by the Health and Social Care Act 2012)
DH	The Department of Health
NHS England	National Health Service Commissioning Board
Secretary of State	Secretary of State for Health
2009 Act	Health Act 2009
2012 Act	Health and Social Care Act 2012
PCRs	The Public Contract Regulations 2015
CCRs	The Concession Contracts Regulations 2016
NHS Procurement Regulations	National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013
ECJ	European Court of Justice
CJEU	Court of Justice of the European Union
CPV	Common Procurement Vocabulary codes
PIN	Prior Information Notice
LTR	Light Touch Regime

1. INTRODUCTION: THE NATURE AND SCOPE OF PROCUREMENT LAW AND ITS APPLICATION TO THE NHS

1.1. In broad terms, procurement law is the law governing the way in which public bodies award contracts to a third party for the supply of goods and services. The general UK public procurement regime is, at least for now, derived from EU law,² as set out in three EU Directives on public procurement issued in 2014 as part of a package of reforms, namely the Public Contracts Directive,³ the Concessions Directive,⁴ and the Utilities Directive.⁵ Procurement law is a complex area that has given rise to a number of high profile legal challenges in the last 5 years, some of which have resulted in significant embarrassment for central and local government as a result of the abandonment of procurement competitions and sizeable damages awards. It is therefore important for anyone concerned with NHS contracting to be aware of the nature of the obligations that procurement law imposes and the risks of breaching those laws.

1.2. The EU Directives referred to above are implemented in England and Wales by various sets of regulations, in particular the Public Contracts Regulations 2015⁶ (“**the PCRs**”). The PCRs impose various general obligations on contracting authorities when carrying out tender processes for public services or works contracts, the most significant ones being the obligations of equal treatment, non-discrimination, proportionality and transparency. Legal duties under the PCRs are enforceable by economic operators, including aggrieved bidders who have been unsuccessful in bidding for an NHS contract. In limited circumstances, third parties who are not

² Although the shape of the future procurement regime post Brexit is unclear, it is reasonably certain that some form of regulation will still apply after the UK leaves the EU: the UK Government is seeking powers via the Trade Bill 2017 to implement the WTO Government Procurement Agreement which sets out minimum standards for procurement competitions.

³ Directive 2014/24/EU of the European Parliament and of the Council of 26 February 2014 on public procurement and repealing Directive 2004/18/EC

⁴ Directive 2014/24/EU of the European Parliament and of the Council of 26 February 2014 on the award of concession contracts

⁵ Directive 2014/25/EU of the European Parliament and of the Council of 26 February on procurement by entities operating in the water, energy, transport and postal services sector and repealing Directive 2004/17/EC

⁶ SI 2015/02

economic operators may also bring challenges to procurement competitions carried out by public contracting authorities by judicial review. Domestic remedies under the PCRs include orders setting aside the decision to award the contract, declarations of ineffectiveness (where contracts have already been entered into) and damages.⁷

- 1.3. NHS England, CCGs, and NHS (as opposed to private) providers and the Department of Health (“**DH**”) are all contracting authorities for the purposes of the PCRs. They are therefore subject in principle to the same general obligations contained in those regulations as other UK contracting authorities when seeking to award public contracts.
- 1.4. However, in the case of contracts for health care services (“**health services contracts**”), for those contracts under £615,278 the PCRs do not apply at all. For those over that threshold, unless they fall within certain specific exemptions and derogations, a specific Light Touch Regime (“**LTR**”) applies.⁸ Under the LTR, the most significant differences to the standard procurement regime are first, that the key duty of advertisement via a contract notice does not apply, and secondly, the use of the standard procurement competition procedures (i.e the open, restricted, and negotiated procedures) become discretionary rather than obligatory. The main features of the LTR as set out in Regulation 74 – 77 and the accompanying guidance issued by the UK Government are considered in detail in Section 3 below.
- 1.5. In addition to the PCRs, CCGs and NHS England are also subject to duties under the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (“**the NHS Procurement Regulations**” or “**NHSPR**”) and the National Health Service Act 2006 (“**the NHS Act**”), which sometimes overlap with and potentially conflict with duties under the PCRs.

⁷ Remedies are discussed in detail at Section 4 below

⁸ For procurement commenced before 18 April 2016, the 2006 Regulations (as amended) apply. This regulated the procurement of health care services as “Part B” services.

- 1.6. The scope of the two sets of regulations are discussed in detail below, but the position in summary is as follows:
- a) The PCRs apply to all contracts (whether for health services or otherwise) above the defined financial thresholds entered into by all NHS bodies;
 - b) The NHS Procurement Regulations apply to all health services contracts (of whatever value) entered into by CCGs and NHS England on the one hand and health service providers on the other;
 - c) The 2015 PCRs and the NHS Procurement Regulations apply where the subject of the contract is the provision of health services, with a value of over EUR750,000, and where the contracting authority is either a CCG or NHS England.
- 1.7. The existence of two tiers of regulation (which are not always consistent between themselves) poses additional legal hurdles and constraints (not least arising from the application of the National Tariff for some services) for NHS contracting authorities seeking to award contracts. The Chapter on NHS Acute Care Contracting (which should be read in conjunction with this chapter) addresses in particular the extent to which price competition can form part of a procurement competition for services specified in the National Tariff.
- 1.8. This Chapter describes both tiers of regulation and sets out the various obligations they contain. It is in four main sections:
- a) **Section 2** provides an overview of the key rules and standard procurement procedures set out in the PCRs. The majority of health services contracts are likely to be of a sufficiently high value to fall within the LTR and therefore these standard procedures will not apply to those particular types of contract. However, a number of specific rules and principles that apply to standard procurements under the PCRs remain relevant in certain respects to health care contracts above the LTR threshold, in particular the application of a set of

specified derogations and exemptions that remove the requirement to advertise altogether. In any event, they also provide important background to understanding the principles applying to procurements governed by the NHS Procurement Regulations, and so are addressed in this section.

- b) **Section 3** describes the obligations that arise in respect of health services contracts that fall within the Light Touch Regime and the principles for awarding such contracts.
- c) **Section 4** considers the NHS Procurement Regulations and the relatively few cases where the courts have considered their interpretation.
- d) **Section 5** contains a description of the various remedies available for breach of either or both sets of regulations, including an overview of procedural issues involved in challenging or defending NHS procurement decisions.

2. THE PUBLIC CONTRACT REGULATIONS – AN OUTLINE

The concept of contracting authorities

- 2.1. The PCRs apply to all “contracting authorities”. Contracting authorities are defined in Article 1 of the Public Procurement Directive as follows:

“the State, regional or local authorities, bodies governed by public law or associations formed by one or more such authorities or one or more such bodies governed by public law”.

- 2.2. The Directive defines “*bodies governed by public law*” as bodies that have all of the following characteristics:

“(a) they are established for the specific purpose of meeting needs in the general interest, not having an industrial or commercial character;

(b) they have legal personality; and

(c) they are financed, for the most part, by the State, regional or local authorities, or by other bodies governed by public law; or are subject to management supervision by those authorities or bodies; or have an administrative, managerial or supervisory board, more than half of whose members are appointed by the State, regional or local authorities, or by other bodies governed by public law”

2.3. The definition in the Regulation 2 PCR adopts this definition verbatim, with the additional clarification that it includes central government authorities. Central government authorities are specified in Schedule 1, which includes the Department of Health, all NHS Trusts, and the NHS Business Services Authority.

2.4. In light of that definition, it is clear that the following are contracting authorities within the health sector for the purposes of the PCRs:

a) DH

b) NHS Commissioners: CCGs, NHS Commissioning Board and Local Authorities;

c) NHS Trusts;

d) NHS Foundation Trusts (insofar as they meet the definition of bodies governed by public law in Regulation 2)

2.5. NHS GP and dental practices would not be caught by the Regulations as they are not financed by the State, but rather are private for profit businesses. Nor would private providers of NHS services.

Public contracts

2.6. The Rules apply to all “public contracts”, of which there are 3 defined types: contracts for the execution of work, the supply of products, or the provision of services.⁹ A contract is only covered by the Public Contracts Directive if it is a contract for pecuniary interest (ie. the service provider gets paid under the contract). Issues can arise in the situations where goods or services are provided free to NHS bodies by the private sector, in the expectation of an increase in publicity (for example the free supply of particular clinical equipment). The test is not whether there is “consideration” in the common law sense, but rather where there is direct economic benefit to the provider: see the opinion of Advocate General Leger in *La Scala*, as applied by Forbes J in *R(on the application of Chandler) v Secretary of State for Children, Schools and Families* [2009] EWHC 219 (Admin).¹⁰

Contract thresholds

2.7. Article 4 of the The Public Contracts Directive sets out a set of thresholds for determining contracts are subject to the Directive, together with a number of expressly excluded categories of contracts.

2.8. The current thresholds which apply as from 1 January 2018 (which are revised every two years by the European Commission) are as follows:

Type of contract	Threshold from 1 Jan 2018
Supply and services contracts (central government)	£118,133
Supply and services contracts (non-central government)	£181,302
Works and subsidised works contracts	£4,551,413
Social and other services contracts falling within the "Light Touch Regime"	£615,278

⁹ Regulation 2 PCRs

¹⁰ See also the discussion in *Arrowsmith, The Law of Public and Utilities Procurement*, 3rd edition (2014) (Sweet & Maxwell) at 6.12 – 6.14.

- 2.9. Unless a specific exemption or derogation applies removing these contracts from outside the scope of the PCRs altogether,¹¹ the specific LTR regime referred to above in the Introduction applies to health services contracts above £615,278.
- 2.10. Contracts below the £615,278 threshold do not fall within the scope of the PCRs and so do not need to be advertised in the European Journal via an OJEU notice, nor is it likely that the general EU principles of equal treatment and non-discrimination apply to them (on the assumption that they would not attract cross-border interest). However, it is important to note that very similar (if not identical) principles apply by virtue of the NHS Procurement Regulations, and thus a CCG that breaches those principles runs the risk of being liable in damages to a bidder who was excluded in breach of the rules. This is discussed further in Section 3 below.

Excluded contracts, “in-house” exceptions and “public-to-public co-operation”.

- 2.11. There are a number of contracts that are excluded altogether from the scope of the Public Contracts Directive. These are set out at Articles 7 – 12 of the Directive. The following are the main exclusions relevant to health service contracts:
- a) Service contracts awarded on the basis of an exclusive right (Article 11);
 - b) Public contracts between entities within the public sector (Article 12)
 - c) Contracts subsidised by contracting authorities (Article 13)
 - d) Particular types of research and development services contracts (Article 14).
- 2.12. The section below focusses on the exceptions contained in Article 12 and 14.

¹¹ See for example the Regulation 32 derogations discussed below at Section 2.8.

2.13. Article 12 of the Public Procurement Directive codifies the previous CJEU case law that developed under the so-called the *Teckal* doctrine. In *Teckal*,¹² the European Court of Justice (“the ECJ”) established that under certain conditions the procurement rules do not apply to arrangements between a contracting authority and another public body, where that public body is closely controlled by the awarding entity (and therefore effectively “in-house”). They are incorporated by Regulations 12(1) to (3) of the PCRs.

2.14. For the exemption to apply, pursuant to Article 12(1) the following conditions have to be fulfilled (known as the control, activity and private participation conditions):

“(a) the contracting authority exercises over the legal person concerned a control which is similar to that which it exercises over its own departments;

(b) more than 80 % of the activities of the controlled legal person are carried out in the performance of tasks entrusted to it by the controlling contracting authority or by other legal persons controlled by that contracting authority; and

(c) there is no direct private capital participation in the controlled legal person with the exception of non-controlling and non-blocking forms of private capital participation required by national legislative provisions, in conformity with the Treaties, which do not exert a decisive influence on the controlled legal person”

2.15. Article 12(2) states that:

“a contracting authority shall be deemed to exercise over a legal person a control similar to that which it exercises over its own departments within the meaning of point (a) of the first subparagraph where it exercises a decisive influence over both strategic objectives and significant decisions of the controlled legal person. Such control may also be exercised by another legal person, which is itself controlled in the same way by the contracting authority.”

2.16. Article 12(3) creates an exemption for contracts awarded to jointly controlled public bodies, with similar exemptions to those specified in Article 12(2). These are incorporated into the PCRs at Regulations 12(4) – (6).

¹² Case C-107/98, *Teckal Srl v Commune di Viano* [1999] E.C.R I-8121

- 2.17. In the context of health care services, CCGs have powers under section 223 of the NHS Act to set up companies to provide health care services (although such powers are circumscribed by section 223A).¹³ In such circumstances, such a company could in principle satisfy the “in-house” requirements of Regulation 12. Whether or not such an “in-house” exemption is however removed by the operation of the NHS Procurement Regulations is discussed in Section 3 below.
- 2.18. Article 12(4) states that a contract concluded exclusively between two or more contracting authorities is excluded from the Directive where all of the following conditions are fulfilled:
- “(a) the contract establishes or implements a cooperation between the participating contracting authorities with the aim of ensuring that public services they have to perform are provided with a view to achieving objectives they have in common;
 - (b) the implementation of that cooperation is governed solely by considerations relating to the public interest; and
 - (c) the participating contracting authorities perform on the open market less than 20 % of the activities concerned by the cooperation”
- 2.19. This reflects the principle established by the ECJ in Case C-480/06 *Commission v Germany* (the *Hamburg* doctrine), to the effect that certain co-operative arrangements between two or more public bodies (so called “horizontal co-operation” or “public-to-public co-operation”) falls outside the Directive and TFEU principles. This is incorporated into domestic law by Regulation 12(7) of the PCRs.
- 2.20. CCGs and NHS England commission health care services but do not provide them, so it is difficult to see a situation arising whereby there could be co-operation between two or more commissioners for the provision of health care services, thus meeting the first of the requisite conditions for the public-to-public co-operation exemption.
- 2.21. However, two companies established under section 223 of the NHS Act could co-operate in this way and this could fall within the exception.¹⁴ But it is doubtful that

¹³ See the Chapters on the Powers and Duties of CCGs.

¹⁴ A view shared by the Procurement Law Association Working Paper at para. 4.23.

the condition set out at Article 12(4)(a) would be met if a contract between a commissioner and an NHS Trust were entered into, given the commissioner/provider split that was at the centre of the major NHS reforms introduced by 2012 Act and embodied in the NHS Procurement Regulations. However, it seems it would be possible for two NHS Trusts to pool resources with a view to providing a service to themselves and potentially to other Trusts and take advantage of this exception (whether the NHS Procurement Regulations affects that position is considered below in Section 4).

- 2.22. Article 14 is a general exclusion clause which excludes contracts for all research and development services, unless the two specified conditions are satisfied. It is an important exclusion which enables research services carried out by NHS bodies to be procured without the need to conduct procurement competitions that comply with the Directive or PCRs. It states the following:

“This Directive shall only apply to public service contracts for research and development services which are covered by CPV codes 73000000-2 to 73120000-9, 73300000-5, 73420000-2 and 73430000-5 provided that both of the following conditions are fulfilled:

(a) the benefits accrue exclusively to the contracting authority for its use in the conduct of its own affairs, and

(b) the service provided is wholly remunerated by the contracting authority”

- 2.23. The effect of the conditions is to exclude from the scope of the Directive the funding by a contracting authority of research whose aim is to develop products for the benefit of the market as a whole. As an exclusion clause, it is likely to be construed narrowly by the CJEU particularly in light of the Recitals to the Directive which seek to prevent contracting authorities taking advantage of this exclusion clause. Recital 35 of the 2014 Directive states that “*fictitious sharing of the results of the R & D*” will not be sufficient to trigger the exclusion and re-iterates that the exclusion will not apply if the contracting authority “*retains an exclusive right to use the outcome of the R & D in the conduct of its own affairs*”. On the face of it, the development of new clinical equipment and the conduct of clinical trials where the results of that research are published in the public interest and in order to improve patient care

should fall within this exclusion. NHS contracting authorities would however need to avoid the inclusion of clauses in any contract awarded to an outside body in which the public body retains the intellectual property rights in the outcome of the research.

- 2.24. Even where research is commissioned exclusively for the use of an NHS contracting authority in the conduct of its own affairs, so long as the remuneration for that service is partly paid for by a third party then the exclusion can still apply. However, again Recital 35 contains the warning that *“purely symbolic participation in the remuneration of the service provide should not prevent the application of this directive”*.

The procurement principles and key duties

- 2.25. There are a number of key legal rules that apply to any contracting authority when conducting a procurement competition that falls within the scope of the PCRs. These are summarised below.

- 2.26. The general rules are set out in Section 2 of Part 1 PCR. Regulation 18 sets out the “principles of procurement”. It states:

“(1) Contracting authorities shall treat economic operators equally and without discrimination and shall act in a transparent and proportionate manner.

(2) The design of the procurement shall not be made with the intention of excluding it from the scope of this Part or of artificially narrowing competition.

(3) For that purpose, competition shall be considered to be artificially narrowed where the design of the procurement is made with the intention of unduly favouring or disadvantaging certain economic operators”

- 2.27. Compliance with these general rules is the primary duty on all contracting authorities. Breaches of these general rules is most often relied on by a disappointed bidder challenging a procurement competition.

Confidentiality and conflicts of interest

- 2.28. In order to operate a fair procurement process, all bidders have to be treated equally within a procurement process. Part of that obligation involves ensuring that bids put in by individual bidders are kept confidential, or a later bidder would have an advantage over an earlier bidder. The maintenance of strict confidentiality of any bids submitted to a contracting authority is thus a key duty set out at Regulation 21 PCR.
- 2.29. Given the commercially sensitive nature of material included in any bid, difficult issues arise in court proceedings where a disappointed bidder wishes to challenge the award of the contract to a successful bidder. The court endeavours to balance the need for a fair trial with the need to maintain confidentiality by creating defined “confidentiality rings” to limit who is entitled to see confidential information from a challenged bidder and the scoring of the winning bid. The precise organisation of such arrangements will depend on the individual circumstances of a case but the court is astute to ensure that its proceedings are not used by disappointed bidders as a way of obtaining confidential information from their rivals for future commercial advantage.
- 2.30. Conflicts of interest are dealt with in Regulation 24, which requires contracting authorities to take appropriate measures to effectively prevent, identify and remedy any conflicts of interests arising in the conduct of the procurement competition. In the first case to consider an application to lift an automatic standstill under the 2015 PCRs, the High Court considered that the alleged breach of this Regulation was sufficiently serious to warrant a refusal to lift an automatic suspension in Counted4 Community Interest Company v Sunderland City Council[2015] EWHC 3898 (Ch). CCG commissioning in which GP practices are potential providers is a particularly high risk area in this respect.¹⁵ NHS England in June 2017 revised its guidance for

¹⁵ See the Chapter on CCG’s duties and powers for more detail on the specific provisions governing GPs involvement in CCG commissioning.

CCGs on managing conflicts of interest in light of the experience of CCGs since the 2014 reforms in dealing with this issue.¹⁶

The standard procurement competition procedures: an outline

- 2.31. Section 3 PCR sets out the competitive award procedures that apply to procurement competitions for contracts that fall within the PCRs. Regulation 21(1) makes it clear that compliance with such procedures is mandatory. It states: *“when awarding public contracts, contracting authorities shall apply procedures that conform to this Part.”*
- 2.32. Under the PCRs there are five procedures, with particular rules that apply to when and how such procedures can be used by a contracting authority. They are:
- a) The open procedure;
 - b) The restricted procedure;
 - c) The competitive dialogue procedure;
 - d) The negotiated procedure; and
 - e) An innovation partnership.
- 2.33. Contracting authorities must award contracts that fall within the scope of the PCRs using one of these specific competitive award procedures. The following is an outline of the features of the main procedures and when they can be used¹⁷. Detailed rules applying to the form of the requisite notices, the use of electronic communications to advertise contracts and receive bids, and time limits for the receipt of tenders, are

¹⁶ <https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-coi-guidance-jul-17.pdf>

¹⁷ Innovation partnerships are not discussed in detail for the purposes of this section.

set out in the Regulations but for the purposes of this Chapter are not discussed in detail.

The open procedure

2.34. The open procedure is the simplest form of the five procedures. It is generally used for reasonably straightforward contracting competitions for the supply of goods and services where the contracting authority has a clear idea of its requirements and the identity of the supplier is not critical: its defining feature is that any interested economic operator may submit a tender in response to a contract notice (Regulation 27(1)).¹⁸ Minimum time limits for the receipt of tenders are specified as 35 days (or, in cases where a prior information notice has been issued, 15 days).

The restricted procedure

2.35. The restricted procedure differs from the open procedure in that the contracting authority can limit the number of tenders it will consider, by only inviting tenders from some of those who have expressed an interest and have satisfied objectively justifiable conditions in order to enable the bidder to enter into the competition. Under this procedure, the same general requirement exists to advertise the contract so that all economic operators have an opportunity to be considered. This can either be done by a contract notice, or, in the case of sub-central government authorities, via a Prior Information Notice (“PIN”). The contracting authority can then select from those interested in bidding a limited number whom it then invites to tender. It does so by applying qualification criteria, the choice of which is also governed the PCRs. The contracting authority is required to use objective and non-discriminatory criteria in making this choice, which have been published in advance. It is also required to specify the minimum number of bidders who will be invited to bid for the contract.

¹⁸ The requirements of a contract notice are discussed further below

- 2.36. An invitation to tender (“ITT”) is then issued to those that have both qualified and been selected. The ITT will contain the procurement documents including the contract notice, the technical specifications which the authority requires the awarded contract to meet and information regarding the award criteria and their weightings.

The competitive dialogue procedure

- 2.37. This procedure was introduced in 2004 via the former Public Sector Directive (the predecessor to the Public Contracts Directive) in order to allow greater flexibility in how contracting authorities could carry out procurement competitions for more complex projects where the contracting authority has not yet finally decided on the particular design. It allows discussions with bidders over their proposed solution. That flexibility is designed to allow for the identification and development of solutions suited to what the contracting authority requires.

The negotiated procedure

- 2.38. There are two types of negotiated procedure under the 2014 Public Procurement Directive: the “*competitive procedure with negotiation*”, or the “*negotiated procedure without publication of a contract notice*”. Under the latter type, a contracting authority can proceed to negotiate with one or more bidders without any prior advertisement or need to conduct a competition at all. Under the Directive and the PCRs it can only be used in very limited circumstances set out below¹⁹, which essentially operate as derogations from the duty to advertise.
- 2.39. The grounds for use of the competitive procedure with negotiation are the same as those that apply to the use of the competitive dialogue procedure set out above. This procedure is very similar to the competitive dialogue procedure and indeed

¹⁹ See the Section below where the Regulation 32 derogations are discussed.

some have queried the rationale for retaining both procedures in the 2014 Directive.²⁰

The duty to advertise: contract notices, PINS and derogations from the duty to advertise

- 2.40. As referred to above, a fundamental requirement of a contract caught by the PCRs is the duty to advertise.
- 2.41. Pursuant to Regulation 26(2) PCR, a contract that falls within the scope of the Regulations can only be awarded if preceded by a “call for competition” (i.e an advertisement). This will usually be via the publication of a “Contract Notice” to inform potential bidders that the contracting authority is embarking on a procurement competition. In certain circumstances a call for competition can be achieved via the issue of a Prior Information Notice (a “PIN”). Both types of advertisement are described below. However, before those types of advertisement is addressed, a prior question arises, namely whether a derogation applies which removes the duty to advertise altogether.

The Regulation 32 Derogations

- 2.42. Regulation 32 provides that a negotiated procedure without notice may be used in a number of the following circumstances, the most relevant ones to health services contracts being:
- a) Regulation 32(2)(a): Where no tenders or no requests to participate (or no suitable tenders or no suitable requests to participate) have been submitted in response to an open procedure or restricted procedure, provided that the initial conditions of the contract are not substantially altered;

²⁰ Arrowsmith, para. 9-02.

b) Regulation 32(2)(b): Where the services can be supplied only by a particular economic operator for any of the following reasons:

(i) Competition is absent for technical reasons; or

(ii) The protection of exclusive rights, including intellectual property rights.

These exceptions only apply when no reasonable alternative or substitute exists and the absence of competition is not the result of an artificial narrowing down of the parameters of the procurement. It has been suggested that the exception at point (i) could apply for example where the facility is owned by an existing provider and the location location is specific and it does not make practical sense to expect bidders to provide a new building (for example A & E and associated trauma and Intensive Care Units)

c) Regulation 32(2)(c): insofar as is strictly necessary where, for reasons of extreme urgency brought about by events unforeseeable by the contracting authority, the time limits for the open or restricted procedures or competitive procedures with negotiation cannot be complied with. The extreme urgency must not be attributable to the contracting authority (Regulation 32(4)). This is a derogation that is likely to be relied on in the commissioning of health care services more than any other sector, for example to deal with a public health issue or where another provider suddenly fails.

d) Regulation 32(9) to (12): where a contracting authority wants to purchase new services which are a repetition of similar services entrusted to the economic operator by way of an original contract, provided that the services are in conformity with a basic project for which the original contract was awarded which was advertised. The basic project must indicate the extent of the possible additional services and the conditions under which they will be awarded.

- 2.43. It is important to note that the derogations above are likely to be interpreted strictly by the Courts and there is no indication in either EU or domestic case law that a more lenient approach applies specifically to the health care sector.

Contract Notices

- 2.44. Contracts awarded by the open procedure must be advertised by means of a “contract notice”. This is an important document: failure to advertise the contract correctly could potentially result in a declaration of ineffectiveness being granted by the Court.²¹ Regulation 49 states that contract notices shall contain the information set out in part C of Annex 5 to the Public Procurement Directive and shall be sent for publication in accordance with regulation 51. Regulation 51 requires contract notices to be sent to the EU Publications Office for advertisement in the Official Journal (hence contract notices are often referred to as OJEU notices).
- 2.45. Part C of Annex 5 specifies 30 separate items of information that contract notices must contain, including a description of the nature and extent of works, or the nature and quantity or value of supplies, nature and extent of services, and the estimated total order of magnitude of contract(s).
- 2.46. In addition to the contract notice itself, Regulation 53 PCR requires contracting authorities to provide electronic access to the relevant procurement documents. This is a package of documents that contains a copy of the draft contractual terms. It is described in Regulation 53 as the following:

“procurement document” means any document produced or referred to by the contracting authority to describe or determine elements of the procurement or the procedure, including the contract notice, the prior information notice where it is used as a means of calling for competition, the technical specifications, the descriptive document, proposed conditions of contract, formats for the presentation of documents by candidates and tenderers, information on generally applicable obligations and any additional documents”

²¹ See further below at Section 4.1.

Prior Information Notices

- 2.47. Regulation 26(9) PCR states that where the contract is awarded by restricted procedure or competitive procedure with negotiation, sub-central contracting authorities may make the call for competition by means of a PIN in accordance with regulation 48(5) to (7) PCR. This therefore allows greater flexibility in procurements carried out by NHS commissioners. As discussed below, under the LTR, a contract for health care services can be advertised using this method.
- 2.48. Pre-2015, a PIN was an optional notice giving general advance notice to the market of a contracting authority's intention to hold a procurement competition. It could in certain instances reduce the timescale for certain stages in the contract award procedure. Under the PCRs, the PIN can now be used as the call for competition itself. The PIN is required to contain the information specified in Regulation 48 PCR (which in turn refers to the information specified at section I of part B of Annex V to the Public Procurement Directive). A PIN can remain valid for 12 months (see Regulation 48(7) PCR).
- 2.49. Changes are made to the rules about the publication of contract notices/PINs by the LTR. The rules are in Regulation 75 PCR which provides:

“(1) Contracting authorities intending to award a public contract for the services referred to in regulation 74²² shall make known their intention by any of the following means:—

- (a) by means of a contract notice, which shall contain the information referred to in part H of Annex V to the Public Contracts Directive; or
- (b) by means of a prior information notice, which shall—
 - (i) be published continuously,
 - (ii) contain the information set out in part I of Annex V to the Public Contracts Directive,

²² Regulation 74 refers to “Public contracts for social and other specific services listed in Schedule 3”, which includes the CPV for health and social care services.

- (iii) refer specifically to the types of services that will be the subject-matter of the contracts to be awarded, and
- (iv) indicate that the contracts will be awarded without further publication and invite interested economic operators to express their interest in writing.

(2) Paragraph (1) shall not apply where a negotiated procedure without prior publication could have been used, in accordance with regulation 32, for the award of a public service contract.

(3) Contracting authorities that have awarded a public contract for the services referred to in regulation 74 shall make known the results of the procurement procedure by means of a contract award notice, which shall contain the information referred to in part J of Annex V to the Public Contracts Directive.

(4) Contracting authorities may group contract award notices on a quarterly basis, in which case they shall comply with paragraph (5) by sending the grouped notices within 30 days of the end of each quarter.

(5) Contracting authorities shall send the notices referred to in this regulation for publication in accordance with regulation 51

2.50. The above rules apply for publication of any NHS clinical services.

Material amendments to public contracts

2.51. A considerable body of ECJ case law had developed prior to the 2014 Directive as to whether a material amendment to a contract would constitute a fresh contract award requiring re-advertisement which has now been codified in the Article 72 of the Directive. Regulation 72 of the PCRs implements this and sets out a series of circumstances in which a contracting authority may make changes to a contract or framework agreement without triggering a fresh procurement.

2.52. Regulation 72 PCR applies to health services contracts which fall within the LTR and sets out the circumstances in which a contracting authority may make changes to a contract or framework agreement during its term, triggering a requirement to re-advertise and carry out a fresh procurement.²³ Those circumstances are set out in full below:

²³ Whether similar material amendments require a fresh procurement competition under the NHS Procurement Regulations is more problematic as those Regulations are silent on this issue: see Section 3 below.

(a) where the modifications, irrespective of their monetary value, have been provided for in the initial procurement documents in clear, precise and unequivocal review clauses, which may include price revision clauses or options, provided that such clauses—

(i) state the scope and nature of possible modifications or options as well as the conditions under which they may be used, and

(ii) do not provide for modifications or options that would alter the overall nature of the contract or the framework agreement;

b) for additional works, services or supplies by the original contractor that have become necessary and were not included in the initial procurement, where a change of contractor—

(i) cannot be made for economic or technical reasons such as requirements of interchangeability or interoperability with existing equipment, services or installations procured under the initial procurement, and

(ii) would cause significant inconvenience or substantial duplication of costs for the contracting authority, provided that any increase in price does not exceed 50% of the value of the original contract;

(c) where all of the following conditions are fulfilled:—

(i) the need for modification has been brought about by circumstances which a diligent contracting authority could not have foreseen;

(ii) the modification does not alter the overall nature of the contract;

(iii) any increase in price does not exceed 50% of the value of the original contract or framework agreement.

(d) where a new contractor replaces the one to which the contracting authority had initially awarded the contract as a consequence of—

(i) an unequivocal review clause or option in conformity with sub-paragraph (a), or

(ii) universal or partial succession into the position of the initial contractor, following corporate restructuring, including takeover, merger, acquisition or insolvency, of another economic operator that fulfils the criteria for qualitative selection initially established, provided that this does not entail other substantial modifications to the contract and is not aimed at circumventing the application of this Part;

(e) where the modifications, irrespective of their value, are not substantial within the meaning of paragraph (8); or (f) where paragraph (5) applies

Grounds for rejection of bids, exclusion of bidders and selection criteria

- 2.53. Before evaluating the bids themselves, contracting authorities can (and in certain instances should) reject tenders on certain grounds, including on the basis of the identity of the bidder. There are four main ways that this is permissible under the PCRs:
- a) First, there is a duty to exclude firms on certain mandatory disqualification grounds;
 - b) Second, under the open and restricted procedures, a contracting authority has a discretion to reject tenders from certain economic operators on specified grounds set out in the Directive relating to those firms' suitability, including in particular their economic and financial standing, professional or technical ability, professional honesty, solvency and reliability;
 - c) Third, authorities can (and in certain instances should) exclude tenders that fail the mandatory requirements laid down in the procurement documents; and
 - d) Fourth, contracting authorities should exclude all bids that are abnormally low.
- 2.54. Regulation 57 sets out a number of mandatory grounds for exclusion of a tender from a particular bidder. These include where a bidder has been convicted of certain criminal offences, primarily bribery, corruption, terrorism and money laundering offences, and where a bidder has been held liable for breaching its tax or social security obligations by an administrative tribunal or a court
- 2.55. Regulation 57(8) sets out the discretionary grounds on which a contracting authority may decide to reject a bid from a particular tenderer. The situations in which it can do so include where a company is bankrupt or in administration and persistent deficiencies in the performance of a prior contract.

- 2.56. Contracting authorities are also under a duty to investigate abnormally low tenders and have a discretion to reject tenders for which there is no satisfactory explanation for the low level of price offered (Regulation 69). However, there is no express duty to reject abnormally low tenders (in contrast to where there is non-compliance with certain social and environmental legislation).²⁴
- 2.57. Regulation 58 enables contracting authorities to impose selection criteria for economic operators to participate in a procurement competition. These criteria may relate to (a) the suitability to pursue a professional activity; (b) economic and financial standing; and (c) technical and professional ability.

Bid evaluation and application of award criteria

- 2.58. Following the submission of bids, in both the open and restricted procedures, the contracting authorities proceed directly to make their choices in accordance with objective evaluation criteria set out in the procurement documents.
- 2.59. Criteria can be set either on a pass/fail basis or a scored basis. In the case of the former, contracting authorities should be careful not to impose these criteria unless absolutely critical, given the lack of discretion to waive mandatory pass/fail criteria once bids have been submitted: In **T-40/01 Scan Office Design SA v European Commission** [2002] ECR II-5046 the European Court made it clear that there is no discretion for the contracting authority to disregard such a failure. It said:

"However, even if the contracting authority has a certain margin of discretion in the context of a negotiated procedure, it is always bound to ensure observance of the terms and conditions of the tender specifications, which they have freely chosen to make mandatory."

²⁴ See Arrowsmith para 7-268 for a fuller discussion as to the uncertainty as to whether there is a duty to reject abnormally low tenders.

2.60. The basic principle governing the award of a contract is that the contract must be awarded to the “most economically advantageous tender”: Article 67(2) of the Public Procurement Directive. Regulation 67 PCR reflects this. It clarifies that the most economically advantageous tender can be identified on the basis of price/cost and/or a price-quality ratio.

“(1) Contracting authorities shall base the award of public contracts on the most economically advantageous tender assessed from the point of view of the contracting authority.

(2) That tender shall be identified on the basis of the price or cost, using a cost-effectiveness approach, such as life-cycle costing in accordance with regulation 68, and may include the best price-quality ratio, which shall be assessed on the basis of criteria, such as qualitative, environmental and/or social aspects, linked to the subject-matter of the public contract in question.

2.61. It is expressly required by Regulation 67(9) PCR (and in any event is required to comply with the general principle of transparency) that contracting authorities disclose in the procurement documents the weightings to be given to the evaluation criteria.

2.62. It is a corollary of the requirement of transparency that award criteria must be clear, precise and unequivocal, so that a reasonably well informed and diligent tenderer can understand their exact significance and interpret them in the same way,²⁵ and, secondly, the contracting authority is able to ascertain whether the tenders submitted satisfy that criteria applying to the relevant contract: *Commission v the Netherlands* [2013] All ER (EC) 804, referred to by Coulson J in a succinct summary of the key principles in *Woods Building Services v Milton Keynes Council* [2015] EWHC 2011 (TCC) at [5] to [12].

²⁵ What is often referred to as the RWIND test: see for example *EnergySolutions EU Ltd v Nuclear Decommissioning Authority (No.2)* [2016] EWHC 1988 (TCC) at [151].

- 2.63. Problems can arise in the use of sub-criteria and their weightings. There is no obligation on a contracting authority to use sub-criteria. Nor, where a contracting authority does use sub-criteria, it seems is there any express requirement for weightings to be ascribed to those sub-criteria.²⁶ However, where an authority uses sub-criteria and weightings for those sub-criteria, even when there is no obligation to do so, both the sub-criteria and weightings ought to be disclosed when issuing the procurement documents: see the CJEU's judgment in Case C-532/06, Emm.G.Lianakis v Dimos Alexandroupolis [2008] ECR I-00251, at para.38.²⁷
- 2.64. Further problems arise where contracting authorities seek to change the award criteria after bids have been received. Whilst changes to criteria after bids have been opened is prohibited, subject to compliance with the principles of equal treatment and transparency, there is nothing to prevent changes prior to that stage. However, if the changes are material, a contracting authority may have to revert to an earlier stage in the process by allowing an opportunity for any other bidders to participate, if the changes are such that might lead a bidder to submit a bid in circumstances where previously it would not have wished to do so based on the published evaluation criteria.
- 2.65. The 2014 Public Contracts Directive sought to clarify some of the previous issues encountered with the 2004 Public Sector Directive regarding the use of performance criteria as award criteria (rather than as selection criteria deployed at the qualification stage). The CJEU in *Lianakis* had held that qualification and experience of staff were matters that could not be taken into account at the award stage (as opposed to the qualification stage). Article 67(2) of the 2014 Directive expressly provides that organisation, qualification and experience of staff can be relevant in applying award criteria.²⁸

²⁶ This is the view also taken in *Arrowsmith* 7-208

²⁷ This was applied by the High Court in *Letting International v London Borough of Newham* [2008] EWHC 1583

²⁸ See *Arrowsmith* 7-191 – 194 for a discussion on the general relationship between qualification/selection and award criteria.

- 2.66. When applying award criteria, the CJEU has stated that the Court should only interfere if there has been a serious and manifest error in the assessment. This was set out by Morgan J in *Lion Apparel Systems v Firebuy* [2007] EWHC 2179 (and most recently applied in *EnergySolutions EU Limited v Nuclear Decommissioning Authority* [2016] EWHC 1988 (TCC)) in the following terms:

“In relation to matters of judgment or assessment, the authority does have a margin of appreciation, so that the court should only disturb the authority’s decision where it has committed a manifest error. When referring to manifest error, the word manifest does not require any exaggerated description of obviousness. A case of manifest error is a case where an error has clearly been made” (at [37] – [38])”

The contract award decision and the standstill period.

- 2.67. Following the application of the criteria and selection of the winning bidder, in all 4 procedures, the next stage is the contract award decision and the publication of a notice about the award. This is an important document as its purpose is to explain to disappointed bidders the reasons why they were unsuccessful. It is also an important document as its service triggers what is known as the standstill period – i.e a specified period in which the awarded contract cannot be entered into (i.e signed). That in turn is significant because once a contract is entered into, the number of remedies open to an aggrieved bidder is limited. A contract award notice must contain the elements set out in Regulation 86 PCR which sets out the mandatory contents of such notices including the reasons that the successful bidder was appointed.
- 2.68. Although only limited amounts of information need to be provided, failure to include these mandatory elements could result in a contract being concluded in a breach of the standstill period, with serious consequences for the contracting parties since a breach of the standstill period can result in a declaration of ineffectiveness. This

remedy, and the others available to aggrieved bidders, is discussed further at Section 4 below.

3. THE LIGHT TOUCH REGIME FOR HEALTH SERVICES CONTRACTS

- 3.1. The procurement of health, social and certain other services is regulated by the so-called Light Touch Regime under articles 74 – 76 of the Public Sector Directive, which are implemented into domestic law by Regulations 74 – 77 of the PCRs. The Crown Commercial Service has published statutory guidance on the new LTR (last updated in October 2016) (“**the CCS Guidance**”).²⁹
- 3.2. The Light Touch Regime regulates the award of contracts with an estimated value in excess of the relevant financial threshold (€ 750,000). With effect from 1 January 2016, the sterling equivalent for the purposes of the threshold is £589, 148. The main obligations that arise under the LTR are set out in the sub-sections below.

Discretion to advertise by either a contract notice or PIN

- 3.3. The key obligation under the LTR is the duty to advertise the intention to award the contract in question, but a discretion is afforded as to the means of advertisement. Regulation 75 requires contracting authorities intending to award a public contract subject to the LTR to advertise in the Supplement to the Official Journal of the European Union, either by means of a contract notice or a PIN as a call for competition. That discretion to choose the means by which advertising is to take place is one of the key differences between the LTR and the standard procurement procedures in the PCRs (the existence of that discretion may affect the availability of the remedy of a declaration of ineffectiveness – this is discussed below in Section 5).

²⁹ See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/560272/Guidance_on_Light_Touch_Regime_-_Oct_16.pdf

- 3.4. By virtue of Regulation 105 PCRs there is no duty to publish an advertisement on Contracts Finder for health care services (although such a duty nonetheless arises under Regulation 4(2) of the NHS Procurement Regulations in any event).

Principles for awarding contracts subject to the LTR

- 3.5. Regulation 76 PCR contains a measure of flexibility for NHS contractors to take wider considerations into account when making contract awards for services where the LTR applies. In particular, by virtue of Regulation 76(7) contracting authorities are not obliged to follow any of the standard procedures that apply to fully regulated procurement competitions (described above in Section 2). However, whatever procedure adopted, contracting authorities must comply at a minimum with EU principles of transparency and equal treatment (Regulation 76(2)).³⁰

- 3.6. Regulation 76 provides:

“(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.

(3) In particular, where, in accordance with regulation 75, a contract notice or prior information notice has been published in relation to a given procurement, the contracting authority shall, except in the circumstances mentioned in paragraph (4), conduct the procurement, and award any resulting contract, in conformity with the information contained in the notice about—

- (a) conditions for participation,
- (b) time limits for contacting the contracting authority, and
- (c) the award procedure to be applied.

³⁰ As noted in the PLA Working Paper at para. 29, there is considerable case-law on the EU principles of transparency and equal treatment and this case-law continues to apply to procurements which are subject to the LTR. Contracting authorities should continue to have regard to the Commission’s interpretative communication on the Community law applicable to contract awards not or not fully subject to the provisions of the Public Procurement Directives.

(4) The contracting authority may, however, conduct the procurement, and award any resulting contract, in a way which is not in conformity with that information, but only if all the following conditions are met:—

- (a) the failure to conform does not, in the particular circumstances, amount to a breach of the principles of transparency and equal treatment of economic operators;
- (b) the contracting authority has, before proceeding in reliance on sub-paragraph (a)—
 - (i) given due consideration to the matter,
 - (ii) concluded that sub-paragraph (a) is applicable,
 - (iii) documented that conclusion and the reasons for it in accordance with regulation 84(7) and (8), and
 - (iv) informed the participants of the respects in which the contracting authority intends to proceed in a way which is not in conformity with the information contained in the notice.

(5) In paragraph (4)(b)(iv), “participants” means any economic operators which have responded to the notice and have not been informed by the contracting authority that they are no longer under consideration for the award of a contract within the scope of the procurement concerned.

(6) All time limits imposed on economic operators for the purposes of this regulation, whether for responding to a contract notice or taking any other steps in the relevant procedure, shall be reasonable and proportionate.

(7) Without prejudice to the generality of paragraph (1), and subject to the other requirements of this Chapter, contracting authorities may apply procedures for the purposes of this regulation which correspond (with or without variations) to procedures, techniques or other features provided for in Chapter 2, as well as procedures which do not.

(8) In relation to the award of contracts subject to this Section, contracting authorities may take into account any relevant considerations, including —

- (a) the need to ensure quality, continuity, accessibility, affordability, availability and comprehensiveness of the services;
- (b) the specific needs of different categories of users, including disadvantaged and vulnerable groups;
- (c) the involvement and empowerment of users; and
- (d) innovation”

- 3.7. There is no reported case law on the workings of the LTR. The CCS Guidance is short on specific examples as to how an NHS commissioner could use the “flexibilities” set out at Regulation 76(4) to run a lawful procurement process which nonetheless departs from the rules of the competition originally set out in the contract notice or PIN provided it has not breached the principles of transparency and/or equal treatment.
- 3.8. Regulation 76 appears to require NHS commissioners to design a procurement process which complies with the principles of transparency and equal treatment, but then permits the NHS commissioner to award the contract in a way that departs from its own advertised process if it is considered appropriate to do so having regard to the factors set out in Regulation 76(8), namely:
- a) the need to ensure quality, continuity, accessibility, affordability, availability and comprehensiveness of the services;
 - b) the specific needs of different categories of users, including disadvantaged and vulnerable groups;
 - c) the involvement and empowerment of users; and
 - d) innovation.
- 3.9. Before changing the rules of the competition, the NHS commissioner has to have given due consideration to the fact that the rules are being changed, decided that the NHS commissioner will still comply with the principles of transparency and equal treatment despite a change in the rules, documented that decision and informed the bidders and anyone else who responded to a contract notice that the rules are being changed.
- 3.10. Whilst this process provides a theoretical opportunity for NHS commissioners to make adaptations to the contract award procedures after the publication of the initial procurement process, it is far from straightforward and opens up an NHS commissioner

to the possibility of a challenge. Accordingly, any NHS commissioner who was considering using these “flexibilities” would be well advised to get expert legal assistance to guide the NHS commissioner through the amended process.

Standstill obligations under the LTR

3.11. Regulation 86(5) exempts contracting authorities from the “standard” standstill obligation (that applies to fully regulated procurements by virtue of Regulation 86 (and described above in Section 2)) where the contract can be awarded without prior publication of a contract notice. Some commentators consider that since LTR contracts can be advertised by a PIN rather than a contract notice, there is no obligation to adhere to a stand still period. The CCS Guidance holds that view and states that a standstill period may not strictly be required. The Guidance states that:

“The legal position is less clear under the new rules for the Light-Touch Regime (LTR). A standstill period may not strictly be required...But in the light of uncertainty, CCS suggests that contracting authorities will usually wish to send a standstill notice and observe the standstill period”.

3.12. However, the general view of procurement practitioners (which the author of this chapter shares) is that contracting authorities are nonetheless best advised to stand still before awarding contracts under the LTR and would expose themselves to a considerable risk of ineffectiveness claims and other legal challenges if they fail to do so.³¹

4. THE NHS PROCUREMENT REGULATIONS – SCOPE AND KEY DUTIES

4.1. As set out above, the LTR in the PCRs applies to health services contracts above EUR750,000. An additional set of regulations also apply to the procurement of all health care services for the purposes of the NHS³², regardless of value: the NHS

³¹ The Procurement Law Association Working Paper at para. 2.16 notes that ECJ case-law in the *Alcatel* and *Commission v Austria* decisions which required a standstill period was based on provisions of the Remedies Directive, which clearly apply to LTR procurements.

³² This includes NHS Contracts under section 9 of the 2006 Act.

(Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (“the NHS Procurement Regulations” or “NHSPR”). These apply to all “relevant bodies” which are defined in Regulation 1 as CCGs and the National Health Service Commissioning Board (i.e NHS England).

- 4.2. The NHSPR govern the “procuring” of health care services for the purposes of the NHS. Procuring services from an NHS Trust is certainly caught by the Regulations.³³ However, “procuring” is not defined in the Regulations, and no express provision is made for “in-house” procurement. The extent to which it captures “in-house” commissioning by CCGs (that would otherwise be permissible under the PCRs under the *Teckal*/in-house exemption discussed above in Section 2) is therefore unclear. In practice, this is only likely to be an issue were CCGs to make extensive use of their circumscribed powers under section 223 of the 2012 Act to form companies, and that does not seem to be the case to date.

The procurement objectives

- 4.3. Regulation 2 NHSPR sets out the objectives of an NHS procurement process. It states that:

“When procuring health care services for the purposes of the NHS (including taking a decision referred to in Regulation 7(2), a relevant body must act with a view to –

- (a) Securing the needs of the people who use the services,
- (b) Improving the quality of the services, and
- (c) Improving efficiency in the provision of the services,

³³ This is arguably one of the biggest changes from the situation prior to the 2012 NHS Reforms, when all intra-NHS procurement may have fallen within the *Teckal* exemption. For a more detailed discussion of this see the Procurement Law Association Working Paper at Section 4.

Including through the services being provided in an integrated way (including with other health care services, health-related services, or social care services).”

4.4. Regulation 3 NHSPR sets out further duties. Regulation 3(2) NHSPR requires the relevant body to act in a transparent and proportionate way, and to “treat providers equally and in a non-discriminatory way, including by not treating a provider, or type of provider, more favourably than any other provider, in particular on the basis of ownership”. These principles are (at least on the face of it) the same as the general duties that apply under EU law to any contracting authority.

4.5. However, subsection 3 adds a new duty regarding the selection of a provider that goes beyond the duty to select the most economically advantageous tender under the PCRs. Regulation 3(3) NHSPR states that:

“The relevant body must procure the services from one or more providers that –

- (a) Are the most capable of delivering the objective referred to in regulation 2 in relation to the services , and
- (b) Provide best value for money in doing so”

4.6. Regulation 3(4) NHSPR refers back to the procurement objective in Regulation 2 NHSPR to improve the quality of the services and efficiency in their provision. It states:

“(4) In acting with a view to improving quality and efficiency in the provision of the services the relevant body must consider appropriate means of making such improvements, including through—

- (a) the services being provided in a more integrated way (including with other health care services, health-related services, or social care services),
- (b) enabling providers to compete to provide the services, and
- (c) allowing patients a choice of provider of the services.

The need to conduct a procurement competition via a contract notice

4.7. The position is clear that for any procurements for health care services over £750,000, a full, OJEU-advertised competition for health services has to be carried out under the PCR.³⁴ It is therefore moot as to whether under the NHSPR a competition has to be carried out for those types of procurements.

4.8. However, the position is less clear for those contracts who fall below that PCR threshold but are nonetheless caught by the NHSPR. This is because there is no express requirement in the NHSPR for a competition to be carried out in all circumstances. Regulation 5 NHSPR introduces the confusion, because at least on its face it provides that the only situation in which a commissioner is entitled to dispense with a competition is where the services is capable of being delivered by just one provider. It states:

(1) A relevant body may award a new contract for the provision of health care services for the purposes of the NHS to a single provider without advertising an intention to seek offers from providers in relation to that contract where the relevant body is satisfied that the services to which the contract relates are capable of being provided only by that provider.

4.9. The position of the Government and of Monitor is that there is no absolute requirement to carry out a competition.

4.10. Monitor's Guidance accompanying the NHS Procurement Regulations ("the **2013 Guidance**") expressly refers to the absence of any requirement on NHS commissioners to run a competition, with the emphasis instead being repeatedly placed on the requirement to commission services in a manner which represents the best interests of patients (as set out in Regulation 2 NHSPR).³⁵ Monitor also refers to the fact that it has no power under the Regulations to force the running of any competition. It also

³⁴ Whether via a PIN or contract notice: see above in Section 2 regarding the discretionary advertisement reoptions under the PCR for LTR contracts.

³⁵ Monitor's Substantive Guidance on the Procurement, Patient Choice and Competition Regulations (September 2013), p. 38. The persuasive force of that Guidance has not been determined by the Courts. However, some commentators suggest that it would be afforded significant weight by the Court (by analogy with the approach the Court took in *R(QSRC) v NHS Commissioning Board and another* [2015] EWHC 3772). See the Procurement Law Association's Working Paper on NHS Procurement p.24 for a fuller discussion of this particular issue.

suggests that the decision as to whether or not to publish a contract notice is a matter for commissioners having regard to the various objectives set out in Regulation 3. It suggests there at least three circumstances in which it would be appropriate to procure without running a competition (in contrast to the single exception referred to in Regulation 5):

- Where there is only one provider that is capable of providing the services in question. In these circumstances, the Procurement, Patient Choice and Competition Regulations make it clear that a commissioner can award a contract to a single provider without publishing a contract notice.
- Where a commissioner carries out a detailed review of the provision of particular services in its local area in order to understand how those services can be improved and, as part of that review, identifies the most capable provider or providers of those services.
- Where the benefits of publishing a contract notice would be outweighed by the costs of doing so.

4.11. The Government has hitherto shared this interpretation of Regulation 5. In response to a published opinion by one of the authors of this Chapter on the (then draft) 2013 Regulations the Government stated that *“the regulations do not impose compulsory competitive tendering requirements on commissioners and expressly preclude Monitor from directing a commissioner to hold a competitive tender”*.³⁶ Its view was that the 2013 Regulations were not intended to change the position under the antecedents to the NHS Procurement Regulations, the procurement guidance entitled *“Principles and Rules for Cooperation and Competition” (PRCC)*. This view also manifested itself again the explanatory note to the NHSPR which were issued by the DH when the NHPR came into force.³⁷ The difficulty with this position is that the PRCC contained no provision similar to Regulation 5.

³⁶ The two opinions by David Lock QC and the single opinion of Ligia Osepciu were provided to the campaign group 38 degrees and are publicly available, as is the Government response dated March 2013.

³⁷ *“In Regulation 5, we have removed the words that inadvertently created the impression that there were only very narrow circumstances in which commissioners could award a contract without competition. Monitor’s guidance on the Regulations will make clear that we are continuing the same approach as now under the Principles and Rules for Co-operation and Competition”*.

- 4.12. It remains arguable that Regulation 5 should be read as specifying the only circumstance where a competition is not required.³⁸ This is consistent with Regulation 4 NHSPR which requires relevant bodies to publish contract notices on the NHS procurement website.³⁹ It states “where advertising an intention to seek offers from providers in relation to a new contract for the provision of health care services for the purposes of the NHS, a relevant body must publish a contract notice on the website maintained by the Board under paragraph (1)”. Such a reading is also consistent with the general position under EU procurement law, whose principles manifest themselves in (even if not directly incorporated by) Regulation 3(2) of the NHSPR.⁴⁰
- 4.13. Whatever the correct legal position (which has yet to be considered by the Courts), the course of action which contains the least risk seems to be for a CCG or NHS England, when carrying out procurements for health services contracts, to publish a contract notice on both the NHS website and, where the services are above the LTR threshold set out in the PCRs, in the Official Journal of European Union (via the European Commission Publishing Agency).

Modification of health services contracts during their term

- 4.14. The question as to whether amendments to contracts not caught by the LTR regime are permissible absent a fresh procurement competition is unclear. The NHS Procurement Regulations make no reference to the circumstances in Regulation 72 of the PCRs under which material amendments are permissible under that regime. Regulation 5(2) of the NHSPR states that:

(2) For the purposes of paragraph (1), a relevant body is not to be treated as having awarded a new contract –

³⁸ There is a very useful and detailed analysis of both views by the Procurement Law Association in Section 3 of its Working Paper

³⁹ <http://www.supplying2nhs.org/>.

⁴⁰ See the Procurement Law Association Working Paper for a fuller analysis as to the significance of the use of EU terminology in the domestic NHS Procurement Regulations.

- (a) where the rights and liabilities under a contract have been transferred to the relevant body from the Secretary of State, a Strategic Health Authority or a Primary Care Trust; or
- (b) where there is a change in the terms and conditions of a contract as a result of—
 - (i) a change in the terms and conditions drafted by the Board under regulation 17 of the 2012 Regulations (terms and conditions to be drafted by the Board for inclusion in commissioning contracts), or
 - (ii) new terms and conditions drafted by the Board under that regulation.

Criteria to determine any qualified provider lists

- 4.15. Further complexities arise in the case of competitions for inclusion on any qualified provider (“**AQP**”) lists. The Chapter on Acute Contracting explains that any provider holding an NHS Standard Contract is required to accept a clinically appropriate referral from any NHS commissioner, even if that provider does not have a contract with that commissioner. Accordingly, any provider which holds an NHS Standard Contract is entitled to treat NHS patients and to be paid for treating such patients, without setting up a network of contracts with different NHS commissioners.
- 4.16. Regulation 7 NHSPR sets up rules for the application of transparent, proportionate and non-discriminatory criteria to determine which providers should qualify to be included on a list from which a patient is offered a choice of provider. There is a key distinction drawn in Regulation 7(2) between lists of providers in respect of first outpatient appointments with a consultant (or member of a consultant’s team), and other providers. Under this Regulation, in respect of the former type of list, a relevant body has to include a provider on a list if that provider meets the criteria established by the relevant body. In respect of other lists, Regulation 7(4) appears to afford a discretion not to include a provider where that would mean exceeding a limit set by the relevant body on the number of providers to be included on the list. A similar discretion applies when determining which providers to enter a framework agreement with and selecting providers to bid for potential future contracts to provide health care services for the purposes of the NHS (Regulation 7(5) and (6)).

- 4.17. Regulation 7 is arguably inconsistent with the operation of Regulation 39 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 in so far as it suggests that NHS commissioners have the right to limit the types of provider to which an NHS patient can be referred for a first outpatient appointment. There is no such limitation in Regulation 39. Accordingly, pursuant to that Regulation, the choice of “clinically appropriate health service provider” is a matter for the referring GP and not an NHS commissioner. The only criteria is that the provider must have a commissioning contract with an NHS commissioner (although this does not have to be an NHS Standard Contract). The inconsistency between the two sets of Regulations has yet to be considered by the Courts.

Anti-competitive behaviour

- 4.18. Various other more minor duties are also imposed by the rest of the Regulations, including in relation to the maintenance of a record of contracts awarded (Regulation 3(5) and Regulation 9). However, a more significant duty appears at Regulation 10 which provides:

(1) When commissioning health care services for the purposes of the NHS, a relevant body must not engage in anti-competitive behaviour, unless to do so is in the interests of people who use health care services for the purposes of the NHS which may include—

(a) by the services being provided in an integrated way (including with other health care services, health-related services, or social care services); or

(b) by co-operation between the persons who provide the services in order to improve the quality of the services.

(2) An arrangement for the provision of health care services for the purposes of the NHS must not include any term or condition restricting competition which is not necessary for the attainment of—

(a) intended outcomes which are beneficial for people who use such services; or

(b) the objective referred to in regulation 2”

4.19. The purpose of this Regulation appears to be to permit an NHS commissioner to engage in contracting behaviour which, objectively considered, is “anti-competitive” if the behaviour is focussed on providing health and social care services in a joined up way or in promoting co-operation between people who provide health and/or social care services in order to improve the quality of the services.

4.20. Anti-competitive was defined in section 64(2) of the 2012 as follows: “anti-competitive behaviour” means behaviour which would (or would be likely to prevent, restrict or distort competition”. Section 62(3) of the Act provides that “*Monitor must exercise its functions with a view to preventing anti-competitive behaviour in the provision of health care services for the purposes of the NHS which is against the interests of people who use such services*”. The extent to which the permissive approach to anti-competitive behaviour as set out in Regulation 10 is *intra vires* the 2012 Act has not been tested in the Courts.

Patient choice

4.21. Regulation 11 NHSPR requires the Board not to restrict the ability of a person to apply for inclusion in the list of patients of a practice providing primary medical services, or to express a preference to receive such services from a particular medical practitioner or class of medical practitioner.

- 4.22. Regulation 12 NHSPR places a requirement on relevant bodies to offer a choice of alternative provider in accordance with Regulation 48(4) of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, in the circumstances laid down in regulation 47 of the 2012 Regulations. These rules apply where NHS patients have not been treated during the maximum waiting times prescribed under Part 9 of those Regulations. Such patients have a right to choose an alternative provider who will be able to provide them with treatment within a reasonable time.

5. REMEDIES AND CHALLENGING AN NHS PROCUREMENT DECISION

- 5.1. This section is divided into three main parts. It first considers the main substantive remedies under the PCRs and the NHSPR respectively (in particular declarations of ineffectiveness, damages and complaints to Monitor). It then considers the automatic suspension (in itself a type of remedy) and gives an outline of the main principles that the Courts apply when asked to lift such a suspension.

Remedies under the PCRs

- 5.2. The remedies available under the PCRs differ, depending on whether or not the contract has been entered into. The remedies outlined below only apply to above threshold procurements. Unless there is a sufficient cross-border interest, there are no remedies for below threshold procurements.⁴¹
- 5.3. If the contract has not been entered into, Regulation 97(2) PCR states that the Court may

“(a) order the setting aside of the decision or action concerned;

⁴¹ See Mansfield DC v Secretary of State for Communities and Local Government [2014] EWHC 2617 for the approach the Court takes in the event of a failure to consider whether there is a potential cross-border interest for below threshold procurements and whether that amounts to a breach of general TFEU principles. A challenge based on such principles would in principle be actionable by way of judicial review, Article 358 infraction proceedings and/or possibly a tortious claim for breach of statutory duty under the European Communities Act 1978, with a 6 year limitation period: see A G Quidnet Hounslow LLP v Mayor and Burgesses of London Borough of Hounslow [2012] EWHC 2639.

- (b) order the contracting authority to amend any document;
- (c) award damages to an economic operator which has suffered loss or damage as a consequence of the breach”

5.4. Where a contract has already been entered into, pursuant to Regulation 98 the Court:

“(a) must, if it is satisfied that any of the grounds for ineffectiveness applies, make a declaration of ineffectiveness in respect of the contract unless regulation 100 requires the Court not to do so;

(b) must, where required by regulation 102, impose penalties in accordance with that regulation;

(c) may award damages to an economic operator which has suffered loss or damage as a consequence of the breach, regardless of whether the Court also acts as described in subparagraphs (a) and (b);

(d) must not order any other remedies”

5.5. The remedy of damages is a significant tool for an aggrieved bidder and one that can present a serious risk to contracting authorities. The Supreme Court has confirmed for an award of damages to be met, the breach has to be sufficiently serious and there must be a direct causal link between the breach of the obligation and the damage sustained by the injured party.⁴² Nuclear Decommissioning Authority v Energysolutions EU Limited (now called ATK Energy EU Ltd) [2017] UKSC 34 at [39].

5.6. The penalties that can accompany a declaration of ineffectiveness are set out at Regulation 102, which provides that where a Court makes a declaration of ineffectiveness, the Court must also order that the contracting authority pay a civil financial penalty of the amount specified in the order.

5.7. Where it does not make a declaration of ineffectiveness in the exercise of its discretion, or where there has been a breach of the standstill period or contract advertising requirements but no declaration has been sought, the Court is under a duty to order at least one, and may order both, of the following penalties: (a) that

⁴² I.e the so-called *Francovich* conditions deriving from the European Court of Justice's decisions in Francovich v Italian Republic (Joined Cases C-6/90 and C-9/90) [1991] ECR I-5357

the duration of the contract be shortened to the extent specified in the order; (b) that the contracting authority pay a civil financial penalty of the amount specified in the order (Regulation 102(2) and (3)). When the Court is considering what order to make under paragraph (1) or (3), the overriding consideration is that the “penalties must be effective, proportionate and dissuasive”.

5.8. The grounds of ineffectiveness are set out in Regulation 99 and in summary are as follows:

- a) Where there has been a failure to advertise the contract via a contract notice (unless a voluntary transparency notice has been served);
- b) A breach of the standstill period or an automatic suspension; or
- c) In the case of a framework agreement, a failure to carry out any call-off competition in accordance with the terms of the framework agreement.

5.9. It is important to note that it is arguable that the remedy of a declaration of ineffectiveness are unlikely to apply to procurements for healthcare services, because by virtue of falling with the LTR there is no obligation to advertise the contract via a contract notice (there is a choice as to whether to do so or via a PIN). Nor is there an obligation to adhere to a standstill period. Nonetheless the CCS Guidance on the LTR Regime and the Standstill Period suggests that it is advisable for standstills to be run. Failure to carry out such a standstill would give rise to potential breaches of equal treatment and transparency, and any decision not to do would have to be carefully reasoned and documented.

Remedies under the NHS Procurement Regulations

5.10. Unlike the PCRs which can only be enforced by the Court, Monitor (now NHS Improvement) is also given enforcement powers under the NHSPR. In addition to its investigative powers under Regulation 13, Monitor has the power to declare an

arrangement for the provision of health care services for the purposes of the NHS ineffective, where it is satisfied that a breach of the primary duties outlined above has occurred.⁴³ It also has to be satisfied that the breach is “sufficiently serious” (Regulation 14(2)). Monitor also has powers to direct a relevant body to put in place measures in order to prevent failures to comply with the Regulations and to mitigate the effect of such failures. It also a power to vary or withdraw an invitation to tender for the provision of health care services (Regulation 15(1)).

- 5.11. The second part of the 2013 Guidance issued by Monitor pursuant to section 78 of the 2012 Act deals with its approach to enforcement. The Guidance states that Monitor expects to follow the interpretation of the regulations set out in the guidance when exercising its enforcement powers under the Regulations (although acknowledging that the Regulations and the 2012 Act ultimately are the statement of law and not the guidance).

Investigations by Monitor

- 5.12. According to its website, Monitor to date has only commenced 5 investigations into complaints alleging a breach of the NHS Procurement Regulations. The timetables issued by Monitor suggest generally an anticipated timeframe of less than 18 months to publish decisions following complaints, although as the guidance notes there is no specified timeframe for investigations into complaints to be concluded. Of the 5 investigations commenced, 2 were closed without any formal findings, one held that there were no breach of the Regulations, and two of the investigations were concluded upon the acceptance of undertakings from the commissioners concerned. Therefore there is no example yet of Monitor having to make any declaration of ineffectiveness.

⁴³ Specifically, regulation 2, 3(1) to (4), 4(2) and (3), 5 to 8 or 10(1).

Parallel proceedings

- 5.13. Part of the reason why Monitor has commenced relatively few investigations may be the reluctance of those outside the NHS to trust one NHS body to adjudicate (and possibly award damages against) another NHS body. Section 76(7) of the Health and Social Care Act 2012 (“**the 2012 Act**”) provides:

“A failure to comply with a requirement imposed by regulations under section 75 which causes loss or damage is actionable, except in so far as the regulations restrict the right to bring such an action”

- 5.14. Regulation 17 NHSPR provides that a person who brings an action under the PCR for loss or damage cannot bring a parallel legal action under section 76(7) of the 2012 Act. However, there are no other restrictions in the NHSPR which limit the right of claimants to sue NHS commissioners for breaches of the duties set out in the NHSPR. Accordingly, a bidder who is wrongly denied a contract to which the NHSPR applies has the right to sue the NHS commissioner for damages in the High Court. A bidder would also have the right to bring a challenge by way of judicial review for a breach of the PCRs. It is doubtful that a complaint to Monitor is a sufficient alternative remedy which would preclude a High Court entertaining a claim for judicial review, not least given the discretion by Monitor as to which investigations it considers appropriate to investigate and indeed the time taken for such investigations to conclude.

Lifting an automatic suspension

- 5.15. Where a contract has not yet been entered into, the issue of a claim form has the effect of automatically suspending the power of the contracting authority to enter into that contract. In such instances, if the contracting authority wishes to proceed to conclude the contract, it has to apply to lift the suspension.

- 5.16. When considering whether or not to lift the suspension the Court applies the *American Cyanamid* tests that apply to standard interim injunctions, namely:
- a) Is there a serious issue to be tried?
 - b) If there is, are damages nonetheless an adequate remedy?
 - c) If damages are not an adequate remedy, where does the balance of convenience lie?
- 5.17. The application of those tests is very fact dependent. However, the cases to date suggest that where the contract in issue is designed to improve patient services and would save an NHS body a considerable amount in financial terms, in practice it will be hard to argue successfully that an automatic suspension should continue. This is because the Court, when assessing where the public interest lies, is likely to take into account and attach significant weight to “*the public interest in the NHS providing the best possible service to the public without disruption and with minimal risk to its patients*” (per Coulson J in *Systemex (UK) Limited v Imperial Colleague Healthcare NHS Trust* [2017] EWHC 1824 (TCC) at [98]).
- 5.18. Some detailed observations as to how the High Court has applied the 3 tests generally and in an NHS context are considered below.

Serious issue to be tried

- 5.19. In considering the first of three tests set out above, once it is accepted that there is a serious issue to be tried then (save in exceptional circumstances where one side has some kind of simple ‘knock-out point’) it is not appropriate as a matter of principle to invite the court to conduct a mini-trial or to ask the court to endeavour to reach any conclusions as to the strength or weakness of one or both sides’ case: *Systemex (UK) Limited v Imperial Colleague Healthcare NHS Trust* [2017] EWHC 1824

(TCC) at [21],⁴⁴ applying *Kent Community Health NHS Foundation Trust v NHS Swale Clinical Commissioning Group and Another* [2016] EWHC 1392 (TCC).

Adequacy of damages

5.20. When considering whether damages are an adequate remedy, the following two general principles identified in *Covanta Energy Ltd v Merseyside Waste Disposal Authority* [2013] EWHC 2922 (TCC) apply:

- a) If damages are an adequate remedy, that will normally be sufficient to defeat an application for an interim injunction, but that will not always be so;
- b) The simple concept of the adequacy of damages has been modified at least to a certain extent, so that the court must assess whether it is just, in all the circumstances, that the claimant be confined to his remedy in damages.

5.21. Again, the outcome of the application of this test is highly fact dependent. For example, the loss of a particularly prestigious contract or the potential for damage to the unsuccessful tenderer's reputation has in certain cases been identified by the courts as being incapable of compensation in damages (see for example *NATS (Services) Limited v Gatwick Airport Limited and Another* [2014] EWHC 3133 (TCC) at [72]). The assessment of the risk of damage to reputation is a particularly fact sensitive question and depends on the strength of the evidence adduced to establish that risk.

5.22. Some NHS bodies who have brought proceedings as the claimants in a procurement challenge have sought to argue that the mere fact that the NHS body is a not for profit organisation or is a public body which exists solely to provide patient services means that damages would be an inadequate remedy. This argument was dismissed by the High Court in the *Kent Community* case referred to above. The Court rejected

⁴⁴ *Sysmex (UK) Limited* was challenging the award of a managed services contract in respect of pathology services, and was ultimately unsuccessful in arguing that the automatic suspension should be continued.

the submission that damages should be regarded as an inadequate remedy simply because the claimant, whether as a not-for-profit organisation or for other reasons, has not suffered and will not suffer substantial financial loss (at [17]). The Court also observed that the mere fact that the Claimant was a public body that exists for the sole purpose of providing NHS healthcare services to its patients in itself was not determinative of the question, as to hold otherwise would undermine the purpose of the procurement and commissioning regime within the NHS, namely to allow procurement of services from private bodies. The Court said:

“As the organisational structures of the NHS and the existence of the regime which permits procurement of services from other types of body or organisation makes clear, this cannot and does not give the Trust a monopoly or the right to primacy or priority in the context of NHS procurement. Nor does it determine whether or not damages would be an adequate remedy. (at [19(i)])”

Balance of convenience and the public interest

- 5.23. The public interest in the lawful conduct of public procurement competitions has been acknowledged by the courts as a relevant factor when considering the third test (the balance of convenience). However, a counter-balance to that public interest is the delay before a case reaches trial, where, for example, upholding an automatic suspension would prevent the efficient and timely introduction of arrangements which CCGs consider to be in the best interest of people within the CCGs' area: *Kent Community Health NHS Foundation Trust v NHS Swale Clinical Commissioning Group and Another* [2016] EWHC 1392 (TCC) at [26]. Where a challenge is brought by an NHS body against a procurement decision taken by a CCG, and both parties take diametrically different views on what is in the public interest, the Court is unlikely to take public interest arguments into account as a significant weight on one side or another (*ibid*).

5.24. The impact of continuing the suspension on the quality of care is a highly material factor in assessing where the balance of convenience lies, and in practice will mean that in most cases where the purpose of the contract being tendered is to improve health services, it is likely that an automatic suspension will be lifted. The court in *Systemex* said:

“where there is credible evidence that patient care will suffer if the suspension is not lifted, it will usually be the case that the least risk of injustice will favour the lifting of the suspension.” (at [72]).

It also held that the costs savings that could be made, if those can be shown to have effect on a Trust’s ability to meet its financial targets (and therefore risk an NHS intervention in the Trust), also are a material factor.

Time limits to bring an NHS procurement challenge

5.25. Different considerations apply depending on whether or not what is pursued is a claim for a breach of the PCRs (normally heard in the Technology and Construction Court), and/or a claim for breach of the NHSPR, or a claim by way of judicial review (heard in the Administrative Court).

5.26. Situations can arise where a challenge is brought both to a commissioning decision under the 2012 Act and a procurement decision under the PCRs. In such instances a claim for judicial review may well be the most appropriate mechanism to bring such a challenge. However, in such instances, care must be taken to ensure that the much shorter time periods for filing such a claim (compared to the standard deadline for filing a judicial review) set out in the specific rule under CPR54.5(6) are observed.⁴⁵

5.27. In certain cases, a claim can also be brought by a person who is not an economic operator as a third party by way of judicial review against procurement decisions. The circumstances in which they would have standing are limited but in an NHS

⁴⁵ This is discussed further below.

context such challenges may be easier to bring particular if a breach of the NHS Procurement Regulations is alleged.⁴⁶

Breach of the PCRs

- 5.28. A breach of the obligations under the PCRs by virtue of Regulation 91 is actionable by any economic operator which, in consequence, suffers, or risks suffering, loss or damage.
- 5.29. Proceedings have to be commenced in the High Court (Regulation 92). The Technology and Construction Court hears claims brought under the PCRs (although not necessarily judicial reviews in which procurement issues form some or all of the grounds of claim, which should still be filed in the Administrative Court).
- 5.30. Strict time limits apply, which in turn depend on the remedy sought and grounds alleged:
- a) **Where a declaration of ineffectiveness is not sought.** Pursuant to Regulation 92 PCR, proceedings must be started within “*within 30 days beginning with the date when the economic operator first knew or ought to have known that grounds for starting the proceedings had arisen*”. The court has a discretion to extend time up to a maximum of 3 months. If, having filed a claim, a claimant identifies fresh grounds of challenge, the Court can allow an extension of time to amend a pre-existing claim, although the better and safer course of action would be to file a fresh claim within 30 days and have them consolidated: see for instance the approach the Court took in *Perinatal Institute v Healthcare Quality Improvement Partnership* [2017] EWHC 1867 (TCC). The Court noted in that case that the Regulations do not in terms impose a particularly onerous test to grant an extension of time and that the test was framed in terms of “good reason” not exceptional circumstances;

⁴⁶ The High Court considered the standing of third parties to bring procurement challenges in *Wylde and others v Waverley Borough Council* [2017] EWHC 466 (the High Court judgment was handed down on 17 March 2017 and is under appeal to the Court of Appeal).

- b) **Where a declaration of ineffectiveness is sought.** A claim must be filed within 30 days of the contract award notice or notification that a contract has been concluded, or, in cases where no such notice or notification has been made, within 6 months.

5.31. Particular care needs to be taken in respect of potential breaches PCR identified by a claimant during a public procurement competition. If there is a challenge to the legality of the tender documents, then the challenger must commence proceedings within 30 days of the issue of those documents. The challenger's cause of action accrues when the defective tender documentation is published, not when a contract is awarded on the basis of that unlawful documentation: see *Jobsin Co UK PLC v Department of Health* [2001] EWCA Civ. 1241. The safest course of action if grounds for claim have been identified in the course of a competition would be to file proceedings before any contract award decision has been made, seeking either expedition of the hearing or a stay of the proceedings until after the contract award decision. The High Court in *Joseph Gleave and Son Limited v Secretary of State of Defence* [2017] EWHC 238 (TCC) confirmed that there is no presumption of an expedited trial if a claim is made during a competition (rather than after the contract award decision).

Breach of the NHS Procurement Regulations

5.32. There is no time limit specified in the NHS Procurement Regulations to make a complaint to Monitor or to commence an action for damages in the High Court. Damages could be claimed for breach of a statutory duty and the primary time limit of 6 years in section 9 of the Limitation Act 1980 appears to apply to such a claim. A claim for judicial review is also possible, for instance seeking a declaration or to quash a decision to award a contract.

5.33. The usual rule under CPR54 is that such a claim must be brought promptly and in any event within 3 months. However, care must be taken to ascertain whether or not the

decision is also “governed by” the PCRs, because if so a much shorter time period (potentially as short as 30 days) may apply.

- 5.34. This is because CPR54.5(6) imposes a similar deadline to a claim brought for a breach PCR. That rule states that:

“where the application for judicial review relates to a decision governed by the Public Contracts Regulations 2015, the claim form must be filed within the time within which an economic operator would have been required by regulation 92(2) of those Regulations (and disregarding the rest of that regulation) to start any proceedings under those Regulations in respect of that decision”.

- 5.35. Regulation 92(2) specifies a 30 day time limit. The test is whether the decision is “governed by” the PCRs not whether the grounds alleged are for a breach of those Regulations. Nor is it sufficient to show that the decision may be affected by the PCRs: see *R. (on the application of QSRC Ltd) v NHS Commissioning Board (NHS England)* [2015] EWHC 3752 (Admin) (in this particular case the Court held that the decision was not governed by the PCRs).⁴⁷

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29 January 2017

⁴⁷ At [115].