

# Foundation Trust Network

## **FTN Response to Co-operation and Competition Panel Consultation Draft Interim Guidelines on Procurement Dispute Appeals**

### **I. General Comments on the Correspondence between the Guidelines and the Co-operation and Competition Rules**

We appreciate that there is an absence of policy in relation to market definitions, and that the Panel is not in the business of setting policy. We also recognise that there is no definition of the use of the term “Co-operation” within the Co-operation and Competition Rules, whereas there is a body of literature and case law that surrounds competition. However, we believe that there are a range of areas in which the Panel could (and should) provide guidance to clarify the approach it will be taking in relation to both commissioning tendering decisions and co-operation- as one of the key principles within the rules themselves - within the market.

We understand that in the absence of such definitions, the Panel’s remit for clarifying the meaning of co-operation and competition will be through the application of the proposed benefits to patients’ test. The assessment of decisions by commissioners regarding whether or not to pursue a co-operative or competitive path in tendering decisions also needs to include an assessment of the likely risks and costs associated with decisions and their impact and the Panel needs to ensure that the guidelines make it clear that these factors will be taken into account.

Examples of issues that may arise includes where GP practice-based commissioning groups signs up with independent/private sector companies to help them bid for work – foundation trusts have cited examples where what such a partnership provides is only part of a service, not a comprehensive package such as that already provided by the incumbent provider – but is being seen as an attractive option by commissioners. In this situation, issues include the impact on continuity of care and Choice - how will patients be able to distinguish between a comprehensive service and a partial service and how will Choice be governed - will patients have any real choice?

Clearer guidance is required from the Panel in relation to the need for Chinese walls, particularly in relation to the transforming community services agenda, collaborative service specification development between commissioners and providers, where commissioners (including GPs under practice-based commissioning) seek to commission from themselves and in relation to the provision of financial incentives corresponding to referral patterns, whether this is by commissioners or providers.

We outline below the critical issues in brief and make a more detailed comment under the relevant questions below.

#### **I.1 Getting the Right Balance between Co-operation and Competition**

There is a key issue about the structuring of the guidelines between the twin principles of Co-operation and Competition. As the guidance currently stands foundation trusts believe that one principle (Co-operation) has been subordinated to another (Competition) and that this will ultimately distort the nature of the market as envisaged through the rules. The balance between them needs to be restored. If there were such

balance it ought to be possible to bring a complaint about breaching co-operation rules. This does not seem currently to be the case.

FTN believes that there should be a section in the final document about the rationale and policies for promoting co-operation – as set out in the Duties in the Health Act 1999 (NHS) and 2003 (for FTs). This could cover the drive for clinical networks, integrated care pilots, AHSCs and HIECs and should tackle the issue of ‘natural monopolies’ and economies of scope.

In addition there is a description of the rationale and policies for promoting competition but there is nothing about the risks of competition and market failures as established in economic literature. System managers and regulators should focus on preventing market failures as well as ensuring fair conduct. It should be within the scope of the competition Panel to consider whether market managers have taken the risks of competition into account when they make decisions. The Panel could make clear in the guidelines its commitment to take such risk into account when it considers referrals.

In addition the Panel has to be sensitive to the fact that unless the balance between the twin principles is perceived to be the basis upon which judgements about conduct in the market will be determined there is a great risk of increasing risk aversion and defensive behaviours on the part of all players.

For more detail on this issue see the answers to questions 9 and 14 below.

## **1.2 The Critical Goal is Competition on Quality not Price**

The fundamental principle of the reform of the health Service, given greater expression and emphasis by Lord Darzi in the Next Stage Review is that in the NHS competition will be on the basis of quality- not price. The guidance must be careful to ensure that the emphasis is on quality, not price, as the purpose of having a rules based national tariff is to underpin the key policy objective of quality, not price as the developmental principle of the NHS as well as to create a fair remuneration system based upon detailed understanding of clinical activity. This has been further strengthened by CQUIN and other schemes for rewarding quality improvement, as well as being recognised as central within the Standard Contracts. In addition, a new regulatory authority, the Care Quality Commission has been set up to underpin the other drivers, Quality Accounts are about to be introduced through legislation and a National Quality Board is being set up to co-ordinate and make sense of these various drivers.

The emphasis seems to be on cost reduction, and innovation, which is said to drive quality improvements. Whilst innovation might drive such quality improvement, cost reduction is a separate issue, and may drive down standards. Foundation trusts understand that price will be a factor in some procurements and tender decision making, but will be very concerned if the emphasis of the Competition Panel guidelines suggests that the prime benefit of competition rests on price, rather than quality improvement. This is one area where there is clear public policy in relation to the impact of competition and the FTN believes this could be clarified in the guidance. Currently the way in which this section is written in the document seems to be fundamentally at odds with what the system is meant to be delivering.

In Table 2 we note that the rules in section 7, Payment regimes must be fair and transparent: Commissioners and providers must adhere to the provisions for determining a non-tariff price contained in the NHS Contract (Clause 7.2.) This should also pertain to agreements around non-mandatory tariffs.

Some members are concerned that the Panel will recognise the differential costs of providing services in different geographical locations.

### **1.3 Proportionately limiting the Burden of Information Demands**

There will be an issue about the way in which the information demands of the Competition Panel will dovetail in with information already supplied through other regulatory channels so that it does not necessarily exacerbate the bureaucratic burden of complaints. Foundation trusts would welcome a statement that, where possible, the competition panel will use existing sources of information and will co-ordinate with the Sponsors to make this possible.

### **1.4 System regulation and conflicts of interest in role of system managers**

System regulation needs to be aligned and overlap and conflicts removed. It is vital for the system regulation to be aligned and avoid regulatory overlap and duplication, particularly in the light of Monitor's new area of responsibility in implementing the Department of Health's competition policy. Whilst the Competition Panel has a limited remit within the system infrastructure its decisions will undoubtedly have significance for the market managers and decisions makers and will make clear conflicts of interest within the system. Many foundation trusts are beginning to be concerned by what they perceive to be a conflict of interest within the SHAs role, of driving market policy and performance managing PCTs, whilst also acting as the first point of appeal for providers.

### **1.5 Development of commissioners**

The guidelines do not explicitly recognise the lack of experience of all players when it comes to competition decision making. In particular providers will worry about inexperienced commissioners who appear to have acted without a sophisticated understanding of risk within the system.

Foundation trusts are concerned that quality of provision and quality of decision making in the wider interests of the community must not be subordinated to a dogmatic application of market ideology. They believe part of the strategic duty of the commissioner is to consider the sustainability of local services. They see a risk that so many parts of a secondary care service (particularly from local DGHs) will be sliced off in an effort by commissioners to create a wider market that the remaining core Secondary service becomes fragile. This would potentially create the opposite effect to that intended and the Panel should outline how it intends to approach this issue.

The FTN recommends that the Panel provide a clear statement of how assessing system balance of risk will be taken into account within the benefit to patients' test of market decision making and parameters and highlighting the priority of patient interest - in order to prevent sub-optimal decision-making by PCTs in relation to service development and tendering.

Further thought also needs to be given to the behaviour of Commissioners prior to services being tendered and how discussions in relation to the development of service specifications should be conducted to balance the principles of Co-operation and Competition. For example, should there be a requirement for PCTs to declare to other providers where they have entered into a relationship with a provider to develop a specification, as this will provide an inherent advantage in the process? This advantage may not be in terms of pricing but is certainly relevant with regard to timing, particularly

where partnership working may be required or it is a particularly complex service. Clearly, no one would want this kind of collaboration to be limited, as it ultimately benefits patients, however, the FTN believes that some boundaries and rules in respect of this need to be set by the Panel.

Finally, the guidance does not seem to cover conduct of the commissioner to ensure existing providers are not prevented from bidding for a new or existing service(s) through acts or omissions. For example, where a tender is let in such a way that a provider cannot bid without sharing of information on costs with the other providers or the PCT provider services, which it subsequently fails to do. One foundation trust has already experienced this in relation to a stroke service.

## **2. Answers to Specific Questions**

### **2.1 Q1. Does this section provide sufficient context to the Panel's consideration of procurement matters?**

Overall, sufficient context has been provided. However, one omission is the role of PCTs and SHAs in market making, which may potentially affect a decision whether or not to tender services and may lead to appeals related to the award of tenders. It would be useful to provide some context in relation to PCTs and SHAs roles in market making.

In addition, there are frequent references to the positive impact of competition and the role of procurement in increasing competition. However, there needs to be some recognition of the negative impact of competition in relation to potential service fragmentation and to service continuity and the necessity for PCTs to also take these factors into consideration when deciding whether to tender services. Shouldn't there be an option for existing providers to challenge a decision to tender where this is not in the interest of the patient or taxpayer?

Finally, the document refers to procurement as a means of fostering patient choice. However, there will be instances where improvements to the quality, safety and value for money of services will result in decreased patient choice and it would be useful to have an indication as to how the Panel will approach such situations, for example, in networks or vertical integration.

### **2.2 Q2. Are the Principles and Rules relevant to procurement matters identified sufficiently clear?**

Yes.

### **2.3 Q3. Are the acceptance criteria clear?**

Yes. However, in relation to para. 3.2 (ii) whilst foundation trusts can ensure that they are available to provide further information and testimony, PCTs and SHAs will not be under their control and will themselves need to accept and commit to the requirements of the Panel, even where they are not themselves the appellants.

In relation to para. 3.2 (iv) it would be useful to have some indication as to who should decide whether the Panel, as opposed to the OFT or ASA, is the appropriate body to consider an appeal – is this the duty of the appellant, PCT or SHA?

#### **2.4 Q4. Should anything be added or excluded from the Panel's acceptance criteria and if so why?**

It would be useful to clarify what will happen where the centre of the dispute depends upon actions based on national policy.

FTN believes that there will be a large volume of complaints in relation to procurement. The path to a more open market and competition in health services is likely to be tricky and the scope for opening unbalanced and unanticipated risk high. In this context the availability of advice will be critical to avoiding unacceptable and unintended levels of risk that could undermine public confidence in competition in the health sector provision.

This is an immature market and many players will be uncertain about how to apply the rules and the appropriate behaviours that go with this. Unlike other markets that have opened in the UK over the last 20-30 years, few players have any record as commercial entities. PCTs will be facing huge challenges, as they do not have the commercial experience and are at the early stages of development in terms of having a commercial approach to procurement and tendering.

In all other markets the players went through a process of privatisation before markets were created, hence they had an opportunity to commercialise their organisations before being subject to competition rules. In health there has been no such privatisation and even though foundation trusts are autonomous and self-governed they still have constraints upon their commercial freedoms. On the commissioning side there is still too little experience in creating and managing a more commercial set of processes for awarding contracts. Hence all players are likely to need a lot of support from the Competition Panel in its early years of operation and the organisation will have to scale up to ensure this demand can be met as an investment in reducing the number of cases downstream.

It is not clear within the guidance whether an advisory service is being provided in relation to procurement disputes. In the interest of reducing service disruption in the case of a successful appeal, it would be useful to all parties if the Panel could consider providing an advisory service to PCTs in relation to their procurement practices to prevent cases being brought before the Panel.

In addition, there should be an impact assessment that models the likely levels of formal referrals uptake the Competition Panel may receive in order to understand the scope and size of demand and inform the development of the service standards.

#### **2.5 Q5. Is the Panel's procedural process for appeals of procurement disputes sufficiently clear?**

Yes, although, as a drafting point, it would be helpful to clarify whether the number of days allowed for each aspect of the process refers to working days.

In relation to para 4.6 the Panel may need to clarify what it means by a “sufficient” interest from third parties. Please also see para. 2.8 below for further comment on the involvement of third parties.

In relation to para 5.4 and limiting eligibility, the guidance provides the example where there is a requirement that a bidder already undertakes a certain volume of activity – the Panel should be aware that use of this criteria may be used to ascertain levels of expertise and experience or it may relate to issues of patient safety and therefore be used for positive reasons; in addition, encouraging providers to submit bids where they do not have the relevant experience is a waste of all parties’ time. This should therefore be taken into consideration.

**2.6 Q6 Does the appeals process for allow parties sufficient opportunity to present their case?**

Yes.

**2.7 Q7. Are the time frames for conducting appeals sufficient?**

Yes, although for some large scale procurement processes where a large number of parties are involved or where there are greater complexities, it is possible that some flexibility in timescales may be required in order to allow parties to gather information fully and present for hearings.

**2.8 Q8: Should third parties be afforded greater involvement in the Panel’s appeals e.g. in terms of providing submissions to the Panel and attendance at hearings?**

Foundation Trusts think that FT Boards of Governors ought to be a specifically named party amongst the parties to be afforded greater involvement in the Panel’s process for investigation. It may also be pertinent to include LINKs and Overview and Scrutiny Committees specifically as third parties.

There should be greater clarity about how the Panel will determine which ‘third parties’ will be approached where it decides it needs further particulars.

If the Panel is to accept keeping the identity of the complainant confidential, it should it should lay out the kind of circumstances in which this would be acceptable for further consultation. Foundation trusts are likely to accept the need for patient confidentiality but likely to be more sceptical about other types of anonymity as many complaints will concern the spending of tax payers money.

Clearly the respondents will have to know the identity of the complainant where this is material to the case they will seek to defend. In these circumstances would the complainant be tied in to public confidentiality and why?

**2.9 Q9. Is the Panel right to seek to balance other benefits to patients and taxpayers against limitations on competition when assessing tender design?**

Foundation trusts believe that the overarching approach to appeals will not be adequate to fully take the Co-operation part of the competition rules into account. There are circumstances in which co-operation rather than competition is a positive value. This is recognised within the Co-operation and Competition rules themselves, but it looks in this section as if co-operation may be being seen as an ‘offsetting

benefit' to patients or taxpayers, rather than a principle in its own right underpinning benefits to patients under which a decision not to pursue competition as the policy solution is justified.

In some instances competition may be limited due to increased collaboration between certain providers, in order to improve benefits to patients and taxpayers. Indeed, in some cases, there may be national policy drivers to do so, for example, integrated care and vertical integration of services. However, in attempting to meet the requirements of national policy and/or requirements of the Panel, PCTs may place undue emphasis on the need for competition when deciding whether or not to tender a service or to make a tender award.

In these cases, the Panel should balance the benefits that could be derived from a situation where competition has been limited in order to increase patient and/or taxpayer benefits.

Foundation trusts would appreciate greater clarification on what would be the burden of proof for the claimant to prove that an action was not in patient/ taxpayer interests.

It would also be helpful for the Panel to state the approach it will take where PCT procurement decisions have been taken in response to national policy drivers and where this has resulted in the purported anti-competitive behaviour – what will take precedence, the Co-operation and Competition Rules or national policy?

#### **2.10 Q10. Should the Panel be applying a different benchmark when assessing PCT decisions not to tender?**

The FTN agrees with the benchmarks for assessing PCT decisions not to tender, but would appreciate some definition or guidance as to the test of “reasonableness” referred to in para. 5.6 bullet point 3.

The FTN also recommends that the Panel outlines the level of information that would be required by a complainant in order to make a complaint. The FTN recommends that the Panel provide some guidance in relation to the level of information that should be released to the market by PCTs, including in relation to their decisions not to tender, as this will provide consistency across the market.

#### **2.11 Q11. Although this list is not intended to be exclusive, are there any other recommendations that should be expressly mentioned in these procurement guidelines?**

There should be greater clarification of the role of the Panel where it is the policies of PCTs and SHAs, DH or regulators that are leading to denying patients' choice.

For example, where SHAs may be driving PCTs to tender or not tender services or if Monitor drove foundation trusts too hard to make surplus and this compromised patient access and encouraged discriminatory behaviour or where commissioners and regulators do not police the requirements not to discriminate with equal vigour across all sectors of providers, leaving a particular sector at a competitive advantage that is not in the interests of patients.

Another example might be either where the DH fails to find a solution for capital flow through the system or the regulator places disproportionately risk averse conditions on access to capital and as a result another sector not subject to the same rigours of

regulatory requirement receives a competitive advantage in investment capacity that is not in the long term interests of developing the infrastructure for providing sustainable patient services across the system.

In relation to the recommendations, a recommendation for PCTs to amend or change their tender evaluation criteria and/or system for scoring such criteria could be included, as these may not be sufficiently robust to allow a fair procurement.

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