Consultation on Monitor's substantive guidance on the Procurement, Patient Choice and Competition Regulations

1. I write with regard to Monitor’s consultation on its substantive guidance on the Procurement, Patient Choice and Competition Regulations. Please note that our comments on this document should be viewed alongside our response to Monitor’s consultation on its draft enforcement guidance.

2. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 46,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. We gratefully acknowledge the contributions of the RCGP Centre for Commissioning in formulating this response.
Summary

4. The RCGP welcomes the opportunity to comment on this draft guidance. We feel that there is much to support in this document, and we particularly welcome Monitor’s recognition that ultimately it is for commissioners to decide how to secure the needs of the healthcare service users for whom they are responsible (p. 10).

5. However, we are concerned that the wording of parts of the guidance do not in fact support the Government’s stated intention to allow commissioners the flexibility to procure services in the way they consider best. We have particular concerns about Chapter 4 of the guidance, which appears to make the assumption that virtually all services will be open to competition unless exceptional circumstances apply. We believe that this could potentially have a major destabilising effect on local commissioning and divert Clinical Commissioning Groups (CCGs) from concentrating their efforts on those areas where a competitive process does have the potential to add value for patients. (Please see our answer to Chapter 4 Qs 1&2 below).

6. During the passage of the Health and Social Care Bill, the Government stated that its intention was that the regulations “would not set a presumption, either way, that services should be open to competition, or not open to competition” and that “this approach would give commissioners flexibility in deciding how best to discharge their duties”.

7. We have previously raised concerns that the ability of commissioners to do this may be compromised by the wording of the regulations themselves, which according to the opinion of a number of respected legal experts limit the freedom of commissioners to decide not to put a new contract out to tender. However, we note that the Government has suggested an alternative reading of the regulations, asserting that they do in fact allow commissioners flexibility in deciding whether or not to tender. While we maintain our reservations about the wording of the regulations themselves, we believe that it is this principle of flexibility that should underpin Monitor’s guidance throughout.

8. While we welcome the option for commissioners to carry out a general review of service provision and thereby identify the most capable provider of those services without running a tender process (4.2.2), we are concerned that the wording of the guidance suggests that the magnitude of the review expected would be such that it would not be practical for many medium and smaller services. It is crucial that that a pragmatic and

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1 Letter from the Right Hon Earl Howe to the Chair of the RCGP, Dr Clare Gerada, January 27 2013
proportional approach is taken, to ensure that this a usable route for commissioners. (Please see our answer to Chapter 4 Qs 1&2 below).

9. We are also concerned that the wording in section 4.5 in regard to new contracts could impact adversely on clinical provider innovation, which is crucial to service redesign. It would be very unfortunate if the wording of the guidance inhibited clinical pathway redesign between primary and secondary care, if providers felt this would automatically lead to a new tender.

10. In addition, we would wish to emphasise that, while we agree that choice, competition are not mutually exclusive (p.18), it should also be recognised in the guidance that there may be cases where choice and competition do not help facilitate the delivery of integrated care (please see our response to Chapter 3 Q3 below). We are concerned that the guidance is written from the perspective that the majority of NHS care is episodic, when in fact the NHS will increasingly need to provide care that is integrated both vertically (primary/secondary care) and horizontally (social services/community/primary care) in order to meet the challenges of an ageing population and a rise in multi-morbidities.

11. Lastly, as the NHS moves towards joint commissioning with local authorities, especially for the most vulnerable in our communities, we would like to see greater alignment in the guidance between health and social care.

**Detailed response**

**Chapter 3. Procurement objectives and general requirements.**

Chapter 3, Q1. Do you agree with the examples of factors that Monitor may consider when deciding whether commissioners have complied with their duty to act transparently, proportionately and in a non-discriminatory way?

Are there other factors that you think we should highlight?

12. Broadly, we feel that these factors represent a sensible, balanced approach to assessing whether commissioners have complied with their duties.

13. We are particularly pleased to see reference to the statutory duties of commissioners to promote research, education and training. However, given the importance of these areas to the NHS, we would like the obligation of service providers in respect of research, education and training to be more positively emphasised in the guidance; for example,
we would like to see mention of the need to promote research, education and training included in the section on procurement objectives in Chapter 3 (3.2).

14. We welcome reference to the sustainability of services. However, we would suggest that one aspect of sustainability that is not mentioned is the degree of local ownership achieved by the provider – for example, the relationships and/or reputation that a provider may have developed in the local system. We believe that it would be reasonable for a commissioner to ask providers to demonstrate how an existing or new service has or will gain this local ownership, which may be critical to successful integration of services.

Chapter 3, Q2. Do you agree with the examples of factors that Monitor may consider when deciding whether commissioners have complied with their duty to procure services from the providers most capable of delivering commissioners’ objective and that provide best value for money?

Are there other factors that you think we should highlight?

15. We agree with the factors and processes mentioned. We welcome the reference to bundling, and the need to consider the advantages and disadvantages of this process on a case by case basis. We would suggest that the guidance also asks commissioners to take into account the need to make the best use of NHS estates and strategic sites.

Chapter 3, Q3. Do you think that the description of integrated care, choice and competition is helpful?

16. We welcome the definition of integrated care as being when “I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.” As noted above (‘summary’), we accept that the delivery of integrated care need not always be at odds with competition rules. However, it should also be recognised in the guidance that there may be cases where choice and competition do not help facilitate the delivery of integrated care.

17. While care can be and often is integrated across different providers working together, it is important to acknowledge that there may be occasions where delivering integrated care does require there being a single provider, to ensure both the complete care of a patient and the sustainability of a provider’s services. We note that reference is made to provision by a single provider in the description of integrated care (p.17), however we would welcome further discussion of this point under the heading ‘Relationship between
choice, competition and integrated care’ (p.18-19). In addition, it should be recognised that in some cases a multiplicity of providers may make integration more difficult.

18. With regard to the description of choice and competition, we would note that while the descriptions of “competition in the market” and “competition for the market” are long established and useful business descriptors, they represent two ends of a spectrum with a number of permutations in between. It would be a mistake if some people interpreted the guidance as presenting a binary option.

19. We would also emphasise that, in the context of the move away from episodic care to a more integrated approach to health, care and support needs, patients will often place shared patient-clinician decision making about treatment options (within the ongoing process of care planning) above provider choice. We therefore feel that the guidance should place greater emphasis on shared decision making about treatment options, in order to dispel the impression that provider choice (through, for example, the AQP model) carries more weight.

Chapter 3, Q4. Do you agree with the examples of the factors that Monitor may take into account in deciding whether commissioners have complied with their general duty to consider appropriate means of improving quality and efficiency, including through services being delivered in an integrated way, patient choice and competition?

Are there other factors that you consider we should highlight?

20. We agree with the examples and welcome the recognition that in some circumstances it may be in patients’ best interests to procure services from a single provider. We would suggest that further emphasis should be placed on the ability of providers to work in partnership with other organisations with whom they are, or may be, in competition. This might include not only patient information sharing, but also cooperation on system resilience, emergency planning, patient booking, training, data sharing under “commercially in confidence” rules, and staff secondments. In short, providers must be prepared to compete on the understanding that patient care should be placed before competitive advantage.

21. We also feel that, as much of integrated care will be in the form of horizontal integration with community and social care providers, some alignment is required with the approach to competition and cooperation by local authorities, many of whom still have in house services.
22. In addition, there are some circumstances in which there are distinct clinical advantages for patients when services are provided by holders of the registered patient list (i.e. the GP practice) as opposed to third party providers; for example, the monitoring of long term medication that requires frequent blood tests. While we accept that these circumstances would need to be tested in an open transparent way and subject to scrutiny, we feel that it is a factor that commissioners should be able to take into account.

Chapter 4. Publishing new contract opportunities for NHS health care services.

Chapter 4, Q1. Do you think the description of the considerations that commissioners should take into account when deciding whether or not to publish a contract opportunity is helpful?

Do you think there are other considerations that we should list?

Chapter 4, Q2. Do you think that the examples of situations where it may be appropriate for a commissioner to award a contract without publishing a contract notice and running a competitive tendering process are helpful?

23. We are concerned that this chapter appears to make a presumption that virtually all services will be put out to competition unless exceptional circumstances apply. As mentioned above (‘summary’), we do not believe that this was the Government’s stated intention. We would therefore suggest that chapter 4 is reworked, to ensure that commissioners are allowed greater flexibility in deciding how best to commission services in order to support the overall objectives of the regulations (3.2).

24. With regard to the circumstances where it may be appropriate not to publish a contract notice and/or tender (4.2), we would observe that the circumstances in which services are capable of being provided by a single provider only are likely to be limited. While this may be true in some rural locations, for most services it is unlikely to be the case in urban areas with multiple potential providers. To this end, we welcome the reference to the necessity of some services to be co-located as a result of clinical interdependencies.

25. While we welcome the requirement for commissioners to act in a proportionate way (4.2.3), we would also point out that the process of weighing potential costs against benefits is more than a straightforward mathematical exercise and there may be considerable uncertainty among commissioners as to whether they are at risk of breaching the guidance if they choose not to go out to tender.
26. We would add that there may often be circumstances where a commissioner decides that the potential risks (as opposed to simply the costs) of running a competitive tender process outweigh the potential benefits. Any new tender carries both risks and costs and, even with a set of favourable circumstances, can impede progress for up to two years during the tendering, contract start and mobilisation phase. It would therefore be reasonable for commissioners, especially when procuring an integrated service, to include reputational, financial and transformational risk in any intervention decision.

27. We would emphasise that there may be very good reasons why commissioners do not want to put new contracts out to tender. For example, commissioners may decide that it is in the interests of the populations they serve to protect the continued viability of services at their local hospital. As mentioned above, we would caution that a presumption that all services will be open to competition except in exceptional circumstances could have a significant destabilising effect, and divert CCGs from concentrating their efforts on the areas where a competitive process does have the potential to add value for patients.

28. As mentioned above (‘summary’), we welcome the option for commissioners to carry out a general review of service (4.2.2). However, while we appreciate the need to review the market and base decisions on evidence, we are concerned that the wording of guidance suggests that the scale of the review would be such that would not be practical for many local services. It is critical that this is a usable route for commissioners and that the guidance encourages a pragmatic and proportional approach. As such, we strongly believe that the guidance should recognise that there will be cases for smaller services where proportionality needs to be applied, such as where there has been an adequate general review of service provision but this has not been a full scale public consultation (which would be both lengthy and expensive).

Chapter 4, Q3. Do you think that the description of the circumstances in which a contract will be treated as a new contract is helpful?

Are there other situations where a contract may amount to a new contract that you think we should highlight?

29. We are concerned that the description of the circumstances where a contract may amount to a new contract lacks clarity and may therefore give rise to unnecessarily restrictive interpretations. It is not clear from the guidance how much variation to an existing contract will be permitted before it constitutes a new
contract, for instance the level of capacity increase that would constitute a new contract.

30. If existing providers and/or commissioners feel that innovation within an existing contract will inevitably lead to a competitive tender process, we believe that there is a very real risk that this could impede provider-initiated transformational change in the best interests of patients, for example where providers are moving from an activity to an outcome based approach. Worked examples to explain clearly what constitutes a new contract would be helpful.

Chapter 5. Qualification of providers

Chapter 5, Q1. Do you agree with the examples of the factors that Monitor might take into account in deciding whether commissioners have complied with their duty to apply and establish transparent, proportionate and non-discriminatory qualification criteria?

Are there other factors that you consider we should highlight?

31. The examples suggested are reasonable, but some worked examples might be helpful in order to reduce the risk of legal challenge, especially where commissioners are asking for bids “for” the market.

32. We welcome recognition of the fact that commissioners may want to limit the numbers of providers on a list from which a patient would otherwise be offered choice.

Chapter 6. Record Keeping

Chapter 6, Q1. Do you agree with the suggestions of the types of information that may be relevant for the purposes of compiling an adequate record of a contract award decision to demonstrate that commissioners have complied with their relevant duties under the National Health Service Act 2006?

Are there other types of information that may be relevant that you consider we should highlight?

33. We feel that this chapter reiterates good transparent practice and is consistent with the need for commissioners to be open with regard to their decisions.
Chapter 7. Assistance and support

Chapter 7, Q1. Do you agree with the examples of the factors that Monitor might take into account in deciding whether commissioners have complied with their duty to ensure that any person providing commissioning support or assistance acts in accordance with the relevant requirements of the Procurement, Patient Choice and Competition Regulations?

Are there other factors that you consider we should highlight?

34. We recognise the point in this chapter that responsibility for adhering to the regulations sits with the commissioner, even if they have outsourced this function.

Chapter 8. Conflict of interest

Chapter 8, Q1. Do you agree with the examples of interests in the provision of services that may give rise to a conflict with the interests in commissioning them?

Are there other examples that you consider we should highlight?

35. We agree with the examples, but would also include indirect financial interest by virtue of being employed, or seeking employment by a provider of a service that is bidding to be awarded a contract

36. We would also make reference in this chapter to professional standards of conduct in any business transaction, such as General Medical Council guidance.

Chapter 8, Q2. Do you agree with the examples of factors that Monitor may take into account when deciding whether a conflict affects or appears to affect the integrity of a contract award?

Are there other factors that may be relevant that you consider we should highlight?

37. While we believe that any conflict of interest must be declared at the first opportunity, we feel that this chapter needs more thought in order to strike the right balance between a purist arms-length contractual relationship and the need to encourage clinical service redesign.

38. In particular, we feel that further clarity is needed with regard to decisions where CCGs may be commissioning new or existing community services from general practice. We already know of examples where commissioners have been deterred from renewing existing successful arrangements due to concerns about conflicts of interests, despite
clear evidence of likely patient benefits. Legal advice, perhaps accustomed to competitive environments outside the NHS, has encouraged a risk averse approach. Unless greater clarity can be achieved, this inhibiting effect will damage progress in an area where there is significant potential for general practice to drive service transformation and improved patient care.

Chapter 8, Q3. Do you agree with the suggestions of the types of information that may be relevant for the purposes of compiling an adequate record to demonstrate that a conflict of interest has been appropriately managed?

Are there other types of information that may be relevant that you consider we should highlight?

39. We agree with the suggestions of the types of information that may be relevant.

Chapter 9. Anti-competitive behaviour

Chapter 9, Q1. The cost/benefit analytical framework is the same as that applied by the Cooperation and Competition Panel when analysing anti-competitive behaviour under the Principles and Rules. Do you think this description is helpful?

40. Broadly we welcome the balanced approach taken in this guidance and the need for commissioners to be explicit in their decision making process, together with the focus on research, evaluation and evidence in making a decision.

Chapter 9, Q2. Do you agree with the examples of the considerations that Monitor may take into account in assessing whether a commissioner has engaged in anti-competitive conduct that is not in the interests of patients?

Do you think there are other examples that we should highlight?

41. In principle these examples are helpful, but in reality commissioners will also face financial pressures. In some cases it might be reasonable for commissioners to apply certain restrictions to prevent provider/supply driven demand, but these restrictions would have to apply equally to all providers of a similar service.

42. We would also note that there may be occasions where commissioners may want to work with primary care and providers to develop local clinical pathways and referral templates. We believe that this should not be regarded as uncompetitive as long as all providers can compete on the same basis. An issue may also arise when a pathway is thought to favour one provider over another, in which case commissioners should be
expected to consider whether this is in the patient’s best interests and offers good value for money.

**Question 10. Patient Choice**

Chapter 10, Q1. Do you agree that we should include a description of the requirements relating to patient choice in the Responsibilities and Standing Rules Regulations that Monitor has the power to enforce under the Procurement, Patient Choice and Competition Regulations?

43. We believe it is helpful to describe the strategic context with regards to provider choice and when it applies, providing it is counterbalanced in the guidance with the importance of shared patient-clinician decision making about treatment options, within the ongoing process of care planning (please see our comments on Chapter 3 Q3 above).

Chapter 10, Q2. Do you agree with the examples of relevant factors that Monitor may take into account in deciding whether commissioners have complied with their duties relating to patient choice?

Are there other relevant factors that you consider we should highlight?

44. We believe that these factors are reasonable and we welcome the reference to the need to ensure that contracts entered into by commissioners impose positive obligations on providers to offer patients the relevant choices.

We look forward to ongoing dialogue with Monitor as it develops this and other guidance relating to its role as sector regulator and we would welcome further opportunities to engage with this process.

Please do not hesitate to contact me if you have any questions about our response.

Yours faithfully,

Professor Amanda Howe MA Med MD FRCGP

Honorary Secretary of Council