

COMPETITION & PROMOTION DISPUTE RESOLUTION PROCESS

FEBRUARY 2009

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1 EXECUTIVE SUMMARY

The information in this document sets out the Competition Dispute Resolution Process of Birmingham East and North PCT (the “PCT”).

As a result of the introduction by the Department of Health (DH) of the promotion of choice and competition in the consultation paper “The future regulation in health and social care”, the PCT as a commissioner is responsible for ensuring that different types of provider are not treated unfairly, either when they are invited to bid for procurements or through choice arrangements. Our role is to ensure that our decisions are fair, transparent and well informed.

Recognising that there may still be times when competition issues cannot be resolved locally, the Government has introduced an independent, non-statutory, advisory body, the National Co-operation and Competition Panel (CCP) tasked with advising Strategic Health Authorities (SHAs), the Department of Health and Monitor (in relation to NHS Foundation Trusts), on issues relating to cooperation and competition in NHS-funded healthcare services. The CCP will only consider issues where action to resolve matters locally has been exhausted. To this end, PCTs and SHAs are required to set up and run local Competition Dispute Resolution Processes and an SHA Competition Dispute Resolution Panel (SHA Panel) to manage disputes at a local level before they are referred to the CCP.

The PCT Competition Dispute Resolution Process will adhere to the core system management principles and the PCT Competition Dispute Resolution Panel (PCT Panel) will hear complaints and disputes which, are thought by the complainant to contravene any of the 10 Principles and Rules of Cooperation and Competition (Appendix 1).

The SHA Competition Dispute Resolution Process will be a process that complainants can pursue if they disagree with the PCT’s decision following the PCT Competition Dispute Resolution Process. The SHA will only consider complaints that have been through the PCT Competition Dispute Resolution Process, or those that have been escalated to the SHA by the PCT itself.

The PCT Competition Dispute Resolution Process adheres to the DH guidance for entry into the Competition Dispute Resolution Process and the timescales that the PCT should deliver to ensure national consistency. It may be updated as required to ensure consistency.

The PCT Competition Dispute Resolution Process also describes the course of action that the Complainant could take if they are in disagreement with the PCT Competition Dispute Resolution Process findings.

2 BACKGROUND

The NHS Operating Framework for 2008/09 describes Principles and Rules of Cooperation and Competition. Furthermore, Annex D of the Operating Framework provides a context for when a cooperation and competition panel should be utilised, by describing the actions expected of SHAs in their application of the principles and rules of cooperation and competition.

The Framework for Managing Choice, Cooperation and Competition was published in May 2008 and identified that a CCP had to be operational by October 2008, when SHAs and PCTs were required to have processes in place to identify, hear and resolve disputes relating to the principles and rules.

3 PURPOSE

- 3.1 The CPP is a point of last resort when the local system has failed to achieve resolution of a dispute. Recognising that there will be occasions when a referral to the CCP is needed, the system that the PCT has in place for managing these disputes needs to be robust and transparent because the first test that the CCP will employ is whether the dispute is valid or could have been resolved elsewhere in the system.
- 3.2 It is important that where possible, disputes are resolved locally. The government is committed to a bottom-up, self-improving means of regulation. However, system managers should be aware that the highest level disputes can reach is the European Court. It is likely that if a dispute has reached this point, all local and national processes have failed to reach a resolution.
- 3.3 Ideally, the majority of cases will be dealt with at the local level, preventing the need for upward referral. Therefore the Competition Dispute Resolution Process that is implemented needs to be consistent with the national approach (for onward referrals to be consistent), but also owned and organised locally (which allows locally driven entry points for the system, identifies disputes quickly and locally provides consistency within the system).
- 3.4 Providers and other potential complainants need to know that they have recourse whenever they have a complaint relating to principles and rules of cooperation and competition. By having a local, published Competition Dispute Resolution Process, those organisations know that they have a forum and means of registering these complaints. Failure of the PCT to provide or operate an effective Competition Dispute Resolution Process could in itself be cause for complaint. Providers need confidence that they are operating in a level playing field, so transparency is key, both of the process and of the decisions.

4 SCOPE

- 4.1 Scope: the PCT Competition Dispute Resolution Process will consider:
 - Disputes directly arising from the principles, actions/behaviours and rules set out in the Principles and Rules for Cooperation and Competition.

- Disputes that have a direct impact on the Principles and Rules
- Disputes related to NHS Promotion Code outside the remit of the Advertising Standards Authority (ASA).

4.2 Exclusions: the PCT Competition Dispute Resolution Process will exclude:

- Contractual disputes of a commissioning nature between the PCT and any provider in respect of an NHS Contract – this should be dealt with through the PCT's established commissioning processes.
- Non-competition issues
- Matters where jurisdiction falls within the OFT statutory duties (“undertakings”)
- Matters where jurisdiction falls within the ASA statutory duties, although the SHA will wish to be kept informed of any issues relating to NHS organisations in the West Midlands that are raised to the ASA. The PCT is required to notify the SHA of any such matters in writing.
- Any disputes that do not relate to the provision of healthcare services commissioned by the NHS.

4.3 Protocol for handling cross boundary issues: In cases where a dispute affects more than one PCT, the PCTs in question will agree between them who will take the lead role, with regard to which organisation the complaint is made against. The dispute will then be dealt with by that PCT in accordance with their published dispute resolution process.

4.4 Core Principles: The following overarching principles are set out in the West Midlands SHA's published Investing for Health (IFH) strategy:

- A health service that is not making changes, sometimes significant and difficult ones, is a moribund service that is failing its patients, staff and public. However, there is always a question of local priorities and, provided there are not demonstrable risks to patients, not every 'sustainability' issue has to be tackled immediately.
- Sustainability is NOT about protecting the historical pattern of provision come what may. Our primary duty is to ensure that current and future citizens have access to highest quality health services. As well as being judged by today's citizens, we have an obligation to their successors.
- There is no one right answer to the complex questions of service configuration – local solutions need to be formulated in dialogue with local populations BUT there needs to be a set of clear tests that should be addressed openly in constructing and debating such local proposals and these need to deal explicitly in the language of risk, quality and safety.
- There is a clear hierarchy that must be adopted in any criteria for considering investment proposals or service change.
 - First, what is right for patients (today's and tomorrow's)
 - Second, what is in the public interest (population health; equity; VFM)
 - Third, organisational priorities.

4.5 The following set of principles are based on the five high level objectives agreed by the national System Management Reference Group for the SHA tier of the dispute resolution process. These are:

- To resolve competition disputes transparently, fairly and consistently.
- To provide confidence to providers that the process is fair and transparent, enhancing willingness to participate in the market.
- To mitigate risks and protect the reputation of the NHS.
- To be compliant with potential acceptance criteria of the CCP.
- To prevent where possible legal challenge/expensive external referral processes.

4.6 There are also a set of nationally proposed underpinning principles that all levels of the dispute resolution process should uphold. These are based on the principles for system management contained in the 'Framework for Managing Choice, Cooperation and Competition' published by the DH in May 2008:

Purpose: Decisions made by system managers should contribute to the goals of the whole system, and should have patient interests and the wider public interest at heart.

Transparency: Where possible, all information should be shared between organisations and individuals within the system – including those relating to conflicts of interest.

Objectivity: Key decisions must be based wherever possible on objective data, information or criteria, or reasonable assumptions, and kept as public records for audit purposes, requiring increased levels of transparency.

Proportionality: Actions, in particular with reference to transactions and/or consequences for organisations of not following agreed rules, must be proportional to the size, complexity or risks of the issue at stake; based on objective information or reasonable judgements; and capable of withstanding public scrutiny and reporting.

Non-discrimination: Commissioners must not discriminate among providers, and providers must not discriminate among patients.

Accountability: System managers should strive to align their authority and legal powers with their accountability and legal duties. It should be clear, in statute and in practice, who is accountable for what; furthermore it should be clear what authority those accountable have to control their areas of responsibility.

Subsidiarity: Decisions should be made by the lowest competent authority. Under this principle, commissioning organisations should manage their local system, and escalate appropriately to regional system managers when issues cannot be managed at a local level.

Consistency: Formulation and implementation of policy must be internally coherent and consistent.

No 'double jeopardy': Where possible, providers should not be held to account inconsistently for the same issue by more than one institution (e.g. system manager, regulator, government department).

Interdependency: When assessing specific issues, commissioners and providers should understand and minimise the potential unintended consequences of any actions.”

5 PROCESS

5.1 The PCT's process must:

- have a clear entry point on its website for all Principles and Rules of Cooperation and Competition (“PRCC”) and NHS Promotion Code complaints.
- be able to appropriately identify any and all PRCC and NHS Promotion Code complaints in the first instance,
- react appropriately,
- triage correctly and
- (as appropriate) investigate and resolve the complaint or refer to more appropriate body or reject the complaint,
- Ensure all evidence and decisions are fully documented

If the complaint cannot be resolved, then the output of the PCT Competition Dispute Resolution Process should allow any senior recipient organisation or body (e.g. West Midlands SHA; CCP, Office of Fair Trading etc) to quickly grasp the nature of complaint and have sufficient information to provide a judgement.

5.2 The Complaint Process

Full details of the complaint process are set out below together with the process flow diagram (Appendix 2)

5.3 The key stages are:

a) Receipt of Complaint:

The PCT website will contain a link to the PCT's Complaints Competition Dispute Resolution web pages where this process and the complaints proforma will be available:

www.benpct.nhs.uk

The website will also contain additional information on what is included/excluded from the scope of the PCT's Competition Dispute Resolution Process and a self assessment section where complainants can assure themselves that they have a reasonable complaint before completing the relevant proforma.

The PCT will receive complaints via the web proforma. The idea of using an electronic form is that it ensures that complaints are received in the same format and that all relevant information is available to the PCT Panel in a consistent manner.

b) Triage (usual maximum of 8 working days)

On submission the completed proforma should be forwarded to the PCT case manager whose responsibility it will be to carry out an initial check to ensure that:

- The content of the dispute is covered by the PRCC or the Code of Promotion.
- The PCT is the lead commissioner in the case being complained about.
- There is evidence of a full and frank disclosure of all relevant and applicable information. (including availability of connected individuals to provide evidence / testimony)
- No legal proceedings have commenced.
- The issue is not a "reserved matter" under the PRCC, as defined in the Panel's Rules of Procedure (to be published on the Panel's website).
- In joint commissioning arrangements with local authorities, this process only applies where a PCT (or PCTs) is the lead commissioner. The PCT should be the commissioner or lead commissioner for the service in question

Once the case manager has completed an initial assessment, and has ensured that the complaint meets the PCT acceptance criteria, the complainant will be sent a formal acknowledgment letter.

c) PCT Panel Stage (usually 25 working days)

At this stage, the complaint will be presented by the case manager to the PCT Panel Chair (a nominated Non-Executive Director) who assesses the complaint. It is the responsibility of the case manager to ensure that all information surrounding the complaint is available to the Chair and the PCT Panel. Information for the PCT Panel will be available at least 3 working days prior to any PCT Panel dates. The PCT Panel dates for the year will be published on the PCT website together with cut off dates for complaints

The PCT Panel Chair will make an assessment of the type of complaint, decide on which PCT Panel members need to be involved, and what if any additional information / evidence is required. If the Chair feels the issue is a "reserved matter", they will seek expert advice and refer the issue directly to the CCP (copying the SHA in on any correspondence).

To avoid conflict of interest and in doing so avoid unnecessary complaints about the PCT Panel itself, the BEN PCT Competition & Promotion Dispute Resolution Panel will include core membership from:

- Director of Resources (Lead Director)
- Chief Operating Officer
- Director of Performance & OD
- Director of Strategy & Redesign

If a panel member considers that they have a conflict of interest which is relevant and material with regard to a specific complaint then they should declare this to the Chair of the Panel and take no part in that Panel. Panel members must refer to Section 7 of the PCT's Standing Orders when considering whether they have an interest which should be regarded as "relevant and material".

Discretionary PCT Panel members may be drawn from (PCT Panel membership for each individual case to be at the discretion of the Chair)

- Procurement/Commercial Advisors
- Legal advisor
- Independent sector representative
- Representative from another commissioning organisation
- Chamber of commerce representative
- Academic health policy expert

The PCT Panel chosen for the case will discuss the case and decide if the evidence provided is sufficient in order to reach a decision. In certain circumstances, they may commission an investigation to try and gather sufficient and impartial evidence. The PCT Panel will review the case and consider both sides of the complaint. If the PCT Panel considers the complaint to be too complex for them to reach a decision on, it can be referred to the SHA Panel.

Once a decision has been reached, both parties will be written to. If the PCT Panel is unable to reach a decision, the matter will be referred to the SHA Panel.

If the PCT Panel upholds the complaint, it will write to any affected parties with the rationale for the decision and the expectations for resolving the dispute along with an action plan to ensure resolution is observed. Similarly, if the case is rejected, the parties will be informed of the reasons why and what can be learned from the experience. Finally, if the PCT Panel cannot reach a decision, this could be for one of two reasons;

1. the decision is beyond the scope of the PCT Panel – in which case, the dispute should be referred to the SHA Panel.
2. there is insufficient evidence for the PCT Panel to reach a decision, which may prompt further investigation to report back to the next PCT Panel with its findings.

At this stage, if the PCT Panel finds that the complaint is beyond its scope and that this is because the investigation uncovered some action that falls clearly into the (for example) “Reserved matters” criteria, a fast-track action/referral needs to be instigated.

6 APPEALS

6.1 Appeals can be made at a number of stages in the process:

- Complainants can appeal to the SHA following a PCT decision
- Complainants can appeal to the CCP following an SHA decision

The SHA has committed to handle appeals impartially and deal with them effectively. The PCT should forward all appeals to the SHA and supply all documentation used by the PCT in coming to its decision.

Appendix 1

Principles and rules for Cooperation and Competition

The principles and rules set out in the Operating Framework for 2008/09, and amplified in Annex D to that document, to which further reference may be made as appropriate.

Principle 1 –Commissioners should commission services from the providers who are best placed to deliver the needs of their patients and populations

Principle 2 -Providers and commissioners must cooperate to ensure that the patient experience is of a seamless health service, regardless of organisational boundaries, and to ensure service continuity and sustainability

Principle 3 –Commissioning and procurement should be transparent and non-discriminatory

Principle 4 -Commissioners and providers should foster patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare

Principle 5 -Appropriate promotional activity is encouraged as long as it remains consistent with patients' best interests and the brand and reputation of the NHS

Principle 6 -Providers must not discriminate against patients and must promote equality

Principle 7 -Payment regimes must be transparent and fair

Principle 8 -Financial intervention in the system must be transparent and fair

Principle 9 -Mergers, acquisitions, de-mergers and joint ventures are acceptable and permissible when demonstrated to be in patient and taxpayers' best interests and there remains sufficient choice and competition to ensure high quality standards of care and value for money

Principle 10 -Vertical integration is permissible when demonstrated to be in patient and taxpayers' best interests and protects the primacy of the GP gatekeeper function; and there remains sufficient choice and competition to ensure high quality standards of care and value for money

Appendix 2

Guideline PCT Competition Dispute Resolution Process

