BIDDING FOR COMMUNITY COPD SERVICES – A SECOND CASE STUDY

Executive summary

The National Strategy for COPD may mean more tenders for respiratory services as commissioners seek to ensure the best standards of care for their populations within limited funds. This is the story of a recent tender to illustrate how it may be done. It should be read in conjunction with the Somerset story as it provides further insights into how tendering processes are affecting NHS providers. This time, the focus is on the role of community service providers.

It should also be read in the context of David Nicholson's letter to commissioners of 13 October 2009: NHS as Preferred Provider.

Here is an example of a successful bid by a community service provider for COPD services in the community.

There are two reasons why it is important. Firstly, the community service provider bid for the contract from a neighbouring PCT, not its own. Secondly there were several other competitors, included the local acute trust and community provider, as well as private sector providers. **Why is that important?** Firstly, when horizon scanning, providers and commissioners should also look across their borders for partners not just to their familiar local providers. Secondly community providers are now autonomous provider organisations (APO's) and will be responding to tenders; the option to present business cases to the commissioner no longer exists in a competitive market, and attracting income from more than one commissioner spreads risk.

There are also lessons about the tendering process itself for bidders and commissioners including the use of competitive dialogue, open book (see footnote) calculations, TUPE and adjudication. Finally, the "softer" side of the story needs telling. This is a story of successful relationship building; of a top team of managers and clinicians pulling together to take on the challenge of responding to a tender, working hard to meet deadlines in a time of rapid organisational change; and the development of a new constructive and responsive relationship between a commissioner and a provider. Challenges remain: to build a similarly successful relationship with staff subject to TUPE who will be part of the new team, as well as developing working partnerships with primary care, the local acute trust and local community provider.

Note: please use IMPRESS Jargon Buster if there are any unfamiliar terms in this report

Introduction
There have been eleven tenders for COPD services since adverts were required on www.supply2health.nhs.uk One of these was the West Herts tender for community based COPD services. For further information see Appendix 1.

Lessons

These are the main lessons from the process and build on those gained in our analysis of the Somerset story and the dos and don'ts of procurement.

The bidding process

Bidders: think hard about what is needed, and then make a decision: shall we bid? When the tender was advertised, as we suggest in our dos and don'ts of procurement, Barnet Community Services (BCS) made a positive decision to bid; they already had experience of delivering a community based COPD service and had a service level agreement (SLA) with West Herts PCT (the PCT) so had a working knowledge of the patch. They made an assessment of the size of the market and the contract and their capability to tender and deliver if successful. BCS reviewed the Somerset story on the IMPRESS website to learn.

Bidders: look at the dos and don'ts of procurement. The interview process may require different expertise from the previous processes, so think hard about who should attend and present. Should the CEO attend? Who will cover finance questions? This is the opportunity to sell your services and your team to the commissioner. Successful sales teams understand about how to build relationships, to listen to their customer, to develop a clear set of messages and how to communicate their message in appropriate ways. Have you balanced the team to match the adjudication panel in terms of experience, knowledge of the patch, patient advocacy, gender and age and styles? Do you have a mindset of "we know best" or "let's do our best to sell our services and our personal capability"? These comments are equally relevant during a competitive dialogue.

All bidders – appreciate the value of good personal relationships particularly between providers and commissioners: build them if they do not exist; nurture them if they do.

All bidders: be business ready. One of the discriminating factors between BCS and its competitor was patient feedback. NHS providers have huge opportunities to know their market, by undertaking proactive customer research: this is not the same as thinking you know what patients want because clinicians see them in clinic and on the ward. If the feedback is positive, build on it. If the feedback offers criticism, learn from it and make changes – commissioners will do their own research and know what patients think.

Acute providers: when horizon scanning, ensure you **look across borders** for partners/competitors and make no assumptions about your likelihood of success or the calibre of your competitors. Community providers may be newer organisations than acute trusts, but they will have turnovers in the region of £50 million plus, and employ over 1000 staff. Also, if you are approached by a community provider to provide consultant input, price it fairly and avoid restrictions on availability.

Acute providers: learn from the success of a bidding team that includes senior managers and clinicians working closely together.

Community providers: you have the potential to work very effectively in new markets. Commissioners want clinical engagement and responsive providers. Community organisations tend to be less hierarchical and have less of a management/clinician division: exploit this to be an effective bidding team.

Commissioners: there is an important role to verify that the proposals are clinically safe and within guidelines so consider how this is achieved (e.g. PBC leads and neighbouring specialists) and be clear on their roles.

Bidders see also advice to providers from Sharon Haggerty, this is her presentation to the Summer BTS meeting.

Using the evidence

Bidders
It is worth considering the distinctions between evidence and knowledge. Bidders should stress their expertise is not just in knowing the evidence-base of what works, which all providers can access easily, but also in their wider knowledge base. Prof Huw Davies of the NIHR SDO characterises it in this way. Evidence about what works prioritises evidence from systematic reviews or the next best alternative. These are readily accessible from Cochrane Reviews and other sources. However, he also characterises other kinds of knowledge, and these may not be equally available to all bidders. They are:
Know-about (problems): e.g. the nature, formation, natural history and interrelations of health and social problems
Know-why*:* explaining the relationship between values and policy/practice
Know-how (to put into practice): e.g. pragmatic knowledge about service and programme implementation
Know-who (to involve): e.g. care teams; building alliances for action

He calls these e*nlightenment* knowledge that reframes the issue, uses methodological pluralism and requires an engagement with values. That is, it involves people, politics and relationships. This is different from what works evidence that he describes as *instrumentalist*, problem-solving knowledge that requires a choice to be made. It provides a hierarchy of quality based on method. It suggests that there is simple technical task of data integration.

Third party providers often do not have the relevant expertise at the outset, but they do their research thoroughly, are able to cite the evidence perfectly and then 'buy in' the expertise that they need at a later date. To differentiate themselves, a strong NHS bidder would value, capture and make use of all enlightenment knowledge.

Finally – delivering the service
Finally, expressing interest gets you to the shortlisting stage, being shortlisted gets you to a bidding position, bidding gets you to the interview, the interview gets you the work. Then you have to deliver! Be ready for TUPE (see Appendix 2) and managing staff anxiety.
BCS has decided to backfill positions in its existing team, and move the senior team into the new service while it gets started.

The service has not started yet, so the story ends here, for now. but we intend to visit the service once established to gain further insights.

Conclusion

IMPRESS advocates the development and use of local respiratory networks as a way of agreeing priorities, pathways, standards and outcomes of care to improve the provision of personalised care to local people. Where it is felt necessary to introduce competition and to use a procurement process such as a competitive tender, there are lessons already learned by some NHS organisations about how to do this fairly and transparently for the benefit of patients. It is worth familiarising yourself with these before engaging in such a process.

Siân Williams and Sharon Haggerty
October 2009

Appendix 1

Key facts and figures about the West Herts tender for community based COPD services

Advertisement (http://www.supply2health.nhs.uk/)

Community based chronic obstructive pulmonary disease (COPD) Service

West Hertfordshire Primary Care Trust is seeking a provider of community COPD services to provide an integrated care pathway with the acute respiratory services provided by West Hertfordshire Hospitals NHS Trust. The COPD service provides high quality care when services are provided in or closest to the patients home in a primary or community settings.

"It will be the responsibility for the provider to ensure the COPD services are provided as an integrated care pathway including the acute respiratory services provided by West Hertfordshire Hospitals NHS Trust.

The PCT will require the service provider to deliver a future service model that:

• Identifies and treats unstable COPD patients to prevent hospital admission
• Optimises pharmacological and non-pharmacological management of COPD patients
• Provides care and support with other NHS providers to ensure an integrated, flexible service is delivered to patients in a timely way
• Provides personalised care tailored to the individual needs of the patient
• Maximises the patient's quality of life and enhances people to live an independent life"

Likely total contract term: 3 years with a negotiable 2-year extension

Advertised contract value: minimum £600,000 maximum £1,100,000 (over 3 years)

Next stage: Expressions of interest

Procurement method: Pre-Qualification Questionnaire

Expression of Interest due: 26/3/09

Procurement process

1. Pre qualifying questionnaire (PQQ)	30 March 2009
2. Invitation to tender (ITT) After the invitation to tender stage the PCT shortlisted two: BCS and BUPA. If we were to read this in 2010/11 it might not be surprising. But in July 2009, this is an astonishing position. The two shortlisted providers were a community provider, and a private provider: no acute trust nor the local community provider was shortlisted	5 May 2009
3. Competitive dialogue The commissioners can choose to include competitive dialogue between shortlisting candidates and interview. It can be a valuable process as it allows the commissioners to ask for further information, and bidders can ask for clarification and further information. Bidders need to be business ready to engage in such a process, and have management and clinical input aligned. It is also a chance to build relationships. One bidder's questions were not shared with the other candidate.	27 May 2009 to 12 June2009

4. Final specification	17 July 2009
5. Respond to final specification	6 July 2009
6. Presentation and interview	15 July 2009

Appendix 2

Note on TUPE

Implementing TUPE is complex. Whilst staff can TUPE to a non NHS organisation, many choose not to do so. The relative safety promised by NHS organisations who go for the social enterprise model is also not a carrot to be dangled to staff. Your rights such as pension rights are only protected for as long as you remain in the post you were in when transferred. If you then gain promotion and move to a new job description, you also lose your pension rights. Those staff who are approaching retirement are disadvantaged as enhanced packages and early retirement are relinquished when moving to a third party provider (even an NHS social enterprise). The promise of uncontested contracts if you move to a social enterprise model of NHS provision is for up to 3 years. This may in fact be for only one year and then if the contract is lost to another third party provider, you lose your pension rights.