Cooperation and Competition Panel

Conduct Guidelines

4 October 2010

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1 EXECUTIVE SUMMARY

1.1 These guidelines set out how the Cooperation and Competition Panel (CCP) deals with complaints about conduct by NHS-funded healthcare commissioners and service providers under the Principles and Rules for Cooperation and Competition (Principles and Rules) which were published by the Department of Health on 30 July 2010 and came into effect in October 2010.[1]

1.2 The Principles and Rules set out the rules that the Department of Health expects commissioners and providers of NHS services to follow to ensure cooperation and competition.

1.3 The role of the CCP in assessing conduct is to review the conduct to provide advice on matters of compliance with the Principles and Rules, including advice to the Secretary of State and his delegated authorities and, in the case of NHS Foundation Trusts (NHS FTs), Monitor. Where appropriate, the CCP applies a cost-benefit analysis to assess the matter.

1.4 Conduct complaints under the Principles and Rules are 'reserved matters'.[2] This means that once a matter has been raised with the party that is alleged to have acted inconsistently with the Principles and Rules and the relevant SHA, the CCP can consider the complaint. In contrast to procurement and advertising disputes, for conduct disputes the complainant does not need to attempt to resolve the dispute using the relevant Strategic Health Authority's (SHA) dispute resolution process. Local engagement that is required for conduct disputes is therefore more limited than that required for procurement or advertising disputes.

1.5 Once a conduct case has been accepted, the CCP will usually reach a decision within 40 working days (Phase I) on whether or not there are reasonable grounds for suspecting that the conduct in question is inconsistent with the Principles and Rules in a material respect. If there are, the CCP may accept assurances that deal with its concerns before the end of Phase I. Alternatively, the CCP may initiate an in-depth investigation (Phase II). The CCP will then decide within 80 working days whether or not it expects that the conduct is inconsistent with the Principles and Rules and whether remedies are appropriate.

1.6 The final decision in relation to conduct matters rests with the relevant decision maker to which the CCP provides its advice. This may be the Secretary of State for Health (or any person or organisation acting under delegated authority from the Secretary of State) or Monitor (in relation to NHS FTs).

2 INTRODUCTION

2.1 These draft guidelines set out the CCP's approach to conduct cases under the Principles and Rules which were published by the Department of Health on 30 July 2010 and which came

[1] The *Principles and Rules for Cooperation and Competition* are available on the CCP's web site at www.ccpanel.gsi.gov.uk. They were first published in December 2007 as part of the 2008/2009 Operating Framework. A revised version was published on 25 March 2010 which was due to become effective in October 2010. However, the Department of Health published a further revision on 30 July 2010; this is the version to which these Guidelines relate.

[2] CCP, draft *Rules of procedure.* These are available on the CCP's web site at www.ccpanel.gsi.gov.uk.

into effect in October 2010. These Guidelines supplement the CCP's Rules of Procedure. In the event of any conflict between the Rules of Procedure and the Conduct Guidelines, the Rules of Procedure will take precedence once they have been finalised.[3]

2.2 The Principles and Rules apply to all commissioners and providers of NHS-funded healthcare services. The CCP is required to advise the Secretary of State for Health (or any person or organisation acting under delegated authority from the Secretary of State) or Monitor (in relation to FTs) whether or not conduct is consistent with the Principles and Rules.

2.3 Complaints can be brought by any party who meets the acceptance criteria outlined in Section 5. This includes members of the public, patients and representative bodies and SHAs, in addition to commissioners and providers such as GPs, Primary Care Trusts (PCTs), NHS Trusts and NHS Foundation Trusts and independent sector providers.

2.4 A number of different types of conduct fall within the scope of the Principles and Rules relating to commissioning, cooperation and conduct of individual organisations. The relevant Principles and Rules are set out below:

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

Principle 2: Commissioning and procurement must be transparent and non-discriminatory and follow the Procurement Guide issued in July 2010

Principle 3: Payment regimes and financial intervention in the system must be transparent and fair

Principle 5: Commissioners and providers should encourage patient choice, including choice of Any Willing Provider, and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare.

Principle 6: Commissioners and providers should not reach agreements which restrict commissioner or patient choice against patients and taxpayers' interests

Principle 8: Commissioners and providers must not discriminate unduly between patients and must promote equality

2.5 A number of rules, actions and behaviours are associated with these Principles and Rules; these are set out in the full version of the Principles and Rules, available at www.ccpanel.org.uk.

2.6 These guidelines describe how the Principles and Rules are applied and cover the following topics:

- Section 3: a summary of the policy rationale for conduct rules
- Section 4: interaction between the CCP and other organisations such as the Office of Fair Trading (OFT) and the NHS Litigation Authority (NHSLA)
- Section 5: acceptance criteria that must be met before the CCP can formally review complaints relating to conduct
- Section 6: the process by which the CCP will deal with conduct cases

[3] The CCP's draft *Rules of Procedure* are available on the CCP's web site at www.ccpanel.gsi.gov.uk.

- Section 7: how the CCP assesses conduct that may breach the Principles and Rules
- Section 8: advice and recommendations to sponsors
- Appendices:
    i. Flowchart summarising the process from acceptance to decision
    ii. Guidance on the content of submissions
    iii. Guidance on informal advice

2.1 As the CCP gains more experience in dealing with conduct matters and policy develops, these guidelines may need to be revised. Consistent with this, the CCP may find it necessary to deviate from these guidelines in the context of any matter that raises novel issues. Where this is the case, the CCP will acknowledge that it has deviated from its guidelines and will set out its reasons for doing so.

2.2 In its White paper, *Equity and excellence: Liberating the NHS*, the Government explained that Monitor is to become the economic regulator for the health and social care sectors. One of its functions will be to promote competition to ensure that competition works effectively in the interests of patients and taxpayers. Monitor will have concurrent powers with the OFT to apply competition law to prevent anti-competitive behaviour.

3 RATIONALE FOR PRINCIPLES AND RULES RELEVANT TO CONDUCT

3.1 This section provides a summary of the rationale for regulating the conduct of NHS providers and commissioners. It is intended as useful background to users of these guidelines, but is not a statement of government policy. The Government, advised by the Department of Health, is responsibility for developing policy on cooperation and competition in the NHS.

3.2 Patient choice and competition can be expected to have numerous beneficial effects: efficiency is improved and innovation and productivity increase, so increasing the quality and, more generally, the diversity of choice as service providers respond to the preferences of their patients. As set out in the *Framework for Managing Choice, Cooperation and Competition*, choice and competition in the NHS can be expected to:

- improve quality and safety in service provision;
- improve health and wellbeing;
- improve standards and reduce inequalities in access and outcomes;
- lead to better informed patients;
- generate greater confidence in the NHS; and
- provide better value for money.[4]

3.3 Certain types of conduct on the part of commissioners or providers can reduce patient choice and competition, and this may have an adverse effect on patients and taxpayers by reducing the incentives that service providers have to improve services. For example, collusive agreements between providers can mean that those providers no longer have to work as hard to attract patients and can charge higher prices to commissioners. Vertically integrated

[4] For more information, see the Framework for Managing Choice, Cooperation and Competition www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084779

organisations can reduce patient choice by directing patients to their own services and use this to foreclose competition. And commissioners can distort competition through unfair financial interventions or payment systems that favour one provider over another.

3.4 The purpose of the conduct provisions of the Principles and Rules is to ensure that providers compete with one another on a level playing field that is not distorted by the actions of providers or commissioners.

3.5 The following sections of these guidelines set out the CCP's approach to applying Principles 1 to 8 to conduct involving NHS commissioners and providers.

4 THE CCP'S INTERACTION WITH OTHER ORGANISATIONS

RELATIONSHIP BETWEEN PRINCIPLES AND RULES AND COMPETITION LAW

4.1 Some types of conduct which fall within the scope of the Principles and Rules may also be subject to UK and EU competition law. Where service providers (in particular a non-government service provider) or commissioners are considered 'undertakings' (for the purposes of the Competition Act 1998 and Articles 101 and 102 of the Treaty on the Functioning of the European Union (TFEU)), conduct that is in breach of the Principles and Rules may also be in breach of this legislation. In some cases, such conduct may constitute a criminal offence.[5]

4.2 Responsibility for enforcing competition law in the UK pursuant to the Competition Act 1998, the Enterprise Act 2002, and Articles 101 and 102, TFEU lies with the OFT. The CCP does not have jurisdiction to enforce the Competition Act 1998, the Enterprise Act 2002 or Articles 101 and 102 TFEU.

4.3 If anti-competitive conduct relates to both NHS-funded and non-NHS funded healthcare services the CCP and OFT will decide at the earliest opportunity which authority is best placed to investigate on a case-by-case basis. However, given the different remedies available, and in particular the wide powers of Monitor and the Department of Health to direct, respectively, FTs and other NHS organisations following advice from the CCP, there may be instances where the CCP will investigate the relevant conduct under the Principles and Rules in addition to the OFT investigating the relevant conduct under the Competition Act 1998, the Enterprise Act 2002 or Articles 101 and 102, TFEU.

4.4 The CCP will inform the OFT whenever it becomes apparent that the conduct in question is a matter for the OFT and not necessarily after it has concluded its inquiry and provided advice to the Department of Health or Monitor.

4.5 The CCP and OFT have established working arrangements which provide a framework for cooperation and constructive communication.[6] The working arrangements explain how the OFT and CCP will deal with cases involving the provision of healthcare services in England and

[5] Under section 188 of the Enterprise Act 2002.
[6] Available on the CCP's web site at www.ccpanel.gov.uk.

that they will keep each other updated on matters of mutual interest or where there are developments that have potential implications for the other organisation.

RELATIONSHIP BETWEEN THE CCP AND NHS LITIGATION AUTHORITY (NHSLA)

4.6 The NHSLA adjudicates on contractual disputes between primary care practitioners and their local Primary Care Trusts (PCTs). Primary care practitioners include GPs, dentists, opticians and pharmacists. The NHSLA acts under delegated authority from the Secretary of State. The NHSLA does not consider matters under the Principles and Rules.

4.7 Complaints to the CCP relating to conduct involving PCTs and primary care providers of NHS-funded services may also raise contractual issues. Similarly, contractual disputes and appeals dealt with by the NHSLA may raise questions under the Principles and Rules. It may also be possible to characterise a particular grievance or dispute either as a breach of the Principles and Rules or as a contractual dispute.

4.8 In these situations, the CCP and the NHSLA will seek to avoid duplication of effort and to minimise the risk of inconsistent outcomes through use of the CCP's acceptance criteria and through dialogue to determine which body is best placed to deal with the matter.

4.9 The NHSLA and CCP have established working arrangements which provide a framework for cooperation and constructive communication between them.[7]

5 CCP ACCEPTANCE CRITERIA FOR CONDUCT CASES

5.1 For the CCP to review a complaint regarding the conduct of a service provider or commissioner, the CCP must consider that the following acceptance criteria are satisfied:[8]

i. the subject matter of the complaint falls within the scope of the relevant Principles and Rules;

ii. the party making the complaint provides all necessary information to enable the CCP to carry out an initial analysis of key issues. The complainant should also include (as a minimum) the information set out in Appendix 2, *Guidance on the content of submissions*;

iii. the complainant has engaged with the party with whom the dispute has arisen and with the relevant SHA before the CCP accepts the case;[9] this is not required for complaints regarding potentially collusive behaviour which should come directly to the CCP.[10]

iv. the CCP is the most appropriate body to consider or resolve the issue as compared to other bodies or regulators including the OFT, the NHSLA and the Advertising Standards Authority (ASA));

v. there are no relevant on-going legal proceedings or investigations. Relevant legal proceedings or investigations brought elsewhere which deal with the same issue.

[7] Available on the CCP's web site at www.ccpanel.gov.uk.
[8] These acceptance criteria do not apply to the provision of informal advice as described in Appendix 3.
[9] This means that the complainant must have brought the matter to the attention of the party with whom they are in dispute, and the relevant SHA, asking them to address the concerns.
[10] Collusive behaviour includes price fixing, bid rigging, market sharing, or the exchange of price or non-price information. Further information can be found in section 7 at paragraphs 7.58 - 7.71.

Proceedings or investigations are considered to be on-going when a matter has been filed in a court or tribunal (or where an investigation has been commenced by professional or government regulatory bodies) and the matter has not yet been determined by the court, tribunal or other body where the proceedings were filed or commenced. If proceedings or investigations are commenced once the CCP has accepted a complaint, this may result in the CCP's process being terminated or suspended at the discretion of the CCP; and

vi. the dispute is not trivial, vexatious or an abuse of the CCP's procedures. A dispute may be 'vexatious or an abuse of the CCP's procedures' where, for instance:
    - the complainant has made several applications or complaints regarding the same or very similar subject matter and these have been rejected, or the CCP is satisfied that they have been dealt with appropriately; or
    - the complainant attempts to mislead the CCP, for instance by providing false, misleading or incomplete information in its submission.

5.2 If an application does not meet the acceptance criteria, the CCP will write to the applicant briefly explaining the reasons for this.

5.3 On occasion it may be necessary for the CCP to prioritise cases due to resource constraints. If so, the CCP will prioritise according to the likely impact of the case on patients and taxpayers, balanced against its strategic significance and the risks and resources involved in taking it forward. This means that there may be circumstances where the CCP will either decline a case or advise the complainant that the case may be accepted at a later date. The complainant will be informed accordingly.

6 PROCESS FOR CONDUCT CASES

6.1 The CCP has adopted a two-phase approach to assessing conduct complaints. The purpose of this approach is to facilitate the efficient assessment of conduct cases and, in particular, to allow any conduct that does not raise material concerns to be dealt with promptly, while providing sufficient time for the CCP to consider more complex cases in a second phase where this is required.

6.2 In summary, once the CCP has decided to accept a conduct complaint, it will inform the complainant and the party that is the subject of the complaint (the parties) and ensure that the latter receives a copy of the complainant's submission. The CCP will publish a Notice of Acceptance on its web site and the parties will be informed of the expected timetable and key steps in the process, which are generally as set out below.

- The party who is the subject of the complaint has the opportunity to respond to the complaint within a specified timeframe.
- The CCP engages with parties and any third parties as it considers appropriate (for example by sending information requests or holding meetings).
- The CCP sends the parties a letter setting out what it considers to be the main issues arising from the complaint (the issues letter).

- The parties have an opportunity to respond to the issues letter and the CCP will send the parties each other's response to the issues letter.
- The CCP takes into account the parties' comments and decides (normally within 40 working days after publishing the Notice of Acceptance) whether or not there are reasonable grounds for suspecting that the conduct in question is inconsistent with the Principles and Rules in a material respect. Three outcomes are possible:
    i. the CCP considers there are not reasonable grounds for suspecting that the conduct is inconsistent with the Principles and Rules in a material respect and publishes advice and recommendations accordingly;
    ii. the CCP considers that there are reasonable grounds for suspecting that the conduct is inconsistent with the Principles and Rules in a material respect, but the parties offer assurances that address any concerns; the CCP publishes advice and recommendations, as well as the assurances; or
    iii. the CCP considers that there *are* reasonable grounds for suspecting the conduct is inconsistent with the Principles and Rules and proceeds to Phase II of its investigation. The CCP publishes a decision briefly outlining its reasons for proceeding to Phase II.
- Towards the end of Phase II, the CCP reaches a provisional view on whether or not it expects the conduct to be inconsistent with the Principles and Rules. It will inform the merging parties of this provisional view in writing and identify any remedies which it believes could address any concerns. The parties will have an opportunity to respond.
- The CCP may hold (further) meetings with the parties.
- Following the parties' response, and within 80 working days from the start of Phase II, the CCP will decide whether or not it expects (on the balance of probabilities) the conduct to be consistent with the Principles and Rules and whether or not remedies are appropriate.
- The CCP then publishes its advice and recommendations, as well as any remedies.

6.3 If there is a material change in circumstances such that the basis for the complaint falls away, the CCP may decide to set aside a case and not issue advice and recommendations. In reaching a decision on whether or not to set aside a case, the CCP will consider the precedent value of its advice and recommendations, whether or not the conduct in question is likely to be isolated or widespread, and the risk of conduct recurring.

APPLICATION, NOTICE OF ACCEPTANCE AND RESPONSE

6.4 A complaint to the CCP concerning conduct under the Principles and Rules should be supported by as much factual information as possible to allow the CCP to make an accurate and prompt assessment as to whether the matter meets its acceptance criteria (see section 5 above). All complaints must also contain (as a minimum) the information set out in Appendix 2, *Guidance on the content of submissions.* General allegations that a complainant considers conduct to be inconsistent with the Principles and Rules are not sufficient for the CCP to take on a case.

6.5 The CCP is generally unable to undertake cases on a confidential basis. This is because service providers or commissioners that are the subject of a complaint must have the opportunity to respond to any allegations about their conduct. However, the CCP will consider requests to keep the identity of the complainant confidential where there is a strong reason for doing so, although in such circumstances the fact that an inquiry is being conducted may be made public. In addition, it is essential that the material elements of the complaint are made known to the party that is the subject of the complaint. In some cases this means that identification of the complainant may be unavoidable. Concerns about confidentiality should be raised with the CCP as soon as possible.

6.6 Once the CCP has decided to accept a matter it will publish a Notice of Acceptance on its web site. The Phase I deadline (40 working days) starts to run from the date of publication. The party that is the subject of the complaint (also referred to as the respondent) will be provided with a copy of the complaint and be invited to respond within a specified timeframe. At the start of the process, the CCP will also write to the parties to inform them that the CCP is dealing with the matter and setting out the timetable that it expects to follow.

INFORMATION GATHERING, INVOLVEMENT OF THIRD PARTIES AND ISSUES LETTER

6.7 Third parties may respond to the invitation to comment which is published on the CCP's web site. Responses to the invitation to comment must generally be provided within the deadline indicated on the CCP's web site. Submissions should be made as early as possible so that they can be considered, verified and taken into account properly. Whenever possible, third parties should substantiate and support any points raised by examples, documents and other factual evidence. It will be more difficult for the CCP to take into account assertions that are not supported by evidence.

6.8 In the course of its review (during both Phase I and Phase II) the CCP may need additional, or more comprehensive, information from the parties (and third parties) than is provided in the initial submission made by the complainant and in the response. The CCP will ask for such additional data, information or documents as soon as it is clear they are necessary. Requests for such information will normally allow a short deadline for response. The CCP will specify what information is required and fix the timescale for responding each time it makes an information request. If that deadline cannot be met, it may be necessary to suspend the timetable ('stop the clock') until the requested information is provided. A notice to this effect will be published on the CCP's web site. If, despite repeated requests, information is not forthcoming the CCP may take a view on whether or not it is appropriate to proceed with the case without the requested information, or to set the case aside.

6.9 Whenever appropriate (during both Phase I and Phase II) the CCP may seek external economic and/or clinical expertise and launch its own economic studies to inform its investigation.[11] Clinical input may be sought from members of the CCP's Clinical Reference Group.[12] Where

[11] CCP staff may also obtain input from the Economics Reference Group. This Group provides expert competition economics advice on issues under consideration by the CCP (http://www.ccpanel.org.uk/about-the-ccp/economics-reference-group.html).

[12] www.ccpanel.org.uk/about-the-ccp/clinical-reference-group.html.

the Group's members do not have the relevant clinical expertise, they will assist in identifying individuals with relevant clinical knowledge.

6.10 Current policy and legislation give weight to patient and public involvement in the NHS.[13] The CCP may therefore seek the views of the relevant Local Involvement Networks (LINKs), provided that, in the opinion of the CCP this would be useful and appropriate. LINKs and other (patient) organisations are also free to respond to the invitation to comment on the CCP's web site.

6.11 Where relevant, the CCP may contact the Care Quality Commission to obtain up-to-date information.

6.12 The CCP may decide to have meeting or hearings with relevant parties (the parties to the complaint and, if appropriate, third parties). Panel Members may attend the meetings or hearings.

6.13 Having reviewed the complaint and the response and carried out initial fact-finding and analysis, the CCP will send a letter to the complainant and respondent setting out what it considers to be the main issues arising from the complaint under the Principles and Rules. The letter may set out any tentative conclusions based on the available evidence at that stage and may invite the parties to submit assurances that address any potential concerns. The parties will be given the opportunity to respond to the issues letter and they will be provided with a copy of each other's response.

END OF PHASE I

6.14 Having reviewed the parties' responses to the issues letter, the CCP will decide (no later than 40 working days after publishing the Notice of Acceptance)[14] whether or not there are reasonable grounds for suspecting that the conduct in question is inconsistent with the Principles and Rules in a material respect. Three outcomes are possible:

- The CCP considers there are *not* reasonable grounds for suspecting the conduct is inconsistent with the Principles and Rules in a material respect and publishes advice and recommendations accordingly;
- The CCP considers that there *are* reasonable grounds for suspecting that the conduct is inconsistent with the Principles and Rules in a material respect, but the parties offer assurances that address any concerns; the CCP publishes advice and recommendations, as well as the assurances.
- The CCP considers that there *are* reasonable grounds for suspecting the conduct is inconsistent with the Principles and Rules and proceeds to Phase II of its investigation. The CCP publishes a decision briefly outlining its reasons for proceeding to Phase II.

[13] The Local Government and Public Involvement in Health Act 2007 established Local Involvement Networks from April 2008.
[14] Subject to any extension of the timetable due to a delay in responding to information requests and any extension agreed with the relevant Sponsor.

PHASE II

6.15 The Phase II assessment will be completed within 80 working days from the beginning of Phase II, subject to any extension of the timetable due to delay in responding to information requests, and any extension agreed with the relevant Sponsor.

6.16 At the beginning of the Phase II process, the CCP is likely to ask further detailed questions of interested parties as well as the complainant and respondent, for example to enable it to assess the costs and benefits arising from the conduct.

6.17 The CCP may decide to have meetings or hearings with relevant parties (the parties to the case and, if appropriate, third parties). Panel Members may attend the meetings or hearings.

6.18 Towards the end of Phase II, the complainant and the respondent will be provided with the CCP's analysis and provisional conclusions; they will have the opportunity to submit further and final comments to the CCP within a specified timeframe. Further meetings may take place between the CCP and the parties. Having taken into account any representations from the parties, the CCP will finalise its decision on whether or not it expects (on the balance of probabilities) the conduct to be consistent with the Principles and Rules. A non-confidential version of the final recommendation will be published on the CCP's web site. The CCP will also provide a copy to the parties.

6.19 The CCP may recommend that action be taken to remedy, mitigate or prevent inconsistency with the Principles and Rules.

6.20 The CCP expects to reach a decision and publish its recommendation within 80 working days from the date of commencing its Phase II review. This is subject to any extension of the timetable due to a delay in responding to information requests, and any extension agreed with the relevant Sponsor.

PUBLISHING AND CONFIDENTIALITY

6.21 The CCP will publish on its web site non-confidential versions of key information and documents received from the parties and third parties in the context of any conduct case that it has accepted. The CCP will also publish notices to 'stop the clock' or set aside a case, and a non-confidential version of the statement of issues (if a case proceeds to Phase II) and final advice and recommendations, including any assurances or remedies.

6.22 Before publication, the relevant organisation will be offered the opportunity to request the excision of business secrets or other confidential information from the public version of the documents and to check factual accuracy. There will normally be a short deadline for response. The CCP will provide the parties with an advance copy of information that will be published. The CCP may publish information where it is compelled by law or the Courts or where it is reasonably necessary to facilitate the CCP's exercise of its functions or in the interest of transparency.

6.23 To the extent that the CCP's reasoning in any decision relies on confidential information, the CCP will make this information available to the relevant Sponsor, subject to the Sponsor confirming that it shall treat such information as confidential and that it shall use the relevant information only for the purpose of its decision.

7 ASSSESSMENT OF CONDUCT

7.1 This section explains how the CCP assesses whether service provider or commissioner conduct is consistent with the relevant Principles and Rules. Each of these Principles and Rules relates to conduct that may directly or indirectly restrict choice or competition.

OVERARCHING APPROACH TO ASSESSING CONDUCT UNDER THE PRINCIPLES AND RULES

7.2 In general, when assessing commissioner and provider conduct, the CCP will assess the effect of that conduct on patients and taxpayers in reaching a conclusion as to whether or not that conduct is consistent with the Principles and Rules. This is appropriate particularly for those conduct provisions that aim to protect patients and taxpayers. Under some of the Principles and Rules there is an obligation on providers and/or commissioners to behave in a certain way (for example in a manner that is transparent and non-discriminatory) and there is no specific reference to patients' and taxpayers' interests. For these Principles, the CCP may take the view that it is appropriate to consider whether or not the conduct is consistent with the Principles and Rules without specifically considering the effect of the conduct on patients and taxpayers.

7.3 When the CCP applies a cost/benefit approach, it will consider, on the cost side, possible adverse effects on patients and taxpayers (including both financial and non-financial impacts) arising from any loss of patient choice or competition stemming from the conduct. The CCP offsets any such costs against any benefits to patients and taxpayers that arise from the conduct. This is not a purely quantitative assessment because costs and benefits may not be quantifiable; the assessment is therefore qualitative as well as quantitative.

7.4 Conduct may give rise to costs to patients and taxpayers if it diminishes patient or commissioner choice and competition. In general terms, conduct that hinders patient choice and/or restricts cooperation or competition may have an adverse effect on patients and taxpayers when, as a result of reducing the intensity of competition between service providers, it reduces the quality and choice of services delivered to patients or it increases the prices paid by commissioners.

7.5 If the CCP identifies material costs arising from the conduct,[15] then the CCP will also have regard to any benefits to patients or taxpayers arising from the conduct in question. These benefits might take the form of clinical or other considerations such as higher quality services, more integrated, seamless services, greater innovation in relation to such services or lower prices to commissioners.

[15] Where the CCP finds that there are no material costs to patients or taxpayers arising from the conduct, it will not necessarily analyse patient or taxpayer benefits ascribed to the conduct.

7.6 Benefits to patients may be clinical or non-clinical. Non-clinical patient benefits may arise where conduct leads to better access, improved surroundings or better amenities. Clinical patient benefits may arise in a number of ways, for example:

- Conduct may lead to improved patient outcomes due to an increase in patient volumes. It has been recognised that in certain treatment groups outcomes are improved where a larger volume of patients is treated in a particular centre.
- Conduct may lead to benefits if it improves the scope of services. There may be an increase in the number of services available, this could be due to a physical association between clinical teams, an ability to utilise equipment which has not before been available to certain clinicians.
- Conduct may involve sharing clinical working practices, with a beneficial impact on patients.
- Conduct may lead to more seamless patient care.

7.7 Where benefits are asserted by the parties, the CCP expects them to provide robust evidence as to the predicted improvements in outcome to their specific patient population or the subset of that population that will accrue the asserted benefit.

7.8 Benefits to taxpayers may take the form of lower costs and better value for money for commissioners and ultimately taxpayers. There are a number of ways in which financial benefits may arise from a conduct:

- Conduct may lead to improved economies of scale and lower short-run variable costs or fixed costs.
- Conduct may lead to improved economies of scope and lower short-run variable costs or fixed costs.
- Conduct may lead to more efficient clinical or managerial processes or working methods.
- Conduct may reduce transaction costs.[16]
- Conduct may lead to improved recruitment and retention of staff, reduction of duplicative patient assessments (a financial benefit arising from provision of more seamless patient care).

7.9 The CCP expects that party whose conduct is the subject of the complaint to identify and describe the benefits to patients and taxpayers that arise from their conduct and to provide any relevant evidence. In considering how benefits ascribed to conduct should be taken into account, the CCP considers the following factors:

- the relationship between the benefits and conduct and whether the benefits could be (or could have been) realised without the conduct, or could be realised in a way that imposes fewer costs on patients and taxpayers;
- the period of time over which the benefits will be (or have been) realised;

[16] Transaction costs are costs that arise because a service is not provided from within the organisation. For example, costs of searching for different providers and gathering information on their prices and/or quality, as well as the costs of procuring or bargaining with those providers to determine the price and quality for purchase of services.

- the robustness of the analysis that identifies the benefits arising from the conduct (in considering clinical benefits, the CCP will have particular regard to supporting research and evidence regarding clinical improvements).

7.10 In evaluating patient benefits the CCP will consider whether or not the benefits that are put forward by the parties are perceived as benefits by patients. The benefits as asserted by the parties must be verifiable by reference to compelling evidence. The CCP recognises that innovation in healthcare is such that no evidence may currently be available for the presumed benefit. Where there is no evidence available to present to the CCP the parties should be aware that there will be additional scrutiny of the measurements put in place to ascertain the outcome of the proposed benefit.

7.11 Finally, the CCP will then assess whether benefits are sufficient to offset any costs to patients or taxpayers that have been identified. The CCP will then conclude whether, overall, there is likely to be a material net adverse effect on patients and taxpayers. If there is, then the conduct will be inconsistent with the Principles and Rules.

RELEVANT PROVISIONS OF THE PRINCIPLES AND RULES

7.12 The following paragraphs explain the provisions of the Principles and Rules that are relevant to conduct and the substantive assessment carried out by the CCP. They have been grouped into three categories. The first category outlines obligations on commissioners in relation to commissioning, procurement, payment regimes and financial intervention. The second category sets out obligations on providers and commissioners that relate to the way in which these organisations interact. The third category relates to conduct on the part of one organisation independently (also known as unilateral conduct).

Conduct of commissioners

- Principle 1: Commissioners must commission services from the providers who are best placed to deliver the needs of their patients and populations.[17]
- Principle 2: Commissioning and procurement must be transparent and non-discriminatory and follow the Procurement Guide issued in July 2010
- Principle 3: Payment regimes and financial intervention in the system must be transparent and fair.

Conduct involving two or more organisations

- Principle 5: Commissioners and providers should promote patient choice, including choice of any willing provider, and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare; and
- Principle 6: Commissioners and providers should not reach agreements which restrict commissioner or patient choice against patients and taxpayers' interests.

[17] Commissioners in this context refers to PCTs as contracting authorities, specialist commissioning groups or other bodies specifically contracted to commission services on behalf of PCTs.

Conduct of one organisation

- Principle 5: Commissioners and providers should promote patient choice, including choice of any willing provider, and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare; and
- Principle 8: Commissioners and providers must not discriminate unduly between patients and must promote equality.

7.13 Generally, complaints regarding commissioning strategy or commissioning decisions which have wide-ranging consequences are treated by the CCP as conduct complaints. Complaints regarding individual procurement exercises such as procedural irregularities are treated by the CCP as procurement complaints. Procurement activities are part of the overall process for commissioning services and a number of principles relate to both commissioning and procurement, for example Principle 1 which requires commissioners to commission services from those providers who are best placed to deliver the needs of their patients and populations; Principle 2 which states that commissioning and procurement must be transparent and non-discriminatory and follow the Procurement Guide; and Principle 5 which places an obligation on providers and commissioners to encourage patient choice.

7.14 In practice, therefore, it may not always be straightforward to determine whether a particular complaint is best categorised as a conduct complaint that relates to commissioning or a procurement dispute. In determining whether a particular complaint should be categorised as a conduct case or a procurement case, the CCP takes into account the following:

- It should not be unduly difficult to raise formal complaints under the Principles and Rules. Where the route for challenging procurement issues is unduly obscure or difficult, the CCP may therefore decide to deal with procurement issues in a conduct case.
- Where there is evidence that commissioners have more general procurement practices that may be inconsistent with the Principles and Rules, these may be dealt with as conduct cases.
- Where commissioning behaviour raises some issues that may be categorised as conduct cases and some issues that may be categorised as procurement cases, the CCP takes the view that due process is likely to be best served by dealing with all the related issues in the context of a single case.

7.15 To the extent that the relevant Principles and Rules cover conduct which is similar to behaviour which is prohibited by the Competition Act 1998, the Enterprise Act 2002 or Articles 101 and 102, TFEU the CCP will consider relevant guidance and case law associated with these provisions where it assists the analysis of the type of conduct that might restrict, distort or prevent competition in the NHS.

Principle 1

7.16 Principle 1 and the associated rules are set out below.

Commissioners must commission services from the providers who are best placed to deliver the needs of their patients and populations.

- Commissioners must commission services from providers who are best placed to deliver the needs of their patients and populations having regard to their overall present and future needs and the sustainability of services
- Commissioners, at board level, should be able to demonstrate a clear rationale for procurement and contracting decisions in terms of quality and value for money
- Commissioners' boards must ensure that their organisations comply with the Procurement Guide, including when considering proposals from practice-based commissioners
- Commissioners must hold all providers to account through their contract for the quality of their services in a proportionate manner, in accordance with the Procurement Guide, and give existing providers two opportunities to address underperformance or implement incremental improvements, prior to engaging potential alternative providers.

7.17 In assessing a complaint under Principle 1, the CCP will analyse the decision made by the commissioner who is the subject of the complaint. In particular, the CCP will consider any costs (detriment) to patients or taxpayers which have arisen from the commissioning decision that result in an adverse effect on patients or taxpayers as a result of a loss of choice or competition.

7.18 For example, costs may arise when the pool of credible bidders for contracts has been significantly restricted without objective justification. Such a restriction could weaken competition on price and quality and reduce value for money for patients and taxpayers.[18]

7.19 If the CCP identifies such costs, it will consider whether the commissioning decision has given rise to any benefits and if so, weigh these against the costs identified. It will be for the relevant commissioner to produce evidence of any benefits. If the costs outweigh the benefits, the CCP is likely to conclude that the commissioning decision was in breach of Principle 1.

Principle 2

7.20 Principle 2 and the associated rules are set out below.

Commissioning and procurement must be transparent and non-discriminatory and follow the Procurement Guide issued in July 2010.

- PCT boards and other commissioners must ensure that their organisations comply with the Procurement Guide, including when considering proposals from practice-based commissioners
- Commissioners must be able to demonstrate at each stage of the procurement process that they have acted in a transparent and proportionate manner
- Commissioners must be able to demonstrate at each stage of the procurement process that they have not acted in an unduly discriminatory manner

[18] Whether or not there is a material adverse effect on competition depends on the number of bidders and their effectiveness.

- Commissioners' decisions to procure services via single or competitive tender must be authorised by the board and underpinned by a clear rationale
- Commissioners must advertise competitive tenders and all contract award decisions on the Supply2Health procurement portal if required by the Procurement Guide and in the Official Journal of the European Union (OJEU) if required under EC law.

7.21 The Procurement Guide explains that the requirement of transparency is fundamental to the accountability of commissioners as public contracting authorities and is applicable to all commissioning activities, including procurement and contracting. There are four main areas of activity where commissioners must be transparent:

- Commissioners must ensure that their short to medium term commissioning intentions are transparent.[19]
- Commissioners must ensure there is transparency regarding the outcome of service reviews and whether a competitive tender is to be used.[20]
- Commissioners must ensure that procurement opportunities are appropriately advertised, contract awards are notified, unsuccessful bidders are given feedback and a standstill period is observed.[21]
- Commissioners should retain an auditable documentation trail that is itself transparent, regarding key decisions.[22]

7.22 The obligation on commissioners to behave in a transparent manner means they should act in a way which is open and which enables interested parties to easily understand their commissioning intentions and procurement processes. When assessing the extent to which a commissioner has acted transparently, the CCP is likely to consider whether key information has been made available to providers and potential providers. Key information might include:

- contracting intentions at the beginning of the financial year and when contracts are likely to be awarded;
- intentions to award an individual contract with details of that contract such as:
    i. description of the services required
    ii. place of delivery
    iii. number or range of services providers who will be invited to tender
    iv. duration of contract
    v. approximate value of the contract
    vi. eligibility criteria
    vii. the award criteria

- a contract award notice which is likely to set out:
    i. description of services
    ii. date of award
    iii. criteria for award
    iv. number of tenders received
    v. name and address of winning bidder

[19] Department of Health, *Procurement Guide*, paragraph 1.22.
[20] Department of Health, *Procurement Guide*, paragraph 1.23.
[21] Department of Health, *Procurement Guide*, paragraphs 1.24 – 1.25.
[22] Department of Health, *Procurement Guide*, paragraph 1.26.

vi. price range
vii. where appropriate, details of any part of contract which is sub-contracted

7.23 The Procurement Guide states that the commissioning process, including any form of procurement, should be non-discriminatory and transparent at all times.[23] In terms of non-discrimination, the commissioning process should neither include, nor favour, nor exclude any particular provider. The process should not give an advantage to any particular sector (public, private, voluntary, charitable or social enterprise). This includes ensuring that decisions are taken on the basis of evaluation criteria rather than with regard to the type of organisation concerned.[24] Different treatment therefore requires an objective justification. Whether or not the basis for different treatment is objectively justified will depend on the facts of the particular case. The CCP will consider whether an asserted objective justification is reasonable in its formulation and effect. A criterion which acts to routinely exclude a category of providers or potential providers and which is unrelated to a provider's ability to provide a particular service is unlikely to be considered by the CCP to be an objective justification.

Principle 3

7.24 Principle 3 and the associated rules are set out below.

Payment regimes and financial intervention in the system must be transparent and fair

- Commissioners must not create payment regimes which unjustifiably restrict choice or competition against patients' and taxpayers' interests
- Commissioners must be able to demonstrate that payment regimes are transparent and fair
- Commissioners and providers must adhere to the provisions for determining a non-tariff price contained in the NHS Standard Contracts
- Commissioners must not make financial interventions which unjustifiably restrict choice or competition against patients' and taxpayers' interests
- Commissioners must be able to demonstrate that financial intervention in the system is transparent and fair
- Rules on financial intervention are set out in the annual Operating Framework and are binding on all PCTs and SHAs.

7.25 Payment regimes and financial intervention in the provision of NHS-funded healthcare services have the potential to distort competition between providers and thereby deny patients and taxpayers the full benefits of competitive provision. Consequently, payment regimes and financial intervention in the provision of NHS-funded health services must not interfere with a level playing field for providers or afford particular providers or commissioners in the NHS an unfair competitive advantage.

7.26 Payment regimes are regimes relating to remuneration of service providers that are generally applicable within sectors or to broad categories of healthcare providers. These regimes may be defined in legislation and may be subject to national or regional negotiation. Examples are

[23] The PCT Procurement Guide also contains many other obligations on commissioners which are not discussed further here.
[24] Department of Health, *Procurement Guide*, paragraph, paragraphs 1.31 – 1.35.

tariffs for elective services and formulas for calculation of remuneration of GPs and dentists under certain types of contracts. It also includes payment regimes put in place by PCTs or SHAs to remunerate service providers within that PCT or SHA's commissioning area.

7.27 Financial interventions are payments outside of the above payment regimes that do not remunerate particular services, for example payments made by PCTs by way of grants, subsidies or financial assistance. Whether a payment is categorised as either falling within a payment regime or as financial intervention is unlikely to affect the assessment or the outcome of the CCP's analysis because similar rules apply to both. A number of different issues arise under this Principle, including:

- payment regimes/financial interventions must not unjustifiably restrict choice or competition against patients' and taxpayers' best interests (Principle 3, Rule 1);
- commissioners must be able to demonstrate that payment regimes/financial interventions are transparent and fair (Principle 3, Rules 2 and 5);
- actions and behaviours under Principle 3 set out appropriate behaviour relating to Payment by Results and the national tariff; and
- Payment regimes and financial interventions must not unjustifiably restrict choice or competition.

7.28 For example, financial intervention in the form of a loan or grant at a preferenetial rate of interest may unjustifiably restrict choice or competition

7.29 Payment regimes and financial intervention that are directly related and necessary for a legitimate purpose (and do not go beyond what is required for this purpose) are generally not regarded as an unjustifiable restriction of choice or competition.

Payment regimes and financial interventions must be transparent and fair

7.30 Payment regimes, financial interventions and financial assistance should be transparent and fair. Non-tariff prices should be determined objectively and transparently.

7.31 Appropriate transparency allows providers and potential providers to calculate with a reasonable degree of certainty what remuneration they will receive for providing services. Transparency also requires, for example, that:

- all payments and financial interventions are clearly and accurately accounted for and documented; and
- information regarding payments and financial intervention is available for scrutiny by the relevant overseers.

7.32 Fairness requires that payments and financial interventions must be calculated on the basis of a known set of objective criteria and not be subject to bias or retrospective change without objective justification. In addition, the way in which payments and financial interventions are allocated as between different service providers must be fair, unbiased and objectively justified. They should not afford a competitive advantage.

7.33 The CCP, in assessing whether such financial intervention is transparent and fair, will consider the following evidence:

- the financial status of the recipient of the funds;
- any existing or potential relationships between the financier and the recipient of the funds;
- the amount of the financial intervention and calculations for arriving at the sum;
- whether funding is available through any other means; and
- whether and how the funds being provided have been accounted for.

7.34 Fairness does not mean that all providers must be paid the same; there may be qualitative or quantitative differences in the services provided and the costs that providers face. If so, these differences may be objectively justified.

7.35 For example, when a service provider is awarded a contract based on an open competition, it is not appropriate for the commissioner to subsequently reduce the contract value without objective justification. To do so is likely to be both non-transparent, because the provider cannot calculate in advance the remuneration it will receive, and non-objective, if the original price was derived at by way of open competitive tender.

Payment by results

7.36 The Principles and Rules state that Payment by Results (PbR) is not subject to local negotiation (but is subject to local flexibilities) and that local flexibilities should be clear, published, approved by SHA and in accordance with the PbR Code of Conduct, Technical Manual and national guidance.

7.37 In this context, the CCP is concerned, for example, that local flexibilities do not undermine incentives to compete. For example, where providers are paid significantly below the national tariff this may undermine the system of competition that the government has put in place and detrimentally affect patient choice (where providers reduce capacity or cease to provide particular services). If providers are paid more than the national tariff this may also distort competition and have an adverse impact on taxpayers. Where appropriate the CCP will carry out a cost-benefit analysis to ascertain whether costs are outweighed by benefits.

Services not covered by national tariff

7.38 Commissioners and providers must adhere to the provisions for determining a non-tariff price contained in the NHS Standard Contracts. For services not covered by the national tariff commissioners should ensure objectivity and transparency in determining prices. Paragraphs 7.23-7.34 deal with to objectivity and transparency.

Financial incentives and assistance

7.39 SHAs must ensure that financial incentives and assistance are used appropriately and are equally available to providers from all sectors. SHAs must work with other SHAs to ensure that cross-boundary treatment of providers is consistent, equitable and fair where possible.

7.40 The CCP is concerned that financial incentives and assistance do not adversely impact on patients and taxpayers as a result of a loss of choice and competition. Incentives or assistance that is directly related and necessary for legitimate purpose (and does not go beyond what is required for this purpose) is generally not regarded as an unjustifiable restriction of choice or competition.

Principle 5

7.41 Principle 5 and the associated rules are set out below.

Commissioners and providers should promote patient choice, including - where appropriate - choice of Any Willing Provider and ensure that patients have accurate, reliable and accessible information to exercise more choice and control over their healthcare.

- Commissioners must comply with the Secretary of State's Directions regarding patients' right to Free Choice in elective care.
- Commissioners must have regard to the Secretary of State's guidance on the use of Any Willing Provider for specific services.
- Where a service is subject to patient choice, commissioners must not unjustifiably refuse to make services available to patients where the provider of the service meets any pre-determined national or local accreditation requirements and where such a refusal would restrict choice or competition against patients' and taxpayers' interests.
- Commissioners and providers must not take any actions which restrict choice against patients' and taxpayers' interests.
- As required in the NHS Standard Contracts, providers contracted to provide services under patient choice cannot subcontract these services to another provider without making this transparent to patients and referring practitioners, for example on NHS Choices.
- All parties to a contract must declare conflicts of interest.
- When making referrals to services subject to patient choice, all referring clinicians (such as general practitioners and hospital consultants) must tell their patients about any financial or commercial interest in an organisation to which they plan to refer the patient for treatment or investigation.

7.42 This Principle is wide-ranging and complaints under this Principle could relate to an agreement between two or more organisations or the conduct of an individual organisation.

7.43 The following paragraphs describe some forms of conduct that may have an adverse effect on patients or taxpayers and be in breach of the Principles and Rules, including:

i. exclusionary conduct including preventing access to patients; exclusive dealing; and tying and bundling; and
ii. predatory pricing.

Exclusionary conduct: inhibiting choice or competition through preventing or limiting access to patients.

7.44 For vertically integrated service providers, which offer different services along the patient treatment pathway, the impartiality of the clinician referring patients from one organisation

to another is essentially lost for referrals within the vertically integrated organisation. This means that a patient's ability to make an informed choice may be compromised. The integrated organisation has a financial incentive to refer patients internally; this incentive arises from the Payment by Results system because a hospital's revenue increases with the volumes of patients admitted. Accordingly some patients may receive treatment from an acute provider they might not otherwise have chosen. In addition, to the extent that it exists now or in the future, a patient's ability to make an informed choice in relation to community care may be compromised. Accordingly some patients may receive treatment from a community services provider they might not otherwise have chosen.

7.45 Agreements between providers at different stages of the care pathway may have a similar effect to vertical integration, for example where the providers agree to refer patients exclusively to one another.

7.46 Evidence relevant to an assessment of whether a service provider has engaged in conduct that breaches this provision may include:

- agreements between service providers related to the movement of patients and, where agreements have not been reached, negotiations or understandings between service providers related to this;
- internal guidance or instructions to staff regarding patient movement between service providers;
- incentives of an integrated organisation to exclude other providers or deny patients choice;[25]
- financial and other incentives for the staff of service providers with the ability to make, or influence, decisions regarding patient movement between service providers;
- feedback from patients seeking to move between service providers; and
- statistics on patient movements between service providers.

Inhibiting choice and competition through other forms of exclusionary conduct

7.47 Non-price exclusionary conduct could take many different forms, including exclusive dealing and tying and bundling. The following paragraphs set out some examples of exclusionary behaviour that may have an adverse effect on competition. This is not an exhaustive list.

7.48 Exclusive dealing is a form of exclusionary conduct. A party (e.g. a provider) with a strong position in the market may try to foreclose its competitors by hindering them in selling to customers (e.g. commissioners or gatekeepers) through use of exclusive purchasing obligations or rebates, together referred to as exclusive dealing. For example, a provider may require an exclusive purchasing obligation in order to ensure that the commissioner of a particular service will purchase exclusively or to a large extent from that provider. Disputes about the role played by commissioners in encouraging patient choice under Principle 5, or commissioning services from the best-placed providers under Principle 1, can be dealt with as conduct complaints or procurement appeals and the CCP will decide which is the most appropriate avenue in each case (see paragraphs 7.13 – 7.14).

[25] Before reaching a view that conduct is exclusionary the CCP we would seek to ascertain whether or not the benefits of exclusion exceed the costs.

7.49 Tying and bundling may be another form of non-price exclusionary conduct. 'Tying' or 'bundling' refers to situations where customers (e.g. commissioners) that purchase one service are required to also purchase another service from a provider that has a strong position in the market. A provider that has a strong market position in one service (or more) of a tie or bundle of services can harm patients and taxpayers through foreclosing the market for the other services that are part of the tie or bundle and, indirectly, the tying service. Disputes about commissioning services from the best-placed providers under Principle 1, can be dealt with either under these Conduct Guidelines or under the CCP's Procurement Guidelines and again, the CCP may decide on the most appropriate process for a particular matter.

Predatory pricing

7.50 The CCP considers that attempts by a provider to prevent successful entry by competitors through pricing strategy (i.e. predatory pricing) is likely to have an adverse effect on competition to the detriment of patients or taxpayers. Predatory pricing involves the following elements:

i. A provider deliberately incurs losses or foregoes profits in the short-term (referred to as 'sacrifice') by temporarily selling services below cost.
ii. the provider has the intention of foreclosing one or more of its actual or potential competitors. Generally, this intention will be assumed if the price charged by the provider for service is below average avoidable cost.[26]

7.51 It may be relevant whether the provider is able to raise prices above the competitive level so as to recoup lost profits, or to otherwise benefit from the sacrifice, once rivals have exited the market or have been disciplined into following the infringing provider's (higher) pricing.

7.52 Generally speaking, patients and taxpayers are likely to be harmed if the provider can reasonably expect its market position after the predatory conduct comes to an end to be greater than it would have been had the provider not engaged in that conduct in the first place, that is, if the provider is likely to be in a position to benefit from the sacrifice. This does not mean that the CCP will only intervene if the provider would be likely to be able to increase its prices above the level persisting before the conduct. It is sufficient, for instance, that the conduct would be likely to prevent or delay a decline in prices that would otherwise have occurred.

Factors taken into consideration

7.53 Depending on the type of conduct under review, factors that the CCP will consider may include:

- the type of conduct;
- the content of any agreement;
- internal documents relating to the pricing or competitive strategy of service providers, referrers or commissioners;
- the extent of concentration in the market;

[26] Average avoidable costs refers to fixed costs and other costs that would be incurred even if the provider temporarily ceased operations (e.g. payment of permanent staff).

- market position;
- barriers to entry or expansion;
- the characteristics of the buyer/commissioner and the buyer/commissioner sector;
- transparency of prices and other competitive variables;
- the sustainability of any collusive behaviour and the incentives for participants to such collusive behaviour to deviate; and
- the sustainability of any unilateral conduct having an adverse effect and the ability of customers to resist such conduct or competitors to compete.

Principle 6

7.54 Principle 6 and the associated rules are set out below.

Commissioners and providers should not reach agreements which restrict commissioner or patient choice against patients and taxpayers' interests

- Providers and commissioners must not reach agreements with each other or between themselves which restrict choice or competition against patients' and taxpayers' interests
- Agreements between providers, commissioners, or between providers and commissioners, to fix prices or rig bids for contracts in ways that are against tax payers' and patients' interests will be considered a breach of the Principles and Rules.
- Agreements to share best practice, including clinical best practice, are unlikely to be considered a breach of the PRCC.

7.55 The CCP will usually analyse complaints relating to agreements which restrict patient choice or competition under this principle. It may also, however, assess such complaints under Principle 5 which provides that commissioners and providers should promote patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare.

7.56 The CCP distinguishes between benign cooperation and cooperation which is anti-competitive. The CCP will only investigate complaints relating to cooperation if there is an allegation that the conduct in question has reduced choice or competition for NHS-funded services. The CCP does not have a performance management role and is it not for the CCP to investigate conduct which relates to, for example, a possible breach of the statutory duty of partnership contained in the National Health Service Act 2006.[27]

7.57 Various different types of conduct likely to raise concerns under Principle 5 and 6 are described below.

Collusive Behaviour

7.58 Collusive behaviour refers to conduct that is likely to restrict choice or competition involving more than one organisation. This can be distinguished from the actions of an individual organisation.

[27] Section 72.

7.59 Before discussing types of collusive behaviour that are likely to have an adverse effect on patients and/or taxpayers, we set out the distinction between what is considered benign cooperation and actions that would constitute objectionable collusion under the Principles and Rules. This is a generally accepted distinction commonly made by competition authorities.[28] Beneficial cooperation refers to cooperation that benefits patients and taxpayers whilst harmful cooperation, in the form of collusion, restricts or prevents choice or competition, which harms patients and taxpayers.

7.60 The effects of cooperative arrangements between competitors must be analysed on a case-by-case basis to determine whether they benefit patients and taxpayers, and if the benefits to patients and taxpayers can be realised in a way that imposes fewer costs. Generally speaking, where cooperation delivers efficiencies, it is more likely to be beneficial than harmful. For example, joint research and development (R&D) and sharing best practice (e.g. sharing information about ways to improve patient safety), or joint purchasing and cooperation that disseminates or launches innovations faster are likely to be considered beneficial.

7.61 Cooperation that reduces or removes uncertainties inherent in the process of competition is typically harmful, e.g. cooperation that restricts price competition. The CCP will consider collusive behaviour that has or is likely to have an adverse effect on patients and/or taxpayers.[29] Collusive behaviour having such an adverse effect can take many different forms including price fixing, bid rigging, market sharing, or the exchange of price or non-price information. Moreover, it is not limited to collusive behaviour between competing entities but it may also arise between parties operating at different levels along the patient pathway (e.g. between a commissioner of a service and providers). The following paragraphs discuss these different forms of collusive behaviour in further detail.

7.62 The exchange of price and non-price information may be a form of collusive behaviour that is likely to have an adverse effect on competition and/or taxpayers. Competitors may exchange information on a variety of matters legitimately and with no risk to the competitive process. Indeed, competition may be enhanced by the sharing of information, for example, on new technologies or opportunities. However, the exchange of information may have adverse effects where it serves to reduce or remove uncertainties inherent in the process of competition, for example the exchange of information relating to planned service changes.[30]

7.63 Price fixing is a form of collusive behaviour which directly or indirectly fixes prices. Price fixing may involve fixing either the price itself or the components of a price, setting a minimum price

[28] An example of collusion was an agreement between independent schools to exchange information about intended fee levels. The Office of Fair Trading took action and imposed fines.

[29] Collusive behaviour includes any explicit or tacit agreement, arrangement or understanding between parties in whatever form and regardless of whether it is (or is intended to be) legally enforceable or not. Tacit collusion may arise where interdependence between parties leads them to anticipate competitors' responses to their own actions and take this into account in their own decisions.

[30] Generally, it is more likely that competition will be adversely affected the smaller the number of competitors operating in a sector, the more frequent the exchange and the more sensitive, detailed and confidential the nature of information being exchanged. Colluding to exchange information on prices may lead to price coordination and therefore diminish competition between competitors. This will be the case whether the information exchanged relates directly to the prices charged, or other elements of a pricing policy such as discounts or costs. The exchange of purely historical or aggregated information will generally be unlikely to breach the Principle and Rules. The exchange of non-price information (such as the number of patients who have been provided with a particular service by the provider) may also have an adverse effect if the information is recent, or concerns future plans, is not aggregated and can be attributable to a particular party.

below which prices are not to be reduced, establishing the amount or percentage by which prices are to be increased, or establishing a range outside which prices are not to move. For example, providers may collude regarding the price charged to commissioners for commissioned services. Parties to collusion may also indirectly fix prices, for example, by agreeing the discounts or allowances which will be granted. Price fixing issues are not limited to collusive behaviour between competing entities. They can also arise between parties operating at different levels along the patient pathway (e.g. a commissioner of a service and providers).

7.64 Assessment of price fixing needs to take into account the way in which prices are set in the NHS. Provision of NHS-funded healthcare services to patients is free to the patient. The price for these services is paid by the commissioner, in most cases a Primary Care Trust. For routine elective services, there is a uniform national tariff for each procedure (which may be subject to local flexibilities). For services which are at tariff, there is little scope for price-fixing by providers. However, for other services, the price that is paid by the PCT may be determined through negotiation or a competitive tender, in which case there may be scope for price-fixing by providers. Where there is no scope for price-fixing, providers may collude in relation to non-price aspects of a service – for instance by agreeing on how they will respond to quality criteria set out in a tender for services or by agreeing their bidding behaviour or by agreeing together how patients will be allocated to their respective services.

7.65 Market sharing is a form of collusive behaviour in which participants collude to share markets, whether by territory, type or size of customer or some other way. Depending on how providers compete with one another, market sharing may take the form of providers allocating patients or patient groups between them; providers allocating between them commissioners to whom they provide commissioned services; or commissioners allocating between them providers to whom they will offer contracts. A group of providers might collude to share a market by, for example, agreeing for each service that is tendered, which of them will submit a bid. Service providers might also collude so as *not* to: provide the same services; provide services in one another's geographic 'territories'; solicit or service one another's patients, providers or commissioners (in the case of contracts for the provision of services); or expand into a sector in which a competitor is an actual or potential rival.

7.66 Bid rigging is another form of collusive behaviour. Tendering procedures are designed to provide competition between potential providers of a service. An essential element of the system is that prospective providers or suppliers prepare and submit tenders or bids independently. Bid rigging occurs when two or more competitors collude in order not to compete genuinely with each other for particular tenders either through collaborating on prices, non-price aspects of a tender or selective participation in a tender.

Principle 8 - Commissioners and providers must not discriminate unduly between patients and must promote equality

7.67 Commissioners and providers must not discriminate between or disadvantage particular patients where this restricts choice or competition against patients' and taxpayers' interests.

7.68 The CCP will investigate complaints that selective treatment of patients is unjustified. Under UK legislation, it is unlawful for a public authority exercising a function of a public nature, including NHS organisations, to perform any act which constitutes discrimination.[31] Public authorities, including NHS organisations, also have a legal duty to promote equality.

7.69 The CCP, in interpreting Principle 8 and assessing allegations of discriminatory conduct, is not seeking to simply reinforce or duplicate the existing legal obligations on NHS organisations in terms of discrimination based on disability, age, gender, religion or belief, sexual orientation or race. Consistent with the CCP's overall role in terms of aiding cooperation, choice and competition in the provision and commissioning of NHS-funded services, the CCP will particularly assess whether discriminatory conduct by providers confers a competitive or economic advantage on them.

7.70 In addition to this, the Payment by Results Code of Conduct[32] expressly requires that 'providers will not discriminate or disadvantage particular patients or commissioners when operating Payment by Results (PbR), including when accepting or declining to treat individual patients and in the provision of services generally'. The aim of the PbR system is to reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. This is achieved by linking payments to activity and adjusting for case mix. The CCP will have regard to the PbR Code of Conduct when assessing discrimination complaints.

7.71 In assessing whether a service provider has breached this principle, the CCP will consider whether or not there is any objective justification (such as clinical, medical, capacity or other considerations) as well as any patient and/or taxpayer benefits arising from any discrimination in which a service provider may engage. The CCP will seek evidence that these considerations have influenced the service provider's decision to discriminate, and will consider the weight of these considerations relative to any other considerations in the provider's decision making process. The CCP will also take into account any action that a service provider has taken, or is taking, to reduce the need for such discrimination in the future. The CCP is unlikely to accept arguments that treatment is too costly as an objective justification for refusing to treat a patient.

8 ADVICE AND RECOMMENDATIONS

8.1 Following an assessment of a conduct complaint, the CCP must provide advice and recommendations to the Secretary of State or his delegated authorities, or Monitor in the case of NHS FTs. In summary, if the CCP finds that the conduct concerned is not consistent with the Principles and Rules, it will recommend action to be taken by the relevant Sponsor which it considers to be reasonable, proportionate and practicable:

- to remedy, mitigate or prevent the conduct concerned; and
- to remedy, mitigate or prevent any detrimental effects on patients or taxpayers so far as they have resulted from, or may be expected to result from, the conduct concerned.

[31] Human Rights Act 1998, Schedule 14

[32] Payment by Results Code of Conduct (February 2008).

8.2 When the CCP has completed a conduct inquiry, the CCP will advise the Secretary of State or his delegated authorities, or Monitor in the case of NHS FTs, as to whether any action should be taken, and if so, the nature of the action recommended by the CCP.

8.3 The CCP will recommend that conduct be allowed to continue and no further action be taken where the conduct is consistent with the Principles and Rules or where it finds that such conduct does not have a material adverse effect on patients or taxpayers. Where the CCP finds that the conduct does not have a material adverse effect on patients or taxpayers due to the presence of offsetting benefits, the CCP may include in its advice recommendations to secure those offsetting benefits to patients or taxpayers.

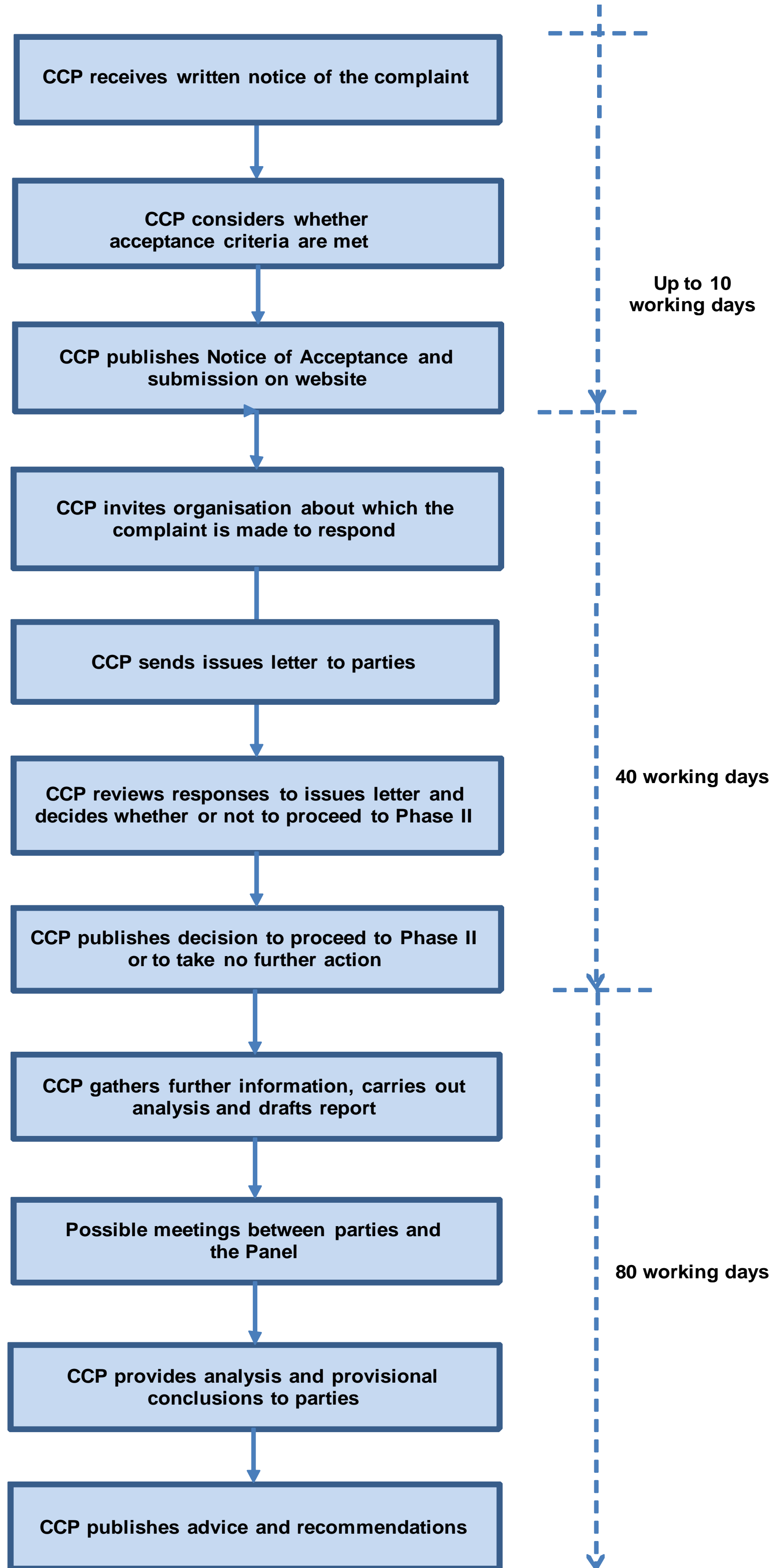
8.4 Where conduct is in breach of the Principles and Rules and has a material adverse effect on patients and/or taxpayers, the CCP will make recommendations as to whether the conduct should not be allowed to continue or should only be allowed to continue under certain conditions.

8.5 When deciding on an appropriate recommendation, the CCP will have regard to its effectiveness, the associated cost and the principle of proportionality.[33] The CCP may also take into consideration prior cases as precedents for remedies. At all times, the CCP may only recommend or advise the relevant Sponsor on appropriate remedies and the ultimate decision rests with the relevant Sponsor.

[33]Between two recommendations that the CCP considers equally effective, it will choose the recommendation which imposes the least cost or is least restrictive.

Appendix 1

FLOWCHART OF PROCESS



GUIDANCE ON THE CONTENT OF SUBMISSIONS

1. In order to investigate a complaint, the CCP requires that complainants provide a detailed submission which at least includes the following details:
   - name, address, telephone number and email address of the complainant;
   - name and title of the person(s) authorised to represent the organisation in the complaint;
   - contact details for the party that is the subject of the complaint;
   - evidence that the relevant acceptance criteria have been met;
   - a detailed statement of reasons why, in the opinion of the complainant, the conduct in question is inconsistent with the Principles and Rules and any supporting evidence, where available;
   - an explanation of how the complainant's business has been affected by the alleged activity and/or how patients or taxpayers have been adversely affected by the alleged activity;
   - a description of the products and services involved;
   - an outline of the relationship between the complainant and the respondent;
   - an outline of discussions with the respondent and local SHA on the topic of the complaint.
   - a chronology outlining relevant events;
   - a non-confidential version of the entire submission for publication on the CCP's web site. The applicant should also indicate which (if any) information in the submission is confidential vis-à-vis the party about whom the complaint is made.

INFORMAL ADVICE

1. The CCP is willing to provide informal advice to parties who have concerns about the application of the Principles and Rules in relation to conduct. Informal advice is intended to assist parties in identifying potential concerns.

2. Informal advice on conduct matters will generally be given orally by the Director of the CCP or other senior members of staff; it represents the view of CCP staff, not the Panel Members. To ensure that resources are used effectively, the CCP reserves the right in all cases not to provide informal advice.

3. Parties seeking informal advice are not required to meet the acceptance criteria outlined in Section 5 of these Guidelines. Informal advice by the CCP is not binding on the CCP and is not a substitute for the CCP's assessment of a matter once it has formally accepted a case. The CCP only provides informal advice on the application of the Principles and Rules, and not, for example, on the Competition Act 1998.

4. To provide informal advice, the CCP will need information about why the party thinks there may be a concern under the Principles and Rules. Although submissions are not expected to be extensive, the quality and accuracy of the CCP's informal advice will, to a large extent, reflect the quality of the information provided. The CCP recommends parties provide clear, full and accurate information in the context of requests for informal advice.

5. There is no administrative timetable for the provision of informal advice, but the CCP will endeavour to accommodate parties' timeframes as much as possible.

6. The CCP will not have tested the information provided by the parties externally. Informal advice should be kept confidential and should not be used by the recipient as advice on which third parties can rely. Correspondence between the CCP and the party requesting informal advice must also be kept confidential and not forwarded outside the party's organisation. The CCP will not disclose informal advice to any other party, but may permit parties to share the advice with other parties including DH and Monitor with its express, prior, consent. If a party receives informal advice and then discloses it to third parties without the CCP's express consent, the CCP will consider whether it is appropriate to provide informal advice to the party which made the disclosure in future.

7. In the first instance, parties seeking informal advice (or simply wishing to discuss whether to request informal advice) should contact the CCP on the details provided on its web site at www.ccpanel.org.uk.