Cooperation and Competition Panel draft interim guidance Response to consultation from the PCT Network

1. INTRODUCTION

The NHS Confederation is the only independent membership body for the full range of organisations that make up today's NHS. We represent over 95 per cent of NHS organisations as well as a growing number of independent healthcare providers.

The Primary Care Trust (PCT) Network works specifically on behalf of Primary Care Trusts. This involves representing PCTs as both commissioners and leaders of the NHS in their local area, and as providers of community health services. We aim to help our members improve the system for patients and staff by raising the profile of the issues affecting PCTs; strengthening the influence of PCT members in policy development, implementation and the public debate; and supporting PCT leaders through networking, sharing information and learning.

The PCT Network welcomes the opportunity to respond to this consultation on the Cooperation and Competition Panel's draft interim guidance on procurement disputes, advertising and misleading information disputes, merger inquiries and conduct inquiries. Our response is based on feedback and discussion with members, and our own analysis of the consultation documents.

The first section of this paper outlines some general comments which we feel relate to all four sets of guidance and to the Panel's general approach to fulfilling its remit. Subsequent sections then provide specific feedback on each set of procedures.

2. GENERAL COMMENTS AND FEEDBACK

The introduction of greater competition into the English health care system presents both opportunities and challenges to PCTs as both commissioners and providers.

Historically, the ability of healthcare providers to exercise their market and political power has been cited as one of major barriers to effective commissioning by PCTs and their predecessor organisations. Independent advice and adjudication on how best to promote choice and plurality and to deal with anti-competitive behaviour will therefore be welcomed by PCTs if it strengthens and reinforces some of their commissioning levers, and supports them in leading a more demand-led NHS. However, the reason for strengthening commissioning in the NHS is not simply to create a more responsive supply-side as an end in its own right. PCTs are responsible for improving health and reducing health inequalities within the populations they serve, and need to use a range of tools and strategies for achieving this. Competition is one of these tools and is potentially very powerful in the right context. However, it is certainly not the only mechanism that commissioners need to understand and deploy in their dealings with health services providers as they seek to improve population level health outcomes. Our members therefore wish to be assured that efforts to promote competition are appropriate and specifically, that they do not undermine the cooperation that is essential to the delivery of integrated, high quality, equitable and affordable healthcare.

PCT members responsible for directly providing community health services also have a strong interest in commissioners' and regulators' approach to managing competition. As autonomous provider units become increasingly independent, they will want to ensure they are given reasonable time and scope to develop as viable entities within the NHS, but also that new opportunities to expand and grow their business are available to them.

Through its scrutiny of procurement processes, merger proposals, advertising practices and other conduct the Panel could have a significant influence on the strategies of individual PCTs as commissioners and providers, and on the NHS's future approach to balancing competition and cooperation. It is therefore crucial that the Panel operates in a way that supports PCTs in discharging their core responsibilities as the local leaders of the NHS. The feedback set out in this document is intended to assist the Panel in achieving this objective.

2.1 USE OF LANGUAGE IN THE CONSULTATION DOCUMENTS

As noted within the consultation documents, the Principles and Rules, along with other policy developments that promote the use of competition and market-mechanisms in the NHS, have introduced some new concepts and processes to transactions involving NHS-funded healthcare services.

In this context, it is inevitable that some of the language and terminology used in the consultation documents will also be new. In some cases (particularly in the documents on mergers and conduct) there is a risk this will have undermined the ability of stakeholders to fully engage in this consultation process and respond to the questions posed, and ultimately to use the guidance.

Even when the terminology is understood, some of the principles set out in the documents may also be difficult to understand in an NHS context until the system is more familiar with competition issues. As such, the guidance could be open to interpretation and misunderstanding, for example, as to what parts of the 'health service' are included and excluded. Are services that are provided jointly with local authorities or other partner organisations included, for example?

We suggest that terms and examples more familiar to those working in the health and social care environment might be incorporated into the final version of the guidance document (although NHS 'jargon' should also be avoided). A glossary of terms to explain some of the more legal and technical terms may be helpful.

2.2 THE PANEL'S APPROACH TO COMPETITION AND PUBLIC VALUE

The Panel states that although its approach is grounded in the established principles of economic and competition analysis, in applying these principles it ensures that it takes account of the special features of the healthcare sector. However, throughout the draft guidance, the panel refers only to the anticipated benefits of competition, and not to the limitations of competition in the healthcare sector.

The documents make clear that the remit of the Panel is to help ensure that the Principles and Rules are applied in a way that supports the delivery of high quality care for patients and value for money for taxpayers. There is also acknowledgement that the benefits of competition need to be balanced against other patient and public benefits in some circumstances. However, there are sections of the guidance that risk presenting the protection of free competition as an end in its own right, rather than as a possible means of protecting the public interest.

This is compounded by a lack of reference to the Panel's approach to cooperation. It is not clear, for example, whether or when the Panel's recommendations could ever be to encourage greater cooperation (other than where this is to facilitate patient choice) or to limit competition.

Feedback received from our members has emphasised that while they recognise that competition can further their aims in many circumstances, they also see cooperation between commissioners and providers, and between different providers, as critical to sustainable and effective health services. Cooperation is essential to ensuring that services are integrated and well coordinated, that economies of scale are achieved, that essential functions (such as training and education and emergency services) do not become fragmented, and that the viability of inter-connected services is not undermined. In many cases PCTs need to encourage providers to operate on a collective basis to deliver service networks in areas such as cancer or cardiac care. Recent guidance from the Department of Health also recognises that some health system objectives require system managers to "broker partnerships to promote 'open' innovation, and to collaborate rather than compete" (DH, 2009).

In making decisions on the appropriate structure of local healthcare markets, and the best way of achieving heath improvement objectives, commissioners need make an objective assessment of the risks and benefits of all possible models and approaches. The default position of the Panel appears to be to assume that competition will be appropriate and beneficial, so that any case for an alternative approach has to be made. We do not believe this is always the appropriate starting point for assessing the decisions made by commissioners. In some circumstances, cooperation will be the fastest, best value and safest way of achieving health improvement objectives. The approach to driving up the quality of elective acute services in an urban conurbation will be different to that for improving the performance of rural ambulance services. The context (including the geographic and demographic context) in which PCTs' decisions regarding the use of competition and the local strategy for market making are being made must be fully acknowledged in the Panel's approach and processes.

Similarly, we believe the Panel could do more to acknowledge the complexity involved in balancing responsibilities for securing high quality and good value services, while delivering what the public values and reducing health inequalities. It is clearly not the role of the Panel to resolve or respond to these tensions, but it may be appropriate and helpful to provide a more balanced view of the context that NHS bodies operate within in introducing each set of guidance.

This should include reference to the requirements on PCTs to undertake public consultation on proposed service changes, and to have regard to the outcomes of such consultation. It is not clear from the current guidance how the requirements for PCTs to undertake public consultation on service change relate to the Panel's procedures. Neither is it clear how the Panel itself will take public opinion into account in making its judgements regarding public benefit (as discussed further below).

2.3 REGULATORY BURDEN AND PROPORTIONALITY

The guidance does not give any indication of how many cases the Panel expects to receive, or has the capacity to deal with. However, if the number of cases is high, this will place a significant administrative burden on both the Panel and the organisations required to participate in inquiries. It is crucial that regulatory procedures do not have a negative impact on the day to day operation of NHS bodies by diverting them from their core responsibilities. Preparation for and participation in

appeals procedures can have significant resource implications. We strongly urge the Panel to ensure that the decisions it takes to accept cases, and the procedures it adopts to administer them, are proportionate to the actual risks to patients and taxpayers of any breaches of the Principles and Rules. This should include ensuring that inquiries are carried out in a timely way and do not unnecessarily restrict organisations' ability to make rapid and pragmatic decisions where appropriate.

If the Panel's procedures are perceived as generating a disproportionate burden of challenge and scrutiny, there is a risk that PCTs will be overly cautious in their decision-making and their approach to market-making. As such the Panel's activities could actually have the effect of limiting market expansion and plurality, as PCTs 'play-it-safe' with existing provider models.

2.4 PANEL ADVISORY FUNCTION

It is hoped and anticipated that the Panel will be supportive of PCTs that are looking to develop their procurement and market management policies in its educational and advisory role regarding competition issues.

2.5 REVIEW AND EVALUATION

We note that the Principles and Rules will be consulted on, and the Panel's guidance likely revised, within the next 12-24 months. We welcome this process as an opportunity for early review of the impact of the Panel's activities. This should include analysis of the number and types of dispute and appeals that have been referred, upheld and rejected by the panel, the nature of the recommendations made, and the impact on local health economies. It is vital that any review considers learning gained by parties affected by the Panel's activities, as well as experience gained by the Panel itself.

2.6 DECOMMISSIONING DECISIONS

In their feedback and comments members have been particularly aware of the financial context in which they will be operating in the coming years. Given anticipated reductions in their budgets, it is increasingly the case that commissioning decisions will be decisions to de-commission, rather than to increase capacity or change service configuration. Some members have queried how the Principles and Rules, and therefore the panel's procedures, might be applied in the case of decisions to reduce service capacity, which may have the effect of reducing choice and competition.

3. MERGER INQUIRIES

3.1 INFORMAL ADVICE

The informal advice process is likely to be helpful, particularly as NHS organisations develop their knowledge and understanding in this area. We understand the reasons why the Panel will not consider hypothetical transactions. However, in order to support learning within the system, it might be helpful for the panel to make available case-studies or other materials that would enable interested parties to evaluate ideas and proposals at an early stage of development.

The relationship between the Panel's guidance and the NHS Transactions Manual guidance should be made more explicit. This is referred to in para. 2.10, and it may be helpful to provide the link to the document and supporting materials on the DH website.

The wording of the guidance suggests that informal advice will be sought by and provided to merging parties (i.e. to service providers) to help them develop their proposals. It is not clear whether commissioners could also seek advice from the Panel regarding mergers that they would like local providers to consider, or merger plans of their providers that they have concerns about.

3.2 FORMAL INQUIRIES

In the case of formal inquiries, the planned decision-making process is relatively clear.

We strongly agree that views from PCTs and SHAs should be sought during merger enquiries. However, the guidance suggests that this will not be sought proactively from specific organisations, but rather through an invitation to comment published on the Panel's website. While relevant commissioners and SHAs should be aware of merger proposals, it is not clear how they will know the timetable for a merger inquiry has commenced if they are not contacted directly by the Panel. We therefore suggest that their views should be proactively sought by the Panel.

3.3 NOTIFICATION THRESHOLDS

Although the statement regarding notification thresholds is clear in principle it could be more specific in its definitions. In particular it would be helpful to clarify what is meant by 'primary care' (does this refer to primary medical, dental and pharmaceutical services, or to wider primary care services?) and 'community services', and how to handle mergers between different types of service provider. Footnote 10 on p.7. does clarify that in the latter case the lowest applicable threshold will apply. This information should be included in the main text where the thresholds are set out.

The rationale for setting different thresholds for different types of services should also be stated explicitly. If the thresholds are intended to relate to the current level of plurality and choice within a particular service market (and therefore the extent to which competition may be reduced by a merger) then this should be made clear (and the categorisation by type of service provider may not be the most appropriate approach).

Some members have raised queries regarding the distinction between mergers and acquisitions (specifically whether any such distinctions exists in terms of the Panel's procedures). We understand that an acquisition by one provider of all or part of another provider would be considered as a 'merger' by the Panel. It would be helpful to make this more explicit if this is the case.

3.4 APPROACH TO ASSESSING THE EFFECTS OF A MERGER

The sections outlining the Panel's approach to assessing the effects of mergers are dense, and use relatively technical language that will be unfamiliar to many readers. As such, it may be difficult for stakeholders within the NHS to form a view as to whether the proposed approach is sound.

The proposal to consider the potential effects of mergers on both patients and tax-payers is welcome, as is the intention to take regard of potential benefits that may arise from mergers even when there is a reduction in competition and choice. However, it is not clear how these assessments will relate to, or be balanced against, each other (if, for example, there is an anticipated adverse effect for patients but significant relative benefits for tax-payers, or vice versa). Furthermore, it is not sufficiently clear how patient benefits will be assessed. The guidance states that the Panel will take particular note of evidence regarding clinical improvements, but

patients also value other factors including location, convenience, integration with other services etc. How will different types of patient benefit be assessed and weighted, and how will patient views/public opinion on this be incorporated?

In para. 5.50, the guidance states that in assessing mergers involving 'challenged' service providers, the principles and conditions set out in paras. 5.45 and 5.46 will be taken into account. It is not clear how paras. 5.45 and 5.46 relate to this point.

3.5 PANEL ADVICE AND RECOMMENDATIONS:

The principle that the Panel may recommend certain remedies to anticipated adverse effects is helpful. However, the extent to which this will be helpful in practice is unclear because the possible nature (and therefore the cost and practicality) of such remedies is not explained in any way. It would be helpful to provide some examples of the type recommendations that might be made to sponsors in such circumstances.

4. CONDUCT INQUIRIES

Our comments on the conduct procedures and methods are similar to those on merger inquiries.

4.1 APPROACH TO ASSESSING CONDUCT

As in the case of assessing potential mergers, the guidance documents and consultation questions use relatively technical language that will be unfamiliar to many readers, and may limit their ability to respond effectively. The documents also use language that readers may consider inappropriate in a healthcare setting (for example, to exchanging information on 'output and sales' in footnote 14).

Related to this, in basing its approach on competition law and regulations that apply in other sectors, there is a risk that some of the specific features of NHS services are not sufficiently acknowledged in the guidance. For example, the section on predatory pricing does not refer to the fact that many NHS services are paid for under a fixed tariff (although this is mentioned in a previous section). The guidance would benefit from the use of language and examples that are more familiar and meaningful to those working in and using the NHS.

The intention to assess not simply whether conduct breaches the Principle and Rules, but whether it actually has an adverse effect on patients and tax-payers overall is welcome. As set out in the response to merger inquiries, however, the approach to assessing patient and taxpayer benefits (including who is involved in making these assessments) is not sufficiently clear.

5. PROCUREMENT DISPUTES

5.1 PROCEDURES

We feel that the procedural process for handling appeals of procurement disputes is sufficiently clear and appears to be fair. However, where timeframes for each stage of the process are given it is not specified in the document that these refer to working (rather than total number of calendar) days. We assume that timetable refers to working days, and this should be clarified.

5.2 BALANCING PATIENT BENEFITS AGAINST LIMITS TO COMPETITION

We believe the Panel is right to seek to balance other benefits for patients and taxpayers against limitations on competition when assessing tender design.

However, it is not sufficiently clear how this judgement will be made. In the absence of evidence regarding the actual benefits of competition in any particular situation, this will be a subjective or at best theoretical exercise. As such, the definitions of patient and tax-payer interest that will be used, the theory which will inform any assessment of these factors, and the processes through which assessments will be made, should be more explicit.

5.3 THE PANEL'S APPROACH TO CONSIDERING DECISIONS NOT TO TENDER SERVICES

We welcome the Panel's recognition that PCTs must use their judgement in making procurement decisions, and its proposal to consider PCTs' individual procurement decisions (including decisions not to tender) in the context of their overall plans. However, we would emphasise strongly that when assessing the reasonableness of PCTs' overall plans, this must refer to their overall plans for improving health and reducing health inequalities, and not simply their plans for introducing choice and competition, which are not ends in their own right. It should also be acknowledged that PCTs' plans must take into account the views and priorities of local people. As in the cases of balancing limits to competition against other benefits, it is currently not sufficiently clear how assessments of PCTs' plans will be made.

5.4 POTENTIAL RECOMMENDATIONS

We believe the list of potential recommendations to be made by the panel is appropriate (noting that it is not exhaustive) and welcome the expectation that the outcomes of Panel reviews will provide learning for PCTs and SHAs to support local dispute resolution in future. It will be important that this includes learning from cases where appeals are not upheld because the PCT's approach is considered reasonable by the panel. For this reason, published explanations of decisions to both uphold and reject appeals should be equally comprehensive.

5.5 OTHER COMMENTS

Although the Panel's acceptance criteria make it clear that the Panel will not consider cases where legal proceedings have commenced, we feel that the relationship between the Panel's processes and judicial mechanisms for appealing against procurement decisions could be clarified. For example, could an SHA or PCT seek advice from the Panel regarding potential legal proceedings (in contrast to the procedures for merger and conduct inquiries, there does not appear to be any mechanism for seeking informal advice from the Panel) and would a judicial review of a procurement process have any regard to recommendations made by the Panel?

6. ADVERTISING AND MISLEADING INFORMATION DISPUTES

6.1 PROCEDURES

We feel that the procedural process for handling referrals and appeals of advertising and misleading information disputes is reasonably clear and appears to be fair. However, where timeframes for each stage of the process are given it is not specified in the text that this refers to working (rather than total number of calendar) days. We assume that timetable refers to working days, and this should be clarified.

Para. 4.14 states that the Panel will only consider appeals about the incorrect application of the requirement in the Principles and Rules to adhere to the code at the local level, and will not hear concerns about the process used to reach a decision at a local level. This distinction is not entirely clear, and may benefit form further elaboration.

The feedback and comments outlined in this document are intended to be constructive in helping the Panel to shape its guidance and approach. If you have any queries regarding any of the points made we would be pleased to discuss these in more detail.