

Foundation Trust Network

FTN Response to Co-operation and Competition Panel Consultation Draft Interim Guidance on the Assessment of Conduct

I. General Comments on the Correspondence between the Guidelines and the Co-operation and Competition Rules

We appreciate that there is an absence of policy in relation to market definitions, and that the Panel is not in the business of setting policy. We also recognise that there is no definition of the use of the term “Co-operation” within the Co-operation and Competition Rules, whereas there is a body of literature and case law that surrounds competition. However, we believe that there are a range of areas in which the Panel could (and should) provide guidance to clarify the approach it will be taking in relation to both commissioning tendering decisions and co-operation- as one of the key principles within the rules themselves - within the market.

We understand that in the absence of such definitions, the Panel’s remit for clarifying the meaning of co-operation and competition will be through the application of the proposed benefits to patients’ test. The assessment of decisions by commissioners regarding whether or not to pursue a co-operative or competitive path in tendering decisions also needs to include an assessment of the likely risks and costs associated with decisions and their impact and the Panel needs to ensure that the guidelines make it clear that these factors will be taken into account.

Examples of issues that may arise includes where GP practice-based commissioning groups signs up with independent/private sector companies to help them bid for work – foundation trusts have cited examples where what such a partnership provides is only part of a service, not a comprehensive package such as that already provided by the incumbent provider – but is being seen as an attractive option by commissioners. In this situation, issues include the impact on continuity of care and Choice - how will patients be able to distinguish between a comprehensive service and a partial service and how will Choice be governed - will patients have any real choice?

Clearer guidance is required from the Panel in relation to the need for Chinese walls, particularly in relation to the transforming community services agenda, collaborative service specification development between commissioners and providers, where commissioners (including GPs under practice-based commissioning) seek to commission from themselves and in relation to the provision of financial incentives corresponding to referral patterns, whether this is by commissioners or providers.

We outline below the critical issues in brief and make a more detailed comment under the relevant questions below.

I.1 Getting the Right Balance between Co-operation and Competition

There is a key issue about the structuring of the guidelines between the twin principles of Co-operation and Competition. As the guidance currently stands foundation trusts believe that one principle (Co-operation) is in danger of being subordinated to another (Competition) and that this will ultimately distort the nature of decision making as envisaged through the rules. The balance between them needs to be restored. If there

were such balance it ought to be possible to bring a complaint about breaching co-operation rules. This does not seem currently to be the case.

FTN believes that there could be a section in the final document about the rationale and policies for promoting co-operation – as set out in the Duties in the Health Act 1999 (NHS) and 2003 (for FTs). This could cover the drive for clinical networks, integrated care pilots, AHSCs and HIECs and should tackle the issue of ‘natural monopolies’ and economies of scope.

In addition there is a description of the rationale and policies for promoting competition but there is nothing about the risks of competition and market failures as established in economic literature. System managers and regulators should focus on preventing market failures as well as ensuring fair conduct. It should be within the scope of the competition Panel to consider whether market managers have taken the risks of competition into account when they make decisions. The Panel could make clear in the guidelines its commitment to take such risk into account when it considers referrals.

In addition the Panel has to be sensitive to the fact that unless the balance between the twin principles is perceived to be the basis upon which judgements about conduct in the market will be determined there is a great risk of increasing risk aversion and defensive behaviours on the part of all players.

For more detail on this issue see the answers to questions 9 and 14 below.

1.2 The Critical Goal is Competition on Quality not Price

The fundamental principle of the reform of the health Service, given greater expression and emphasis by Lord Darzi in the Next Stage Review is that in the NHS competition will be on the basis of quality- not price. In Para 2.5 the document postulates that amongst the benefits of competition ‘costs are driven down’. This is placed as the first of such benefits from competition, but the purpose of having a rules based national tariff is to underpin the key policy objective of quality, not price as the developmental principle of the NHS as well as to create a fair remuneration system based upon detailed understanding of clinical activity. This has been further strengthened by CQUIN and other schemes for rewarding quality improvement, as well as being recognised as central within the Standard Contracts. In addition, a new regulatory authority, the Care Quality Commission has been set up to underpin the other drivers, Quality Accounts are about to be introduced through legislation and a National Quality Board is being set up to co-ordinate and make sense of these various drivers.

The emphasis is on cost reduction, and innovation, which is said to drive quality improvements. Whilst innovation might drive such quality improvement, cost reduction is a separate issue, and may drive down standards. Foundation trusts understand that price will be a factor in some procurements and tender decision making, but will be very concerned if the emphasis of the Competition Panel guidelines suggests that the prime benefit of competition rests on price, rather than quality improvement. This is one area where there is clear public policy in relation to the impact of competition and the FTN believes this could be clarified in the guidance. Currently the way in which this section is written in the document seems to be fundamentally at odds with what the system is meant to be delivering.

In Table 2.1 we note that the rules in section 7, Payment regimes must be fair and transparent: foundation trusts have reported that PCTs are already using tariff as a maximum price rather than a fixed one, explicitly seeking tenders for services at below

tariff. Commissioners and providers must adhere to the provisions for determining a non-tariff price contained in the NHS Contract (Clause 7.2.) This should also pertain to agreements around non-mandatory tariffs.

Some members are concerned that the Panel will recognise the differential costs of providing services in different geographical locations.

1.3 Proportionately limiting the Burden of Information Demands

There will be an issue about the way in which the information demands of the Competition Panel will dovetail in with information already supplied through other regulatory channels so that it does not necessarily exacerbate the bureaucratic burden of complaints. Foundation trusts would welcome a statement that, where possible, the competition panel will use existing sources of information and will co-ordinate with the Sponsors to make this possible.

1.4 The Positioning of Foundation Trusts as Organisations within the NHS System

Para 2.3: Foundation trusts are not 'Government' organisations. They are autonomous independently governed NHS organisations that have additional and enhanced commercial freedoms to those afforded to NHS Trusts. These latter could more properly be described as Government organisations. Foundation trusts would prefer that the Panel uses a formula when referring to them that more accurately describes that character and role as organisations.

1.5 Assets

The guidance mentions that the Panel will be developing its position on assets. Foundation trusts have a legal responsibility for their assets and will have invested significantly in them. They would therefore oppose the notion of any body being able to require them to give up or share their assets with other providers, particularly if private sector providers are not required to do the same.

1.6 System regulation and conflicts of interest in role of system managers

System regulation needs to be aligned and overlap and conflicts removed. It is vital for the system regulation to be aligned and avoid regulatory overlap and duplication, particularly in the light of Monitor's new area of responsibility in implementing the Department of Health's competition policy. Whilst the Competition Panel has a limited remit within the system infrastructure its decisions will undoubtedly have significance for the market managers and decisions makers and will make clear conflicts of interest within the system. Many foundation trusts are beginning to be concerned by what they perceive to be a conflict of interest within the SHAs role, of driving market policy and performance managing PCTs, whilst also acting as the first point of appeal for providers.

1.7 Development of commissioners

The guidelines do not recognise explicitly recognise the lack of experience of all players when it comes to competition decision making. In particular providers will worry about inexperienced commissioners who appear to have acted without a sophisticated understanding of risk within the system.

Foundation trusts are concerned that quality of provision and quality of decision making in the wider interests of the community must not be subordinated to a dogmatic application of market ideology. They believe part of the strategic duty of the commissioner is to consider the sustainability of local services. They see a risk that so many parts of a secondary care service (particularly from local DGHs) will be sliced off in an effort by commissioners to create a wider market that the remaining core Secondary service becomes fragile. This would potentially create the opposite effect to that intended and the Panel should outline how it intends to approach this issue.

The FTN recommends that the Panel provide a clear statement of how assessing system balance of risk will be taken into account within the benefit to patients' test of market decision making and parameters and highlighting the priority of patient interest - in order to prevent sub-optimal decision-making by PCTs in relation to service development and tendering.

Further thought also needs to be given to the behaviour of Commissioners prior to services being tendered and how discussions in relation to the development of service specifications should be conducted to balance the principles of Co-operation and Competition. For example, should there be a requirement for PCTs to declare to other providers where they have entered into a relationship with a provider to develop a specification, as this will provide an inherent advantage in the process? This advantage may not be in terms of pricing but is certainly relevant with regard to timing, particularly where partnership working may be required or it is a particularly complex service. Clearly, no one would want this kind of collaboration to be limited, as it ultimately benefits patients, however, the FTN believes that some boundaries and rules in respect of this need to be set by the Panel.

Finally, the guidance does not seem to cover conduct of the commissioner to ensure existing providers are not prevented from bidding for a new or existing service(s) through acts or omissions. For example, where a tender is let in such a way that a provider cannot bid without sharing of information on costs with the other providers or the PCT provider services, which it subsequently fails to do. One foundation trust has already experienced this in relation to a stroke service.

2. Answers to Specific Questions

2.1 Q2: Are the Acceptance Criteria Sufficiently Clear:

Yes, except point iv - what is the difference between anti-competitive conduct, which should be dealt with by the SHA if possible, and collusive conduct, which should be referred to the Panel? How is "collusive" conduct defined, and how is it distinguished from co-operation and collaboration in the interests of providing an integrated service? In many cases, through Service Specifications, local PCTs are beginning to commission services in areas in which existing services have grown up organically as collaborations between more than one Provider. If Providers wish to preserve these collaborative arrangements, many of which secure high levels of integration of care for patients, how will this be distinguished from "collusion"?

2.2 Q3. Should anything be added or excluded from the Panel's acceptance criteria and if so why?

It would be useful to clarify what will happen where the centre of the dispute depends upon national policy such as disputes around tariff prices?

2.3 Q4. What are your views on the Panel's approach to informal advice?

The paper does not discuss the issue of volume of calls for advice that the Panel will receive.

FTN believes that there will be a large volume of advice being sought from the Panel. The path to a more open market and competition in health services is likely to be tricky and the scope for opening unbalanced and unanticipated risk high. In this context the availability of advice will be critical to avoiding unacceptable and unintended levels of risk that could undermine public confidence in competition in the health sector provision.

This is an immature market and many players will be uncertain about how to apply the rules and the appropriate behaviours that go with this. Unlike other markets that have opened in the UK over the last 20-30 years, few players have any record as commercial entities. Even the oldest foundation trust has only been authorised for five years and the staging of the authorisation process has meant that many now authorised foundation trusts have far less commercial experience than their first wave colleagues. Half of the eligible NHS Trusts are still waiting in the wings to be authorised

In all other markets the players went through a process of privatisation before markets were created, hence they had an opportunity to commercialise their organisations before being subject to competition rules. In health there has been no such privatisation and even though foundation trusts are autonomous and self-governed they still have constraints upon their commercial freedoms. On the commissioning side there is still too little experience in creating and managing a more commercial set of processes for awarding contracts. Hence all players are likely to need a lot of support from the Competition Panel in its early years of operation and the organisation will have to scale up to ensure this demand can be met as an investment in reducing the number of cases downstream.

In addition, there should be an impact assessment that models the likely levels of formal referrals uptake the Competition Panel may receive in order to understand the scope and size of demand and inform the development of the service standards.

2.4 Q5. Is the Panel's process for conduct complaints sufficiently clear and fair?

Yes. However, the guidance is very much aimed at commissioners and providers of NHS services. It is not clear whether the Panel will be considering complaints from those outside of the NHS, such as patients and patient representative groups. If so, then will they be able to refer directly to the Panel? If this is the case, FTN would argue that this creates an uneven playing field and providers should also have the ability to refer directly rather than via SHAs. Also, what is the situation where the providers wish to appeal a decision of the Panel?

2.5 Q6 Does the Panel's process for conduct complaints allow parties sufficient opportunity to present their case?

Yes

2.6 Q7. Are the time frames for conducting the complaints process sufficient?

They should be

2.7 Q8: Should third parties be afforded greater involvement in the Panel's process for investigation conduct complaints in terms of providing submissions to the Panel and attendance at hearings?

Para 5.2: Foundation Trusts think that FT Boards of Governors ought to be a specifically named party amongst the parties to be afforded greater involvement in the Panel's process for investigation.

Para 5.14: There should be greater clarity about how the Panel will determine which 'third parties' will be approached where it decides it needs further particulars.

Paras 5.4/5.5: If the Panel is to accept keeping the identity of the complainant confidential, it should lay out the kind of circumstances in which this would be acceptable for further consultation. Foundation trusts are likely to accept the need for patient confidentiality but likely to be more sceptical about other types of anonymity as many complaints will concern the spending of tax payers money.

Clearly the respondents will have to know the identity of the complainant where this is material to the case they will seek to defend. In these circumstances would the complainant be tied in to public confidentiality and why?

2.8 Q9. What are your views on the Panel's test, namely assessing conduct based on any adverse effects on patients and taxpayers?

Para 6.4: Foundation trusts believe that the overarching approach to assessing conduct will not be adequate to fully take the Co-operation part of the competition rules into account. There are circumstances in which co-operation rather than competition is a positive value. This is recognised within the Co-operation and Competition rules themselves, but it looks in this section as if co-operation may be being seen as an 'offsetting benefit' to patients or taxpayers that may arise from the conduct in question, rather than a principle in its own right underpinning benefits to patients under which a decision not to pursue competition as the policy solution is justified.

FTN believes there is a case for starting from the viewpoint that in circumstances where co-operation is desirable and has positive benefits for patients and the taxpayer, this will not be seen as a breach of the rules at all, but an upholding of them. The way in which the twin principles are balanced against each other will have profound knock on impacts upon the perspective from which the panel is likely to view the various potentially anti-competitive behaviours described in the document.

Foundation trusts would appreciate greater clarification on what would be the burden of proof for the body allegedly breaching the rules to prove that it was in patient/ taxpayer interests, or for the claimant to show that the breach was also bad for patients?

There is no reference to whether parties may make a complaint on the basis that co-operation has been breached. If the twin principles of co-operation and competition were given equal weighting, there should, in fact, be scope in this framework to bring a complaint about breaching co-operation rules.

The adequacy of the Panel's proposed test of contestability will depend on the definition the Panel adopts in relation to collusion.

Finally, the guidance mentions predatory pricing by incumbents to prevent new entrants to the market. What about the unsustainable pricing of services as loss leaders by new

entrants with the resources to undercut local providers in order to gain a foothold in the market and ultimately cream off the most profitable work, leaving a weakened local NHS provider to attempt to provide a sustainable service to cover the less profitable work?

2.9 Q10. What are your views on the Panel's approach to offsetting the benefits of conduct to patients and/or taxpayers against the adverse effects on patients and/or taxpayers?

6.15: Whilst market sharing can be a form of collusive behaviour, in a regime that is promoting co-operation as well as competition, providers working together may be the only way to deliver the required level of sophistication, investment, accessibility and continually improving quality of care and service to patients. This could certainly be the case in cancer and other networks. In these circumstances what would be the indicators of collusion and what evidence would be sufficient to establish this?

Since the academic evidence on the impacts of competition and/or co-operation on patients and taxpayers is mixed, it would be hard to make reliable judgements of the impact or otherwise of a particular behaviour. How would the Panel approach collusion within providers, where there was more than one branch/ location? Would they have the same approach to collusion between foundation trust franchises and independent sector providers run by the same company?

2.10 Q11. Are there any types of conduct that should be expressly addressed in these guidelines which are currently not?

There should be greater clarification of the role of the Panel in advising sponsors where it is their policies that are denying patients' choice. For example if Monitor drove foundation trusts too hard to make surplus and this compromised patient access and encouraged discriminatory behaviour or where commissioners and regulators do not police the requirements not to discriminate with equal vigour across all sectors of providers, leaving a particular sector at a competitive advantage that is not in the interests of patients. Another example might be either where the DH fails to find a solution for capital flow through the system or the regulator places disproportionately risk averse conditions on access to capital and as a result another sector not subject to the same rigours of regulatory requirement receives a competitive advantage in investment capacity that is not in the long term interests of developing the infrastructure for providing sustainable patient services across the system.

In addition, Chinese walls between GPs as Providers and as Commissioners should be a key feature of this guidance and there is no mention of it. The dual role of the GP is a real threat to effective competition. How will patients be able to distinguish between services and what advice will they receive from the GP; will they have any real choice? It is up to the Panel to provide clear guidance and requirements on GPs in relation to their conduct and the information that they will need to provide to patients in relation to the full range of services available. One of the dangers of an over emphasis on competition is that services which are currently integrated are broken up.

The development of a Service Specification is only a guarantee that services across the PCT will be equitable if:

- All Providers deliver the full Service Specification, or (if some Providers only deliver part of the Service Specification) All patients are fully advised about which Providers deliver which parts of the Service Specification before they make a choice of provider, and what are the advantages and disadvantages of

each. Otherwise, patients will make potentially unwise and ill-informed choices, and end up worse off than under a previous integrated monopoly provision.

2.11 Q12. What are your views on the Panel's approach to assessing conduct breaches by focusing on their effects as opposed to intention?

FTN agrees with this approach but would expect that in an immature market where all players are learning how to conduct themselves, intention should offer a mitigation defence in terms of remedies that might be applied.

2.12 Q13. What are your views on the Panel's approach to assessing exclusionary conduct without necessarily having regard to dominance?

The issue of market power is clearly one significant factor in determining conduct against the rules, but FTN accepts it is not the only one.

2.13 Q14. Do you believe the Panel's approach to assessing conduct is sound?

Para 6.17. Refers to 'conditions of competition which do not correspond to normal conditions of the market'. But healthcare in England does not constitute a 'normal market'. It is a managed quasi market. There is no Government policy as to how much competition is desirable, or assumption that the more competition there is the better patients will fare as there is in other markets. The health economy is complex and for the NHS to remain sustainable requires a delicate balance of a range of inter-related infrastructure organisations, mechanisms and incentives. Competition is not an end in itself but a tool within the armoury to improve the quality and responsiveness of patient and user services. The regulatory tool box includes other tools such as public information supply on service quality and benchmarking. It is relevant to use competition in some situations but not in others either where competition is not a viable strategy or where comparability and co-operation are more likely to achieve the desired outcome.

The FTN believes the competition Panel will need to develop some norms for the shape and scale of this market over time that are likely to be different to other existing markets.

Para 6.19: The Guidance refers to inhibiting competition through frustrating their access to patients. There are also situations in which patients are denied the choice of provider they want for continuity of care and forced to use other providers as a result of government policy. Such a situation is the conflict between Government policy on Top Ups to NHS care and its interaction with the limits of the private patients cap in foundation trusts. Will the Panel advise sponsors on situations where patients are denied choice of organisation as a result of the interconnections of public policy as part of its duties to feedback from case studies and its vantage point over the system as a whole?

Finally, there are a range of questions that guidance may need to explore further. Some of these are listed below:

- How would the panel approach sharing of information in order to improve quality, e.g. through benchmarking programmes?
- How would the panel approach integrated care pilots currently being developed in response to the Next Stage Review and which could breach the rules?

- What if there is disagreement between the Panel and the Trust Special Administrator about the actions necessary to maintain services?
- How would predatory pricing work in a fixed-tariff market?

2.14 Q15. Is the Panel's approach to assessing discriminatory treatment of patients sufficiently clear and fair?

6.42: FTN applauds the strong adoption of the non-discriminatory principle. The FTN would expect the Competition Panel to feedback to Sponsors if their behaviour is driving providers towards discriminatory behaviour.

Foundation trusts work in an environment that is highly regulated, including being subject to overview and scrutiny committee deliberations. In addition, their terms of authorisation specify which services they must provide. They are not able to drop non profitable lines of activity. We note there is an allowance for 'justified' discrimination, but would worry that this could be a cover for cream skimming, for example referring more complex cases back to the NHS, or under-treating complex patients so that they require revision in the NHS. This would inevitably lead to an un-level playing field.

2.15 Q16. Is the Panel's approach to assessing financial intervention sufficiently clear and fair?

The issue of 'inducements' will be very tricky to determine. FTN would want to see the Panel having access to health industry advice and expertise on the issue of inducements and behaviour in this area as what may appear to the uninitiated to be an inducement is actually a service innovation in the interests of patients. In our evidence to the Marketing Code consultation we pointed to several examples of this including providing layettes through GP services for expectant mothers.

2.16 Q17. Although this list is not intended to be exclusive, are there any other recommendations that should be expressly mentioned in these conduct guidelines?

There should be greater clarification of the role of the Panel in advising sponsors where it is their policies that are leading to denying patients' choice.

There should be some coverage of outcomes when the Panel is called upon to judge a complaint from a Provider against the commissioning behaviour of a PCT, for example, when a PCT has not taken sufficient account of the need for collaboration / co-operation in the provision of local services, and Providers believe that an over-emphasis on competition is acting to the detriment of patients.

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