Principles and rules for Cooperation and Competition

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For Recipient's Use			

1. Context

System Management

1.1 System management strives to make each local system the best it can be. This comprises of three components. First, the tasks associated with building the system – rolling out practice-based commissioning (PBC), ensuring patient choice becomes a reality, getting providers ready for foundation status, and so on. Second, ensuring that the system is coherent – for example, ensuring that objectives on access are complemented by changes to contracts or processes. Third, making the system operate effectively in the interest of patients – sometimes this will mean injecting more competition through new providers, other times it might require enforcing cooperation between providers. It means understanding, for instance, that choice might be able to drive up performance in elective care, but only smart commissioning can improve the quality of intensive care where no meaningful choices can be made. Beyond these technical though important components, system management is about protecting and enhancing the reputation of the NHS to improve patient care, building upon the values which are common to all. It is not new - SHAs and PCTs seek to manage their systems now, including aspects of competition, but practice is variable and there is a risk of inconsistent decisions being made between SHAs and PCTs.

1.2 The concept of system management has come to the fore in light of the Government's reforms of the NHS. Since 2000 the service has seen unparalleled levels of extra investment. During the same period the NHS has moved from a system model based on tight control of the means of provision, towards an open system with a defined purchaser/provider split. The drive for this change was the need to make the NHS focused on the needs of the patient. A key element of policy is the introduction of patient choice. In elective care, patients are now able to discriminate between several providers for their care, making their decision based on aspects of provided care that are important to them. Key to this is the provision of appropriate information on provider performance, which will expand considerably from April 2008. But as well as creating an open system and offering patients a choice, the NHS is also changing in other areas: payments increasingly follow the patient, stronger commissioners increasingly reflect the needs and wants of the patients and the public within their financial envelope, and the development of stronger quality regulation (*The future regulation of health and adult social care in England - response to consultation*, November 2007). Following on from these changes a Next Stage Review of NHS services is being undertaken by Professor Lord Darzi of Denham. Lord Darzi's review is focused on creating a long-term, clinically driven view of the future of health services, focusing on quality and not quantity of provision, and driven by a greatly improved sense of transparency about the nature, outcomes and objectives of the service.

1.3 This widening range of provision, increasing autonomy of NHS organisations, devolution of decision-making (including PBC and procurement) and greater patient choice means that system management will be conducted in a more open context with increased scrutiny. We therefore need to develop a more rigorous approach, with clarity about roles, functions, competencies, expected behaviours, and rules, and build capability within the Department of Health (DH), SHAs and PCTs for effective system management. This is particularly true of issues relating to competition.

1. Context (continued)

1.4 An important first step is therefore to provide a clear statement of principles and rules for cooperation and competition, prior to setting up an independent Competition Panel to provide advice on issues of competition which cannot be resolved locally. The competition principles are grounded in 'core' system management principles, on which we will elaborate when we publish the System Management Roles and Functions in February. The core principles are: transparency, objectivity, proportionality, non-discrimination, subsidiarity, consistency, and no double jeopardy.

1.5 The following pages set out the cooperation and competition principles and rules, and consist of

- **Guiding principles** derived from established policy;
- **Rationale** that the principle seeks to address;
- **Actions/behaviours** for various organisations that work towards satisfying the principle; and
- **Rules** to be followed by all organisations.

Principles and Rules for Cooperation and Competition

1.6 The ten principles outlined in this document are:

1. **Commissioners should commission services from the providers who are best placed to deliver the needs of their patients and population**
2. **Providers and commissioners must cooperate to ensure that the patient experience is of a seamless health service, regardless of organisational boundaries, and to ensure service continuity and sustainability**
3. **Commissioning and procurement should be transparent and non-discriminatory**
4. **Commissioners and providers should foster patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare**
5. **Appropriate promotional activity is encouraged as long as it remains consistent with patients' best interests and the brand and reputation of the NHS**
6. **Providers must not discriminate against patients and must promote equality**
7. **Payment regimes must be transparent and fair**
8. **Financial intervention in the system must be transparent and fair**
9. **Mergers, acquisitions, de-mergers and joint ventures are acceptable and permissible when demonstrated to be in patient and taxpayers' best interests and there remains sufficient choice and competition to ensure high quality standards of care and value for money**
10. **Vertical integration is permissible when demonstrated to be in patient and taxpayers' best interests and protects the primacy of the GP gatekeeper function; and there remains sufficient choice and competition to ensure high quality standards of care and value for money**

1. Context (continued)

1.7 These principles and the rules that follow apply equally to established NHS, social enterprise and third sector organisations as well as the independent sector, practice-based commissioners (PBCs) and primary care. Currently the focus of the actions and rules is on the acute sector, where the majority and most material competition issues have to date arisen - however the principles apply to all sectors and as the system evolves and system players' relationships mature, the actions and rules will be updated. These principles and rules will form the basis of the DH's approach towards managing cooperation, competition and competition-related activity in the NHS. They will be subject to review at least annually as relationships mature and the system evolves, and particularly in the light of the final report of the Next Stage Review. These principles and rules apply from April 2008. This document references extensively the new Standard NHS Contract, however all locally commissioned contracts will, over time, include the same clauses as found in the standard contract to cover competition issues. Where available, each rule contains reference to the previous policy, guidance or technical publications to which it relates and will apply equally to subsequent updates of those documents.

1.8 In the DH response to the consultation on measures for the new regulator, we undertook to set up a panel of experts to provide independent advice to SHAs, where competition issues and disputes could not be resolved locally. Further details of the Competition Panel will be published in 2008. There will be opportunities for stakeholders to engage with DH as these details are drawn up.

1.9 This document does not exhaustively detail the roles and functions of commissioners and system managers. It is complementary with, and should be read in the context of the following:

- **World Class Commissioning** competencies and assurance framework
- **Statement of System Management Roles** to be published in February
- **The NHS Contract**
- **The manual for organisational transactions** to be published in the spring

1. Context (continued)

1.10 For the avoidance of doubt, please note that:

- In respect of acute elective services, we expect there to be competition driven by patient choice. For all other services it is for individual PCTs, as commissioners and public sector contracting authorities, to decide and agree with their respective SHA which services should be subject to direct competition, the extent of such competition, and how this should be secured (having regard to these principles and rules).
- It is for PCTs, as commissioners, to decide transparently which services require to be tendered (having regard to these rules and principles). These rules should not be interpreted as meaning that all services should be tendered in all circumstances.
- National policy on the direct provision of services by PCTs has not changed. It is for individual PCTs to decide whether to continue to provide services. Whether they continue to provide such services or not, we expect the principles and rules set out in this document to be observed.
- Vertical integration is permissible when demonstrated to be in patients' and taxpayers' best interests and protects the primacy of the GP gatekeeper function. The exception is the provision by hospitals of list-based primary care services. Any PCT wishing to contract with hospital providers for the provision of list-based services must agree this with the DH through their SHA.
- This document will be reviewed following the publication of the final report of the NHS Next Stage Review. Nothing in these rules or principles should be construed as anticipating, constraining or precluding any recommendations from the Review.
- These rules apply equally to PBCs, and NHS contracts with third sector organisations. The rules are consistent with the Compact on Relations between Government and the Voluntary and Community Sector in England (1998) (The Compact) and 'Partnership in Public Services – An action plan for Third Sector involvement' (Cabinet Office 2006) and will be updated in light of subsequent versions. These rules apply equally to, and do not preclude, any grant funding.
- We expect commissioners and providers to have regard to these principles and rules in negotiating contracts for 2008/09.
- The Principles and Rules do not preclude joint commissioning between PCTs and Local Authorities, or pooled budgets.

2. Principles and rules for Cooperation and Competition

Principle 1 – Commissioners* should commission services from the providers who are best placed to deliver the needs of their patients and populations		
Rationale	Actions/Behaviours	**Rules**
• To create world-class clinical services and a world-class NHS, commissioners must commission services from the best providers.	• Commissioners must ensure that the public has available quality assessments and metrics of all incumbent providers using independently verifiable information. • Commissioners should obtain and use in commissioning activities, feedback from patients on their experience of care, and consider the wider community impact of providers from whom they commission. • SHAs should ensure that commissioner contracts are appropriately managed and negotiated, but should not directly let contracts for patient care. • Where providers fail to meet standards specified by their commissioners, commissioners should work with them for a reasonable period to foster improvement providing that this does not knowingly put any patient at risk of harm – and if this becomes the case, communicate this to the regulator. • If services fail to improve, commissioners should consider termination or non-renewal of contract and alternative providers, rather than continuing to support a provider that is failing to provide a good service. • PCTs should ensure sufficient separation (e.g via a specification of services/SLA on comparable terms with other provider contracts) between commissioning and provider services. SHAs should oversee this process.	• PCTs are the only contracting authority for NHS direct patient care**. Practice-based commissioners must operate through PCT-let contracts. • Commissioners must hold all providers to account through their contract for the quality of their services in a proportionate manner. • PCT provider services should be subject to these competition rules in the same manner as any other provider and be managed on equal terms to other providers. • Commissioners must adhere to good practice commissioning guidance (Health Reform in England: update and commissioning framework, July 2006).

***For the avoidance of doubt, all reference to 'commissioners' in this document refers to PCTs as contracting authorities**
****An exception to this rule is specialist mental health services where the PCT may choose to delegate responsibility to another NHS body**

2. Principles and rules for Cooperation and Competition

Principle 2 - Providers and commissioners must cooperate to ensure that the patient experience is of a seamless health service, regardless of organisational boundaries, and to ensure service continuity and sustainability		
Rationale	Actions/Behaviours	**Rules**
• Patients rightly expect to experience seamless care regardless of the organisation providing it.	• Commissioners should ensure commissioned pathways across provider boundaries are clear, safe, rational, and responsive to patient need. Providers should support and cooperate with commissioners in this duty. • Although these rules do not apply to social care, both commissioners and providers should ensure effective and timely handover of patients/clients with social care providers and commissioners. • Commissioners should publish common provider patient experience measures. • Providers and commissioners must exchange the necessary information to ensure the patient experience of a seamless health service.	• Consistent with the values of the NHS, patients' interests must be put first. • PCTs and providers must ensure appropriate cooperation and effective handover along pathways. • PCTs should use the relevant contracting mechanism as their primary performance management lever. • All providers must have regard for the Duty of Partnership legislation.

2. Principles and rules for Cooperation and Competition

Principle 3 – Commissioning and procurement should be transparent and non-discriminatory		
Rationale	Actions/Behaviours	**Rules**
• To provide the best value for money, encourage innovation, and protect the reputation of the NHS, commissioning and procurement should be transparent and non-discriminatory.	• Commissioners must engage fully and transparently with providers around future procurement requirements and timetables, using where appropriate their PCT Prospectus and provider forum. • PCTs must gain consent of their boards and inform SHAs where they decide not to tender a contract for a new or significantly changed service. • PCT procurement activity must be proportionate to the size and complexity of the service(s) in question, and appropriate to the type of provision. • Commissioners must maintain an auditable documentation trail which will be a tool for SHA performance management and any competition appeals. • PCT tenders must be advertised on the forthcoming PCT procurement portal*. • Commissioners should have regard to the principles and undertakings in the Compact with the third sector's Funding and Procurement Code of Good Practice (FPCGP) , particularly paragraphs 2.9 (programme design) and 3.8-9 (proportionality of procurement)**.	• Commissioners must follow the guidelines set out in the Procurement Guide (to be published). • Commissioners must comply with the PBC accountability framework and tender where a PBC proposal would result in a major services change or the creation of a monopoly.

***Procurement Portal to advertise all PCT contract opportunities will be established for 2008/9**
****No aspect of these Principles precludes grant funding of voluntary and community organisations, where it is appropriate and not anti-competitive to do so**

2. Principles and rules for Cooperation and Competition

Principle 4 - Commissioners and providers should foster patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare		
Rationale	Actions/Behaviours	**Rules**
• Choice is an important way of empowering individual patients. For patients to exercise choice they need to know what is available and how different providers compare; and there should be sufficient providers to offer meaningful choice where appropriate.	• In respect of acute elective services, we expect there to be competition driven by patient choice. For all other services it is for individual PCTs, as commissioners and public sector contracting authorities, to decide and agree with their respective SHA which services should be subject to direct competition, the extent of such competition, and how this should be secured (having regard to these principles and rules). • It is for commissioners to specify the services they require, along with their requirements for access and quality of services. The exact configuration of services will be agreed between commissioners and providers. Commissioners must consider minimum scale required to provide a clinically safe service. • In making such commissioning decisions, commissioners should engage transparently and constructively with a full range of providers (Commissioning framework for health and well-being, March 2007). • From April 2008, 'Free Choice' applies to all routine elective services. Under Free Choice the opportunity for 'any willing provider' to supply services should not be constrained by the commissioner other than in exceptional circumstances, e.g. concern about aspects of clinical quality. Any restriction must be agreed with the SHA. This also applies to relevant routine elective services provided in out of hospital settings.	• All organisations must adhere to the Government's choice policy (Choice at referral guidance framework 2007/8, and subsequent updates). • Providers, referrers to and commissioners of NHS services must not restrict choice via collusive behaviour or any other action. • Information requirements, NHS Contract clauses 29 and Schedule 5. • Conflict of interest declaration, NHS Contract, clause 53. • Providers cannot subcontract to other providers for choice services without first stating their intention to do so on NHS Choices, and without the expressed will of the patient (and prior approval of the PCT). All activity and prices for subcontracted work must be overseen by the provider's board.

2. Principles and rules for Cooperation and Competition

Principle 4 (continued) - Commissioners and providers should foster patient choice and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare		
Rationale	Actions/Behaviours	**Rules**
	• PCTs cannot request removal of providers from Choose and Book, unless the Contract has expired or all or part of the services have been terminated or suspended. • Commissioners, with assistance from SHAs, should regularly review the services they commission to spot potential collusion. • Commissioners must adopt best practice procurement processes in order to prevent collusion. • All providers of NHS commissioned services will be required to make appropriate information available for inclusion on the 'NHS Choices' website. • All parties to a contract must declare conflicts of interest.	

Principle 5 - Appropriate promotional activity is encouraged as long as it remains consistent with patients' best interests and the brand and reputation of the NHS		
Rationale	Actions/Behaviours	**Rules**
• To offer informed choice and foster innovation and high standards of care, providers need to be able to promote their services appropriately.	• PCTs with support from SHAs should monitor promotional activity using the process set out in the NHS Contract or using appropriate similar procedures. • The Advertising Standards Agency (ASA) will consider matters that fall under its remit. The Competition Panel will cover other areas of promotion that relate to competition, in accordance with its remit.	• PCTs and providers must have regard for the ASA codes which will be supplemented by an NHS Code of Promotion (to be published).

2. Principles and rules for Cooperation and Competition

Principle 6 - Providers must not discriminate against patients and must promote equality		
Rationale	Actions/Behaviours	**Rules**
• Consistent with the values of the NHS, patients' interests must be put first. The promotion of equality is a high priority.	• Providers may offer a restricted range of services to patients only to the extent that this is consistent with their contracts with commissioners and based on the provider's Directory of services on the date the contract is signed or subsequently amended. For NHSFTs any restrictions on range of services offered to patients must be consistent with their Terms of Authorisation. • Providers should ensure, and be able to demonstrate, equality of access and service in any other respect covered by existing equality legislation.	• Relevant providers must comply with NHS Contract clause 54. • Providers must fulfil their objectives under equality legislation. • Providers should not discriminate against or disadvantage particular patients or commissioners (Payment by Results Code of Conduct, March 2007).

2. Principles and rules for Cooperation and Competition

Principle 7 - Payment regimes must be transparent and fair		
Rationale	Actions/Behaviours	**Rules**
• A tenet of ensuring a 'fair playing field' for all providers is that payment regimes must be transparent and fair.	• The national payment by results guidance makes clear that Payment by Results is not subject to local negotiation, except for, and only to the extent afforded by, any local flexibilities* (including local unbundling) specified in guidance, including the Operating Framework. • By the start of the financial year SHAs should agree with their commissioners and consult with providers on the commissioning rules for the year, including local flexibilities, and publish these rules. • Before agreeing the terms of local flexibilities with providers, PCTs must a) obtain approval from SHAs based on objective patients interest evidence or criteria and b) publish the price and the rationale. Any flexibilities agreed must be non-discriminatory between providers. • SHAs must keep a record of all agreements on PbR services that contain local flexibilities and must set out the grounds where a decision is made not to apply the flexibility across all providers. • For services not covered by a national tariff, commissioners should ensure objectivity and transparency in determining prices for services. • Commissioners should have regard for section 3 of The Compact's FPCGP.	• Local commissioning rules must be consistent with these competition principles and the PbR Code of Conduct. • Commissioners and providers must adhere to the provisions for determining a non-tariff price contained in the NHS Contract (Clause 7.2). • Commissioners must not contract with providers whose pricing strategy currently constitutes predatory pricing (i.e. deliberate action by an incumbent provider to constrain market entry by competitors through pricing strategy).

***Throughout this principle 'local flexibilities' is defined according to the PbR Technical Manual and subsequent updates**

2. Principles and rules for Cooperation and Competition

Principle 8 - Financial intervention in the system must be transparent and fair		
Rationale	Actions/Behaviours	**Rules**
• A tenet of ensuring a 'fair playing field' for all providers is that financial intervention in the system must be transparent and fair.	• PCTs and SHAs are expected to follow the rules on financial intervention set out in the 2008/09 Operating Framework or its subsequent updates. • SHAs are responsible for ensuring financial incentives are used appropriately and 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. • PCTs and SHAs should have regard for, and assess fully, the state aid issues implications of financial intervention. Failing to take proper account of the state aid rules can have major implications, in the worst case, requiring funds to be recovered. It is therefore important that all stakeholders give proper consideration to state aid issues in any financial intervention, and seek advice from the Department for Business, Enterprise and Regulatory Reform where required. • Commissioners and SHAs must uphold PbR rules as set out in the Code of Conduct and Technical Manual and not require providers to price at discount to tariff, unless the PCT is under special measures.	• Rules on financial intervention are set out in the 2008/9 Operating Framework and are binding on all PCTs and SHAs.

2. Principles and rules for Cooperation and Competition

Principle 9 - Mergers, acquisitions, de-mergers and joint ventures are acceptable and permissible when demonstrated to be in patient and taxpayers' best interests and there remains sufficient choice and competition to ensure high quality standards of care and value for money		
Rationale	Actions/Behaviours	**Rules**
• Mergers, acquisitions and joint ventures can increase efficiency and quality, improve productivity and foster innovation, but require certain safeguards.	• Providers should inform PCTs and SHAs at the earliest stage possible of a proposed transaction. • Commissioners, with support from SHAs should assess proposed transactions clearly and objectively against the processes laid out in the NHS transactions manual. • Where there might be insufficient choice and competition to ensure high standards of quality and value for money, SHAs should consider referral of the transaction to the Competition Panel for consideration where they are unable to secure a satisfactory outcome at a local level. • In the case of a substantive joint venture, all parties must satisfy their boards and partners that the proposal satisfies these competition principles. NHSFTs should also refer to Monitor's REID guidelines for acquisitions and joint ventures.	• When considering a corporate transaction providers must adhere to standard NHS Contract clause 49 (Change in Control). • NHS Trusts must obtain consent from Secretary of State for joint ventures, mergers and acquisitions. • FTs must comply with Monitor's REID guidelines for acquisitions and joint ventures and obtain Monitor's approval for mergers. • Providers, where they are acting as 'enterprises' must adhere to the Enterprise Act 2002, and consider self referral to the Office of Fair Trading.

2. Principles and rules for Cooperation and Competition

Principle 10 - Vertical integration is permissible when demonstrated to be in patient and taxpayers' best interests and protects the primacy of the GP gatekeeper function; and there remains sufficient choice and competition to ensure high quality standards of care and value for money		
Rationale	Actions/Behaviours	**Rules**
• Vertical integration can increase efficiency and quality, improve productivity and foster innovation, but requires certain safeguards.	• Where vertical integration is proposed by a provider, commissioners must ensure there are sufficient safeguards in the contract to mitigate against inappropriate referrals. • Before agreeing to any vertical integration activity, commissioners should consider the degree of patient choice that will be present after the change is made.	• Commissioners should not contract directly with secondary providers seeking to own, manage or control general medical list based services that would result in referrals to their own secondary provision function, without having agreed robust and proportionate safeguards and with the express agreement of the DH. • Providers must obtain prior written consent from the co-ordinating commissioner before exercising a change in control NHS Contract clause 49. • Parties to the contract must declare conflicts of interest NHS contract, clause 53. • All referring clinicians (such as general practitioners and hospital consultants) must tell their patients about any financial or commercial interest in (or are employed by) an organisation to which they plan to refer a patient for treatment or investigation. When treating NHS patients they must also tell the commissioner (GMC Good Medical Practice 2006, paras. 74 – 76). This interest will also be declared on NHS Choices.