

Principles and rules for cooperation and competition



DH INFORMATION READER BOX

Policy HR / Workforce Management Planning/ Clinical	Estates Commissioning IM & T Finance Social Care / Partnership Working
Document purpose	Policy
Gateway reference	14611
Title	Principles and Rules for Cooperation and Competition
Author	System Management & New Enterprise Division
Publication date	30 July 2010
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Local Authority CEs, PCT Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of Finance, GPs, PCT and SHA Directors of Commissioning, Commercial Support Units, Providers of NHS funded Healthcare Services
Circulation list	
Description	This document sets out the principles and rules which the Department of Health expects commissioners and providers of NHS services to follow to ensure cooperation, while protecting competition, in NHS services. It includes obligations regarding fair commissioning, requirements to cooperate, prohibitions of anti-competitive behaviour and rules on approval of mergers.
Cross reference	Procurement Guide for Commissioners of NHS-Funded Services
Superseded docs	Principles and Rules of Cooperation and Competition (Department of Health; March 2010)
Action required	n/a
Timing	n/a
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For recipient's use	

Introduction

The Principles and Rules of Cooperation and Competition (PRCC) form part of the Operating Framework in establishing the system rules governing cooperation and competition in the commissioning and provision of NHS services in England. The second version of the PRCC was published in March 2010. Subsequently the PRCC have been reviewed to ensure they are consistent with the White Paper: *Equity and Excellence: Liberating the NHS* which set out the Government's strategy for the NHS including the commitment that, wherever relevant, patients should have a choice of any willing provider that meets NHS standards, within NHS prices.

The ten principles for cooperation and competition

The revised PRCC have been slightly amended to reflect:

1. the broader range of commissioners
2. the revised Procurement Guide that is being issued today (principle 2)
3. the importance of any willing provider (principle 5)
4. the later date for implementing the principle and rules on access to essential services (principle 7).



Figure 1 The ten principles for cooperation and competition

Obligations on commissioners	Cooperation and agreements	Conduct of individual organisations	Mergers and vertical integration
<p>1</p> <p>Commissioners must commission services from the providers who are best placed to deliver the needs of their patients and populations.</p>	<p>4</p> <p>Commissioners and providers must cooperate to improve services and deliver seamless and sustainable care to patients.</p>	<p>7</p> <p>Providers must not refuse to accept services or to supply essential services to commissioners where this restricts commissioner or patient choice against patients' and taxpayers' interests.</p>	<p>10</p> <p>Mergers, including vertical integration, between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients' and taxpayers' interests, for example because they will deliver significant improvements in the quality of care.</p>
<p>2</p> <p>Commissioning and procurement must be transparent and non-discriminatory and follow the Procurement Guide issued in July 2010.</p>	<p>5</p> <p>Commissioners and providers should promote patient choice, including – where appropriate – choice of any willing provider, and ensure that patients have accurate and reliable information to exercise more choice and control over their healthcare.</p>	<p>8</p> <p>Commissioners and providers must not discriminate unduly between patients and must promote equality.</p>	
<p>3</p> <p>Payment regimes and financial intervention in the system must be transparent and fair.</p>	<p>6</p> <p>Commissioners and providers should not reach agreements which restrict commissioner or patient choice against patients' and taxpayers' interests.</p>	<p>9</p> <p>Appropriate promotional activity is encouraged as long as it remains consistent with patients' best interests and the brand and reputation of the NHS.</p>	

Status of the Principles and Rules for Cooperation and Competition

The PRCC set out the rules that the Department of Health expects commissioners and providers of NHS services to follow to ensure co-operation and competition. The principles and rules are not legally binding provisions enforceable by the courts. For NHS Bodies matters of compliance with the PRCC are currently the responsibility of Boards and, in respect of PCTs and NHS Trusts, are overseen by Strategic Health Authorities (SHAs) as regional system managers. The current obligations of NHS Foundation Trusts (FTs) to comply with the PRCC are as required by Monitor (Independent Regulator of FTs) and set out in the *Compliance Framework and FTs' Terms of Authorisation*.

The role of the Cooperation and Competition Panel (CCP) is to provide advice on matters of compliance with the PRCC, including advice to the Secretary of State and his delegated authorities¹, and in the case of FTs, Monitor, following investigation of complaints alleging a potential breach of the PRCC. The role of the CCP is not to set policy, but instead to provide advice on matters of compliance with the PRCC.

As set out in the White Paper and its supporting consultation documents, our intention is to create an NHS that is much more responsive to patients and achieves better outcomes. Our intended arrangements for the future include:

- more autonomous providers
- a responsibility for GP consortia to commission most healthcare services
- an NHS Commissioning Board
- an Economic Regulator

The status of these principles and rules is expected to change in light of the response to the consultation documents and development of the system. The PRCC are expected to continue to apply until the new competition regime is established as proposed in 2012.

Structure of the Principles and Rules

Each of the PRCC principles includes a rationale, rules and a description of appropriate actions and behaviours. The rationale for each principle provides some context and sets out the underlying reason for each principle. The rules are requirements for commissioners and providers of NHS-funded services. An alleged breach of a principle or rule would form the basis of a complaint to an SHA, Monitor, the CCP or the Advertising Standards Agency, as appropriate (although these arrangements will be affected by the changes in accountabilities that are introduced following the publication of the White Paper and response to consultation documents).

The actions and behaviours are intended to constitute recommendations on the appropriate actions or behaviours that organisations should aim to achieve when complying with the principles and rules. Both the rules and the actions and behaviours refer to certain statutory duties where they are relevant to protecting cooperation and competition. However, this is not intended to be an exhaustive list of the applicable legal obligations in the area.

At the end of each Principle, there is a section providing guidance on how the appropriate regulator is likely to apply the principle and rules. These sections provide brief guidance on procedural issues and the tests that the regulators are likely to apply when considering potential breaches of the rules.

The PRCC does not set out exhaustively the obligations on commissioners and providers of NHS services. They should be read in the context of the general statutory obligations on commissioners and providers of NHS services and regulatory guidance documents, including the NHS Constitution; Operating Framework; Procurement Guide; the Transactions Manual and the Standard NHS Contracts.

The CCP issued draft guidelines and criteria in 2009 and received comments as part of a stakeholder consultation on them. It is intended to consult further on revised guidelines and criteria, following the issuing of these revised PRCC.

Application of the PRCC to different organisations and initiatives

The principles and rules are intended to apply to all commissioners and providers of NHS services irrespective of whether they are public, private or third sector organisations. The principles governing commissioning apply to PCTs, to specialist commissioners and to practice-based commissioning consortia, shadow GP commissioning consortia or any other bodies with express delegated responsibility to commission or subcontract on behalf of the PCT(s). The principles governing cooperation and individual conduct apply to all commissioners and providers of NHS services. The merger controls set out in Principle 10 apply to all NHS Trusts or FTs and to private or voluntary sector providers of NHS services where they are required under their contracts to seek the commissioner's approval for a change in control. In relation to primary care, where there are clear legislative or contractual provisions or processes (including provisions for dispute resolution) governing the subject matter, these will take precedence over the PRCC; in other cases the PRCC principles and rules apply.

1. These include the Department of Health, Strategic Health Authorities, Primary Care Trusts and NHS Trusts.

The principles and rules apply to pilots or other temporary initiatives. For example, the participants in a pilot will need to ensure that they comply with the principles and rules governing providers' conduct, in particular the rules preventing individual providers or groups of providers from acting anti-competitively. If a pilot qualifies as a merger under Principle 10, it should be referred to the CCP where required under the CCP's mergers guidance.

Responsibilities of different organisations in applying the PRCC

Currently, SHAs are responsible for managing the performance of PCTs and NHS Trusts in their regions and have responsibility for ensuring that these organisations comply with the principles and rules. In particular, SHAs are responsible in the first instance for ensuring that PCTs and NHS Trusts comply with the statutory duties for NHS organisations to cooperate. SHAs also hear disputes regarding procurement or advertising in the first instance.

These arrangements will be affected by the changes in accountabilities that are introduced following the publication of the White Paper and response to consultation documents.

Monitor is responsible for ensuring that FTs comply with the principles and rules. It is responsible for ensuring that FTs comply with the statutory duties for NHS bodies to cooperate.

The CCP considers appeals against SHA decisions relating to procurement disputes under Principle 2 and advertising disputes under Principle 9. (In some cases, the Advertising Standards Agency is responsible for investigating potential breaches of the Code of Practice for the Promotion of NHS Funded Services. More information can be found in the CCP's guidelines.)

The CCP will remain responsible for investigating complaints regarding conduct that may potentially breach the principles and rules until the establishment of the Economic Regulator. It also investigates the effect of qualifying mergers under Principle 10. The CCP has published guidance on its processes and approach to investigating complaints and mergers. These include its Rules of Procedure and guidelines on how it will assess different types of cases.

Following an appeal, complaint or merger referral, the CCP is responsible, until the establishment of the Economic Regulator, for advising the Secretary of State and Monitor (in the case of FTs) on whether there has been a breach of the PRCC. The Secretary of State or his delegated authorities and Monitor (in the case of FTs) must individually then decide whether they agree with the CCP's advice and recommendations and what action, if any, to take.

Implementation of the revised PRCC

These revised PRCC will be implemented from October 2010, subject to consultation by Monitor on appropriate changes to the Compliance Framework for FTs. This is consistent with the principles of Better Regulation.

Explanatory Note on Principle 7

In certain circumstances, individual providers may have the ability to restrict choice or competition by refusing to use services supplied by others or refusing to supply essential services to others. For example, an established provider with a powerful position in a local market might be able to prevent commissioners from transforming services and introducing new providers by refusing to supply essential services such as hospital consultants to them. Principle 7 therefore establishes requirements for individual providers to accept services or provide services in cases where refusal would restrict choice or competition against patients' and taxpayers' interests.

While this type of cooperation is essential in some circumstances, it is also important to protect providers' right to choose their trading partners and to accept and provide services on reasonable commercial, financial and clinical terms. The Department of Health, Monitor and the CCP have therefore committed to carry out a programme of work on the types of services to be covered under the Principle, the circumstances in which refusal to accept or supply services could restrict choice or competition against patients' and taxpayers' interests, and appropriate terms.

The Department of Health, Monitor and the CCP recognise that further work is needed before Principle 7 can be applied to the NHS. Principle 7 is therefore included as guidance only and will not be applied from October 2010 as set out in the Principles & Rules in March 2010.

In addition to accepting and supplying services, there may be arguments in favour of requiring incumbent providers to grant access to their equipment or facilities in certain circumstances. However, there may also be significant costs and difficulties in establishing third party access arrangements. We have therefore concluded that it would be premature to introduce new rules governing access to facilities or infrastructure in the revised PRCC at this stage.

Instead, the Department, Monitor and the CCP will consider access to equipment or facilities as part of their work programme on accepting and supplying services. The project will consider potential competition concerns regarding access to facilities within the NHS, the costs and benefits of regulating access, and the range of options for regulating access.

Principle 1: Commissioners² must commission services from the providers who are best placed to deliver the needs of their patients and populations.

Rationale: To create world-class clinical services and a world-class NHS, commissioners must commission services from the best providers.

Rules

- 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.

Actions and Behaviours

- PCTs are currently the principal contracting authority for NHS-funded services. Practice-based commissioners and, in the future, shadow GP commissioning consortia operate within a system of PCT-let contracts
- 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 an existing provider is underperforming commissioners should work with the provider for a reasonable period to foster improvement, for example, utilising the two-stage escalation process set out in the Standard NHS Contracts
- If services fail to improve, commissioners should consider termination or non-renewal of contract and engagement with alternative providers, rather than continuing to support a provider that is failing to provide a good service
- Commissioners should intervene to address risk to patient safety, including suspension or termination of services where necessary, maintaining appropriate communication and cooperation with SHAs and the appropriate regulator (eg Monitor or the Care Quality Commission)
- PCTs and other commissioners should ensure sufficient separation between commissioning and their provider services. SHAs should oversee this process.

2. All references to ‘commissioners’ in this document refer to PCTs as contracting authorities, specialist commissioning groups or other bodies specifically contracted to commission services on behalf of PCTs

Applying Principle 1 and its Rules

- In assessing procurement dispute appeals under Principle 1, the CCP will review the decision taken by the commissioner to determine whether it is reasonable in the context of the PRCC
- Where appropriate, the CCP may apply a cost-benefit assessment when assessing conduct under the Principle
- In these cases, the CCP will assess the costs (detriment) to patients and taxpayers from reduced choice or competition resulting from the conduct
- If the CCP identifies such costs, it will assess the benefits of the conduct and weigh these against the costs. If the costs outweigh the benefits, the CCP is likely to find that there is an adverse effect on patients and taxpayers and a breach of the PRCC.

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

Rationale: To provide the best value for money, encourage innovation, protect the reputation of the NHS and ensure compliance with Law, commissioning and procurement should be transparent and non-discriminatory.

Rules

- 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
- 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.

Actions and Behaviours

- 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 the minimum scale required to provide a clinically safe service
- Commissioners should engage fully and transparently with existing and potential providers regarding future procurement requirements and timetables
- All providers, including NHS bodies, should be given a fair and equal opportunity to bid for new contracts
- Commissioners' procurement activity should be proportionate to the size and complexity of the service or services in question, and appropriate to the type of provision
- Commissioners should maintain an auditable documentation trail which will be a tool for SHA performance management and any appeals
- Commissioners should have regard to the commitments in the Compact - the agreement between the Government and the Third Sector in England, in particular pages 11 and 12 on 'Allocating Resources' and the associated 'Commitments for Government'. In addition the associated guidance; The Compact and Procurement Law; and Commissioning Guidance provides further detail that should be considered.
- PCTs and other commissioners should have regard for their obligations to engage with their Oversight and Scrutiny Committees³ and Local Involvement Networks⁴ and their successor arrangements.

Applying Principle 2 and its Rules

- In assessing procurement appeals under this Principle, the CCP will review the decision taken by the commissioner to determine whether it is reasonable in the context of these Principles and Rules.

3. Duties as set out in Sections 242-247 of the NHS Act 2006

4. Duties as set out in Sections 221-229 of the Local Government and Public Involvement in Health Act 2007

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

Rationale: A tenet of ensuring a 'fair playing field' for all providers is that payment regimes and financial intervention in the system must be transparent and fair.

Rules

- 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.

Actions and Behaviours

- 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 annual 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
- Commissioners should have regard to the PbR Code of Conduct and national guidance when applying local flexibilities to Payment by Results tariffs
- Before agreeing the terms of local flexibilities with providers, PCTs should a) obtain approval from SHAs based on objective evidence or criteria regarding patients' interests and b) publish the price and the rationale. Any flexibilities agreed should be non-discriminatory between providers
- SHAs should keep a record of all agreements on PbR services that contain local flexibilities and 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 to the commitments in the Compact - the agreement between the Government and the Third Sector in England, in particular pages 11 and 12 on 'Allocating Resources' and the associated 'Commitments for Government'. In addition the associated guidance; The Compact and Procurement Law; and Commissioning Guidance provides further detail that should be considered.
- Commissioners and SHAs are expected to follow the rules on financial intervention set out in the Operating Framework

continued...

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

Rationale: A tenet of ensuring a 'fair playing field' for all providers is that payment regimes and financial intervention in the system must be transparent and fair.

Rules	Actions and Behaviours
	<p><i>continued...</i></p> <ul style="list-style-type: none">• SHAs are responsible for ensuring 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• Commissioners and SHAs should have regard for, and assess fully, the state aid 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, Innovation and Skills where required• Commissioners and SHAs must uphold PbR rules as set out in the Code of Conduct and Technical Manual.

Principle 3

Applying Principle 3 and its Rules

<ul style="list-style-type: none">• In assessing conduct complaints under this Principle, the CCP will carry out a cost-benefit assessment• This involves assessing the costs (detriment) to patients and taxpayers from reduced patient choice or competition resulting from the conduct	<ul style="list-style-type: none">• If the CCP identifies such costs, it will assess the benefits of the conduct and weigh these against the costs• If the costs outweigh the benefits, the CCP is likely to find that there is an adverse effect on patients and taxpayers and a breach of the PRCC.
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Principle 4: Providers and commissioners must cooperate to improve services and deliver seamless and sustainable care to patients.

Rationale: NHS bodies are subject to a statutory duty to cooperate.⁵ Cooperation across boundaries and providers in the interests of patients is essential.

Rules

- NHS bodies should comply with their statutory duty to cooperate, which is a board level responsibility
- Providers and commissioners must cooperate to maintain patient safety and improve quality of care
- Providers and commissioners must cooperate to ensure that the patient experience is of a seamless health service, regardless of organisational boundaries
- Providers and commissioners must cooperate to ensure service continuity and sustainability
- Commissioners and providers should respect contractual obligations to share best practice.

Actions and Behaviours

- Cooperation is an essential behaviour amongst commissioners and providers of NHS-funded services to share best practice and maintain seamless and sustainable care
- 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
- For example, providers and commissioners must exchange the necessary information to ensure the patient experience of a seamless health service
- Similarly, both commissioners and providers should ensure effective and timely handover of patients/clients with social care providers and commissioners
- Commissioners should use the relevant contracting mechanism and appropriate other funding mechanisms to ensure appropriate cooperation
- Agreements to cooperate should be appropriately documented and transparent
- Commissioners and providers should have regard for the NHS Constitution including its pledges for patients and staff
- As set out in Principle 6, commissioners and providers should not reach agreements which restrict choice and competition if they operate against patients' and taxpayers' interests.

Applying Principle 4 and its Rules

- Responsibility for the duty to cooperate lies with boards and is overseen by SHAs and the regulators.

5. Duty as set out in Section 72 of the NHS Act 2006

Principle 5: 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.

Rationale: 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.

Rules

- 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' interests⁶
- 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

Actions and Behaviours

- Commissioners and providers should respect patients' right to choice as set out in the NHS Constitution
- From April 2008, 'Free Choice' applied to all routine elective services. The NHS Constitution and Directions issued in 2009 make Free Choice a legal right for patients.⁸ Under Free Choice the opportunity for 'any willing provider' to supply services should not be constrained by the commissioner except where there are serious concerns about aspects of clinical quality or patient safety. Any restriction must be agreed with the SHA. This also applies to relevant routine elective services provided in out-of-hospital settings
- In respect of acute elective services, legal Directions require PCTs to offer patients 'free choice' of provider of routine elective services. The Directions also require PCTs to ensure that information is available to support choice and to report action taken in response to choice-related complaints
- National policy and guidance also requires PCTs to offer patients choice in an increasing range of services outside of elective care, including maternity, long-term conditions and end-of-life care, as well as GP services, and where possible to apply any willing provider models
- Outside of those services where patient choice is required under national guidance and the NHS Constitution, it is for commissioners locally to determine priorities and approaches to expanding choice
- PCTs and other commissioners 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
- All providers of NHS commissioned services should comply with obligations to make information available on NHS Choices.

6. The Department of Health, with Monitor and CCP, will be conducting a programme of work in 2010 on access to assets and the impact on choice and competition. In the meantime, the PRCC does not impose requirements on individual providers to provide third party access to their assets, equipment or infrastructure to facilitate choice or competition

7. This reflects the obligation set out in GMC Good Medical Practice 2006, paragraphs 74-76

8. Duty as set out in the Primary Care Trusts (Choice of Secondary Care Provider) Directions 2009

Applying Principle 5 and its Rules

- In assessing conduct complaints under this Principle, the CCP will carry out a cost-benefit assessment
- This involves assessing the costs (detriment) to patients and taxpayers from reduced patient choice or competition resulting from the conduct
- If the CCP identifies such costs, it will assess the benefits of the conduct and weigh these against the costs
- If the costs outweigh the benefits, the CCP is likely to find that there is an adverse effect on patients and taxpayers and a breach of the PRCC.

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

Rationale: Collusion or restrictive agreements to limit choice and competition may act against patients' and taxpayers' interests.

Rules

- 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 PRCC.
- Agreements to share best practice, including clinical best practice, are unlikely to be considered a breach of the PRCC.

Actions and Behaviours

- Organisations regularly enter into a wide range of agreements, including relating to the delivery of services. In many cases, these agreements will have no negative impact on choice or competition
- However, in some cases, organisations may enter into agreements which prevent or reduce competition. For example, a group of providers might agree to refer patients to a single provider for a particular condition. Alternatively, two providers might establish a joint venture to invest in new services
- These types of agreements could deliver benefits such as allowing providers to specialise or invest in new facilities. However, they could also reduce the competition which would otherwise drive up quality or efficiency
- For example. there could be a breach of the PRCC when:
 - (i) two providers agree to bid for a contract together against patients' and taxpayers' interests; or
 - (ii) organisations agree to fix prices against patients' and taxpayers' interests; or
 - (iii) a commissioner and one or more providers agree to prevent the entry of a new provider to deliver services against patients' and taxpayers' interests.
- Organisations should therefore not enter into agreements which restrict competition if their overall effect is to operate against patients' and taxpayers' interests.

Applying Principle 6 and its Rules

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| <ul style="list-style-type: none">• In assessing conduct complaints under this Principle, the CCP will carry out a cost-benefit assessment• This involves assessing the costs (detriment) to patients and taxpayers from reduced patient choice or competition resulting from the alleged collusion or restrictive agreement or agreements | <ul style="list-style-type: none">• If the CCP identifies such costs, it will assess the benefits of the cooperation and weigh these against the costs.• If the costs outweigh the benefits, the CCP is likely to find that there is an adverse effect on patients and taxpayers and a breach of the PRCC. |
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Principle 7: Providers must not refuse to accept services or to supply essential services to commissioners where this restricts commissioner or patient choice against patients' and taxpayers' interests.⁹

Rationale: If providers refuse to accept or supply certain services, this may reduce choice or competition and adversely affect patients and taxpayers.

Rules

- Individual providers must not unreasonably refuse to supply services to commissioners where this restricts choice or competition against patients' and taxpayers' interests
- Individual providers must not unreasonably refuse to recognise or accept services commissioned from other providers where this restricts choice or competition against patients' and taxpayers' interests.

Actions and Behaviours

- In certain circumstances, established providers may be able to restrict choice or competition by refusing to accept or provide services
- For example, in certain circumstances, a provider could prevent commissioners from redesigning services, or developing new models of care using other providers, by refusing to accept or deliver services
- Providers who do not face strong competitive constraints are most likely to be able to take actions which restrict choice or competition against patients' and taxpayers' interests
- These providers should therefore supply services to commissioners or accept services from other accredited providers where this is necessary to permit choice and competition and in patients' and taxpayers' interests
- However, incumbent providers can only be expected to accept or supply services on reasonable terms
- Patient safety remains paramount. Providers cannot be expected to accept or supply services if this would demonstrably undermine clinical standards or patient safety
- In addition, providers cannot be expected to accept or supply services if this would demonstrably undermine service continuity or financial sustainability.

Applying Principle 7 and its Rules

- The CCP will assess the costs and benefits of conduct under Principle 7. It will assess whether the conduct in question can be expected to have an adverse effect on patients and taxpayers.

9. This principle is subject to further work and will not be applied from October 2010.

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

Rationale: Consistent with the values of the NHS, patients' interests must be put first. The promotion of equality is a high priority.

Rules

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

Actions and Behaviours

- Commissioners should meet the provisions of the Equality Act 2010. To ensure patients are treated fairly and equitably, and to address inequalities in health outcomes, they should act to avoid discrimination between patients of different characteristics in choice of provider. This should be transparent in their commissioning strategies.
- Providers should respond to commissioners' requirements to promote equality and address health inequalities
- Providers should not refuse access to patients on unreasonable grounds
- Providers may offer a restricted range of services to patients only to the extent that this is consistent with their contracts with commissioners and, where services are subject to patient choice, reflected in the information made available to patients via NHS Choices
- For NHS FTs any restrictions on range of services offered to patients must be consistent with their Terms of Authorisation
- Providers should fulfil their obligations under equality legislation and their contracts
- Commissioners and providers should have regard for the NHS Constitution¹⁰, which states that the NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief¹¹.
- Commissioners should have regard to the commitments in the Compact - the agreement between the Government and the Third Sector in England, in particular pages 19 and 20 on 'Advancing Equality' and the associated 'Commitments for Government'.

10. The NHS Constitution for England, Department of Health, March 2010
11. Duty as set out in Section 1 of the Health Act 2009

Applying Principle 8 and its Rules

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| <ul style="list-style-type: none">• In assessing conduct complaints under this Principle, the CCP will carry out a cost-benefit assessment• This involves assessing the costs (detriment) to patients and taxpayers from reduced patient choice or competition resulting from the conduct | <ul style="list-style-type: none">• If the CCP identifies such costs, it will assess the benefits of the conduct and weigh these against the costs• If the costs outweigh the benefits, the CCP is likely to find that there is an adverse effect on patients and taxpayers and a breach of the PRCC. |
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Principle 9: Appropriate promotional activity is encouraged as long as it remains consistent with patients' best interests and the brand and reputation of the NHS.

Rationale: To offer informed choice and foster innovation and high standards of care, providers need to be able to promote their services appropriately.

Rules

- Commissioners and providers must comply with the ASA's Advertising Codes and the Code of Practice for the Promotion of NHS-funded services.

Actions and Behaviours

- PCTs with support from SHAs should monitor promotional activity using the process set out in the NHS Standard Contracts or using appropriate similar procedures.

Applying Principle 9 and its Rules

- The ASA will consider matters which fall within its remit
- The CCP will advise SHAs and commissioners on advertising issues which cannot be resolved locally

- The CCP will act as an appellate body in relation to decisions taken by SHAs regarding alleged breaches of the code.

Principle 10: Mergers, including vertical integration, between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients' and taxpayers' interests, for example because they will deliver significant improvements in the quality of care.

Rationale: Mergers and vertical integration can increase efficiency and quality, improve productivity and foster innovation, but may require certain safeguards.

Rules

- Commissioners, SHAs and providers must comply with the guidance on referral and approval of mergers set out in the CCP's rules of procedure
- Providers must obtain prior written consent from the co-ordinating commissioner if approval is needed for a change in control
- Commissioners must protect the primacy of the GP gatekeeper function. Contracts that allow secondary care providers to own, manage or control general medical list based services that could result in referrals to their own secondary care services must not be awarded unless there are agreed robust and proportionate safeguards¹² and the express agreement of the relevant SHA.

Actions and Behaviours

- For the purposes of the PRCC, the term 'merger' is used inclusively to refer to mergers, acquisitions, joint ventures and other transactions between NHS service providers that result in two previously independent organisations (or parts of organisations) coming under common management or control
- Providers should inform relevant PCTs and SHAs of a proposed transaction at the earliest opportunity
- SHAs should comply with the NHS Transactions Manual on assessment and approval of mergers and other transactions
- SHAs should assess whether proposed transactions involving NHS Trusts including PCT provider services are likely to deliver benefits to patients and taxpayers before they are referred to the CCP for assessment and make representations on them as part of CCP investigations
- Commissioners should assess the advantages and disadvantages of different forms of integration when developing commissioning strategies or assessing proposals by providers to integrate services
- In particular, commissioners should also consider the degree of patient choice and the scope to contest services after the change is made
- Commissioners should also ensure that there are sufficient safeguards to avoid inappropriate referrals
- Commissioners should ensure that, where appropriate, there are clauses in all new contracts requiring approval for a change in control.

¹² For example, the contracts developed under the previous administration's Equitable Access to Primary Medical Care (EAPMC) programme include a number of safeguards to ensure that vertical integration does not lead to inappropriate referrals from primary care into other services. These include requirements to ensure financial separation between primary care services and other services, requirements to provide commissioners with regular information on referral patterns, and provisions allowing commissioners to intervene if there is evidence of inappropriate referrals.

Applying Principle 10 and its Rules

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| <ul style="list-style-type: none">• In assessing mergers under this Principle, the CCP will carry out a cost-benefit assessment• This involves assessing the costs (detriment) to patients and taxpayers from reduced patient choice or competition resulting from the merger | <ul style="list-style-type: none">• If the CCP identifies such costs, it will assess the benefits of the merger and weigh these against the costs• If the costs outweigh the benefits, the CCP is likely to find that there is an adverse effect on patients and taxpayers and that the merger is inconsistent with the PRCC. |
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