Licence conditions – choice and competition: consultation on draft guidance for providers of NHS-funded services

1. The Royal College of General Practitioners (RCGP) welcomes the opportunity to respond to Monitor’s consultation on ‘Licence conditions – choice and competition: draft guidance for providers of NHS-funded services’.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 46,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. We gratefully acknowledge the contributions of the RCGP Centre for Commissioning, RCGP Clinical Commissioning Champions and RCGP Council members in formulating this response.

4. We have noted the government’s March 2013 consultation response on licensing providers of NHS services, which states that the Secretary of State intends to propose
regulations to Parliament that would exempt providers of primary medical and dental services under contracts with the NHS Commissioning Board (now NHS England) from the requirement to hold a licence. Therefore our response to this consultation is based on the assumption that primary care services such as GP practices will not ordinarily be subject to the licence – an exemption which we welcome.

5. However, we also note that the government intends to conduct a review of licensing during 2016-17. Thus, while we would urge the government to maintain the exemption for primary care, our response to this consultation is cognizant of the possibility that the current exemption may be subject to change. We would also like to seek clarification as to the extent of the current exemption. (Please see paragraphs 11-12 below).

**Our response**

6. Firstly, we would wish to note that we support the role of Monitor as a *specialist health sector* regulator. It is essential that the regulator has a specialist knowledge of the health care sector, so that it is able to fulfil its duty to protect and promote the interests of patients and can to make informed, commensurate decisions. We would therefore urge Monitor to ensure that clinicians and patients are at the heart of the organisation and are included in the regulatory process.

7. We congratulate Monitor on producing a clearly worded document on what is a complex area. It is essential that the guidance is clear and easily understood by commissioners and licensees, and so we commend Monitor’s use of straightforward language.

8. However, we have a number of concerns regarding how the guidance will be interpreted by Monitor and providers (and their lawyers). As we have stated in previous consultation responses to Monitor, it is our view that, in the main, it should be for commissioners to determine when competition is an appropriate tool to improve services locally. Commissioners must have the right to report to Monitor anti-competitive behaviour which is against patients’ interests, but Monitor should be required pro-actively to encourage competition between providers *only* when it can be shown to be necessary to improve patient care.

9. We are concerned that this guidance tends to emphasise competition for its own sake above the need of CCGs to ensure a stable and efficient local health economy. We are also worried that the guidance is written from the perspective that the majority of NHS care is episodic, and underestimates the complexity of the referral process – where
different approaches will often be needed on a case by case basis in order to put the interests of the patient first.

10. We would emphasise that commissioners should be free to develop an approach to capacity planning that allows providers to focus on what they do best. While this should not preclude competition, in some cases it could be regarded under the guidance as collusion (‘Role of commissioners’ pages 23-25) – for example, where as part of capacity planning different providers agree to focus on different clinical areas with the support of the collective commissioners in that area. This may be especially relevant for complex care needs such as major trauma or cancer. We would urge Monitor to include in the guidance an analysis of the problems that choice and competition conditions could cause - including for the delivery of integrated care - and how Monitor, as the sector regulator, might mitigate against these potential problems.

11. As we have noted above (4), it is our understanding that providers of primary care services such as GP practices will not ordinarily be required to hold a licence. However, we are aware that the exemption will be subject to a review in 2016-17 and, while we would urge the government to make the exemption permanent, we believe that it is important to consider the potential implications for GP providers should they be required to hold a licence in the future.

12. We are particularly concerned about the potential implications of the guidance on Licence Condition C2 for GP federations, i.e. groups of practices collaborating to improve the quality of care and provide and develop a greater range of services. The draft guidance states that Monitor will consider: "Whether a licensee has agreed with another provider to allocate certain services, patients, groups of patients or patient flows between themselves. This includes allocating patients in particular geographical areas or patients requiring particular health care services between themselves". In the light of this statement, we are concerned that collaborative work by GP providers in a federation, a model that is intended to improve the quality, safety and integration of services and that is supported by the RCGP, could be seen as being anti-competitive and therefore breach the licence condition.

13. In addition, we are worried about the implications of the guidance on Licence Condition C2 for mergers of GP practices, which are currently common occurrences as GPs retire and smaller practices become unsustainable. We would urge Monitor to avoid a situation where such mergers of GP practices may be interpreted as anti-competitive behaviour.
14. We welcome the definition of integrated care as being "planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes." We accept that the delivery of integrated care need not always necessarily be at odds with competition rules. However, it should also be recognised in the guidance that there may be cases where choice and competition do not help facilitate the delivery of integrated care. While care can be and often is integrated across different providers working together, it is important to acknowledge that there may be occasions where delivering integrated care does require there being a single provider, to ensure both the complete care of a patient and the sustainability of a provider’s services. In addition, it should be recognised that in some cases a multiplicity of providers may make integration more difficult.

15. Similarly, we are concerned that the guidance does not give due consideration to the importance of long term support for people with complex multi-morbidities. There is no mention, for example, of how competition and cooperation might be interpreted in light of the work of the ‘Year of Care Programme’.

16. We would therefore urge Monitor to give further consideration to the challenges and risks that the choice and competition conditions could cause for the delivery of integrated care. This should include, for example, cases in which federations of GP practices, whose members are likely also to be involved in local CCGs, are involved in the development of integrated community services. To this end, we look forward to Monitor’s worked examples of how it would expect to apply the competition licence condition to integrated care arrangements.

17. We welcome Monitor’s expectation that it will update the guidance as it gains more experience in this area. In our view, it would be helpful if Monitor could regularly publish a summary of lessons learned, with worked examples to guide commissioners and licensees.

We look forward to ongoing dialogue with Monitor as it develops this and other guidance relating to its role as sector regulator and we would welcome further opportunities to engage with this process.

Please do not hesitate to contact me if you have any questions about our response.

Yours faithfully,

Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council