Monitor consultation on Fair Playing Field Review – for the benefit of patients

1. I write with regard to the Monitor consultation on Fair Playing Field Review – for the benefit of patients.

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. The College welcomes the opportunity to respond to this consultation – though in some way we would query whether this is an appropriate time to be carrying out such a review. In particular, with the commissioning environment in England about to undergo massive changes, it is surely unclear whether some of the issues identified – such as the perceived prejudice towards incumbent providers – will remain
relevant. Notwithstanding these doubts, we have responded to the specific questions below.

**Question 2:** Do you believe that a diverse range of providers is an important lever for helping to improve patient care? Please provide specific examples in either case.

Where there are underperforming providers, the existence of a diverse range of providers may well be a useful support to commissioners in their efforts to improve patient care. In other situations, though, and especially where there is a shortage of funding or existing providers are struggling to provide an effective service within financial limitations, we would argue that prioritising a diversity of providers may be a distraction from efforts to improve existing services. For example, where there is a range of providers, and some are able to ‘cherry-pick’ more profitable services, it is plausible that this will be to the detriment of patient care around mental health, elderly care and multimorbidities.

Moreover, where providers have different responsibilities, for example with regards to medical education, diversity may have a harmful effect on the capacity of the whole system to deliver effective patient care.

The principle should be that, where there are good local services, it is not necessary artificially to seek to impose a diversity of providers. Commissioners, in conjunction with local communities, are best placed to judge this.

**Question 4:** In the responses to our initial call for evidence, effective commissioning was overwhelmingly identified as important to ensuring a range of providers can offer their services. To what extent do you think the main issues relating to commissioning and the fair playing field are being addressed through the current reforms?

We agree that effective commissioning is of vital importance. CCGs are not even operational yet – in our view it is very important that they be given the freedom to use their expertise and judgement, in conjunction with local communities, to commission as they see fit, so long as they meet appropriate standards of transparency. This may mean, where incumbent providers are providing a good service that fits the requirements of patients and the whole local healthcare system, that it is will more appropriate to recommission their service than to seek the development of a range of providers or apply an any qualified provider approach. In other places offering a diverse choice of providers may really stimulate a stagnant or complacent provision and improve the quality of patient care – but crucially, CCGs and local communities are in the best place to
determine this, and this should always be seen as one of a range of options. The risk is that, where there is no need for change, the imposition of any qualified provider and repeat tendering will sap finance from CCGs to no patient benefit. The recent Department of Health consultation on ‘Securing Best Value for NHS Patients’\(^1\) confirmed the position of the Health and Social Care Act 2012 that there was not a presumption of choice and competition in the commissioning of services, and this is a position that we would support – we append here our response to that consultation, as much of it is relevant.

**Question 6:** Are you aware of any specific examples where costs arising from differences in pension costs between NHS, private sector and VCS providers have had an impact on provider decisions about whether to compete for contracts (or provide services covered by AQP policy) and on provider’s ability to attract high quality staff?

One of our contributors cites an example in Hampshire where a private provider was able to win an out-of-hours contract partly because of a lower tender price – due to withdrawing from the NHS pensions scheme for medical staff.

**Question 7:** Which of the issues identified in the review do you feel is the most important to your organisation? Are there any important issues that you feel we have missed?

It is our view that the issue of clinical education and training is the most important of those identified here. It is a serious concern to us that differing obligations with regards to education and training between different types of providers will not only lead to an ‘unfair playing field’ but will harm the overall health system – by denying trainees access to experience with many categories of treatment and patient that will be dealt with by providers ‘cherry-picking’ the most remunerative cases. We would argue that a clear standard requirement around education and training should be included in all contracts for those providing NHS services.

This is a direct concern for general practice, as well as for GPs as commissioners. It is quite possible that private providers of general practice (i.e. large commercial providers or financially orientated federations) may well opt out of GP training whilst still making use of trained GPs as salaried doctors in their services. In practice GP training is often regarded as supernumerary – i.e. there is a perception that trainees expend rather than provide resource – and therefore there is a clear incentive for private providers to avoid

committing to all the processes and standards required for trainer and training practice status.

Public sector providers also have requirements around commitment to major incident resilience etc – in the interests of a level playing field, and also of public safety, these sorts of requirements should apply to other providers as well.

The reference to GPs in this section – ‘a perception that GPs often direct patients towards the main incumbent provider’ – is very unfair. GPs make decisions based on what is best for their patients, on their knowledge and experience of which services are effective, and on what their patients want; in many areas, patients often want to access their local, most conveniently reachable services. If those services are effective the GP will refer accordingly. It would clearly be wrong for GPs to put the goal of securing a level playing field above the interests of specific patients.

Question 8: Which type(s) of provider do you feel are most disadvantaged by the current NHS playing field and why?

There is a perception that voluntary sector providers may be more disadvantaged than most under current arrangements – but this may well change as new commissioners begin to engage with their responsibilities, so long as these providers can demonstrate that their interventions are effective and evidence-based.

Smaller GP practices, those in rural areas (dependent on dispensing income) or in areas of deprivation are all disadvantaged – less attractive from a business point of view, less likely to attract funding and thus less able to develop their services.

4. We gratefully acknowledge the contributions of members of the RCGP Council and our Centre for Commissioning in formulating this response

Yours sincerely

Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council
5. I write with regard to the Department of Health consultation on Securing Best Value for NHS Patients.

6. 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.

7. The College welcomes the opportunity to respond to this consultation. In the main, we feel this is a very constructive document, reflecting many of the improvements brought into the Health and Social Care Bill during its passage, such as the more nuanced role for Any Qualified Provider, the removal of Monitor’s duty to promote competition, and the freedom of commissioners to decide when and how to use competition to improve services. This last, in our view, is the crux of the present document – that there is no presumption that choice and competition are the best approaches to take in any given situation, and commissioners are able to decide how to proceed, underpinned by a robust and transparent decision-making process, and based on their local knowledge of what is best for their populations and patients. Choice and competition should be a tool available to CCGs for service improvement, not an imposition that overrides all other concerns.

8. We note that both Monitor and the NHS Commissioning Board will be producing guidance on how these regulations will work in practice and how commissioners can work best within them. The College is very keen to collaborate with these bodies and input into this guidance, to ensure it is of maximum usefulness to GP commissioners.

**Procurement**

*Do you agree that we should establish broad principles for good procurement practice in the regulations, rather than setting more prescriptive procedural rules?*

Yes, we agree. As mentioned above, we really welcome the approach taken overall, which emphasises that commissioners will have the flexibility to decide under which circumstances they should apply any qualified provider, tendering or service improvement through contract
management, provided they follow transparent, rigorous processes and can objectively justify their decisions. This is entirely appropriate.

Our only query here would be with some of the wording, such as in paragraph 2.22 where the document says ‘the draft proposals would therefore require commissioners to use choice and competition where appropriate to improve quality and efficiency’ – this sounds too much like re-introducing a presumption in favour of choice and competition mechanisms.

We would like to see the final regulations have less ambiguous language, and re-state clearly the principle that it is for commissioners to decide when it is appropriate to apply one or other of the approaches to procurement, based on their local knowledge and the interests of their populations and patients. Provided that CCGs have followed correct processes and can justify their decisions, they should not have to be concerned that Monitor may step in to override their commissioning decisions.

- **Do we need to introduce any additional safeguards to ensure that commissioners comply with good procurement practice?**

No, but we would like to see additional guidance as to how these regulations intersect with the Public Services (Social Value) Act, which will require all public sector procurement and contract decisions to consider economic, social and environmental benefits beyond the contract specification. There is a very positive opportunity for health commissioners to make better use of the broader social value that third sector providers in particular can bring, and the College would be keen to contribute to the development of guidance in this respect.

We support the proposal (paragraph 2.28) not to prescribe the steps commissioners must take to engage with providers. It is right that commissioners should take steps to engage effectively with current and potential providers to understand what services the market may be able to provide. However, it is not clear that the requirement to advertise will always be necessary to achieve this - for example where it is obvious that there is only one provider able to provide the service required. Under such circumstances, forcing commissioners to advertise would merely impose an additional burden on time and resources, without any additional benefit to patients. Nor in itself would advertising necessarily be a guarantee of transparency around the basis on which commissioning decisions have been taken. What is important is that, where commissioners have made the decision not to advertise an opportunity, they are able transparently to justify their decision as in patients’ interests.

- **Could the proposals have any perceived or potential impact on equality including people sharing protected characteristics under the Equality Act 2010?**

No comment at this stage.
**Patient choice**

The College has indicated its position on the extension of patient choice on many previous occasions, including recently in responses to the DH consultations ‘No Decision About Me, Without Me’\(^2\) and ‘Developing our NHS Care Objectives’\(^3\). Broadly, we view the role of provider choice as one of a range of options for increasing personalisation of care for patients, but the core of patient choice as being in a process of shared decision making, typically between patient and GP. Decisions on provider choice need to be taken with regard to risks, in the extension of choice, of increasing health inequalities, of inhibiting the integration of care, and of harming the care provision of some, particularly rural, communities.

We see an important role for the extension of choice as one piece of the ‘toolkit’ available to commissioners. It is less likely to have this useful capacity if imposed on commissioners without consideration for local circumstances.

• **Do you agree that the regulations should protect patients’ rights to exercise choice as set out in the NHS Constitution?**

We recognise, given the structural changes there will need to be a mechanism to ensure that the existing right to exercise choice contained in the NHS constitution are consistently adhered to across the NHS – we do not have a view on whether these regulations are necessarily the optimum way of achieving this. We would however add that, should there be a move to introduce new rights to exercise choice in new areas as parts of the constitution it is essential that these are subject to a full consultation process before any decisions are taken.

• **Are there any further safeguards that should be established through the regulations or elsewhere to protect the extension of choice?**

It is very much our view that there is not a need to establish additional requirements in the regulations to extend patient choice. As set out in paragraphs 3.12 and 3.13 of the consultation, CCGs and the NHS Commissioning Board already have duties to act with a view to enabling patients to make choices, but how best to exercise this is a decision that should be taken locally by commissioners, based on the insight they have themselves and on discussions with Health and Wellbeing Boards on what is in the best interests of their patients. A requirement in the regulations to further extend choice of provider might well, if

\(^2\) RCGP, Response to ‘No Decision About Me, Without Me’ (August 2012)

\(^3\) RCGP, Response to ‘Developing our NHS Care Objectives’ (September 2012)
overriding local concerns, prove harmful to patient interests, and needs always to be balanced against other duties that commissioners have, such as that to promote integration.

**Anti-competitive conduct**

- Do you agree that we should adopt an effects based approach to assessing restrictive conduct by commissioners, rather than assuming that conduct which restricts competition is automatically against patients’ interests?

Yes, we very much agree that this is the right approach, and appreciate this recognition that the NHS, whilst benefiting from competition in many ways, is very different from other areas in which competition rules apply, and requires a different approach to competition regulation. There are many areas in which conduct that restricts competition to some extent may be appropriate in the NHS, and, given current financial imperatives, it is of vital importance not to impose competition where to introduce it will not overall be to the benefit of patients.

- What can the Department of Health, NHS Commissioning Board and Monitor do to ensure that commissioners understand the requirements so that they can effectively ‘self-assess’ whether or not their conduct falls within the rules?

The drawback of this ‘effect based approach’ is that there is likely to be considerable uncertainty amongst commissioners as to what counts as anti-competitive and whether their conduct will be considered appropriate, which will have an inhibiting effect on innovative service developments and the extension of successful arrangements. In this respect, we query the use of the term ‘indispensable’ (paragraph 4.14 and figure 8) – this seems to us a very extreme test by which to assess any action, and is likely to have an inhibiting effect on commissioners and providers. They may be able to show that their actions have been transparent and reasonable, and likely to be in the best interests of patients, but indispensability will be very difficult to prove.

Further, particularly in the light of the proposed indispensability test, we seek reassurance that the requirements in this section are not principally directed at decisions on whether to tender – which are very adequately covered in section 2 of the consultation document. It would be unfortunate if, having understood and met the requirements of section 2, commissioners were still inhibited in (or indeed found themselves liable to legal action for) their procurement decisions on account of the requirements of section 4. It is our view that these requirements warrant some careful clarification to make this outcome less likely, prior to publication of the regulations.

Finally, we acknowledge that these regulations will be accompanied by guidance to be produced by Monitor and the National Commissioning Board. We believe that this will be critical to ensure that the regulations are not interpreted in unintended ways, which could
have consequences such as placing unnecessary restrictions on commissioning decisions. As a body working closely with GP commissioners, the College will be very keen to seek opportunities to work with Monitor, the Board and the Department of Health to help make this guidance as relevant and helpful as possible.

- **Are there particularly problematic behaviours which we should address specifically, for example in the requirements or in Monitor’s guidance for commissioners?**

  As stated above, the question of whether and how these requirements apply to initial decisions as to which commissioning route to take (i.e. AQP/contract management/tendering), given that these are covered elsewhere in the regulations, needs careful delineation.

**Conflicts of Interest**

- **Do you agree that the Act and proposed requirements impose sufficient safeguards to ensure that commissioners manage conflicts of interest appropriately?**

  GP commissioners will want to act with transparency and full probity. The College, through its Centre for Commissioning, has already published guidance on managing conflicts of interest⁴.

There is a danger that, notwithstanding the content of the regulations, commissioners will be left in considerable uncertainty about how to manage conflicts of interest, particularly with regard to decisions where they may be commissioning new or existing community services from primary care providers. We already know of examples where commissioners have been deterred from renewing existing successful arrangements, despite clear evidence of likely patient benefits. Legal advice, perhaps accustomed to competitive environments outside the NHS, has encouraged a risk averse approach. Unless greater clarity can be achieved, this inhibiting effect will damage the potential for one of the major areas of improved patient care and service transformation arising from the present health reforms.

We would greatly welcome a clear affirmation from ministers and the National Commissioning Board that commissioners, while putting in place the necessary processes to ensure transparency and manage conflicts of interest, are encouraged to consider commissioning additional services from primary care providers. For many GPs in particular this and similar reassurances will be critically important to ensure the credibility of the new commissioning systems and their willingness to engage with CCGs.

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Thereafter, further clear guidance on how to manage potential or perceived conflicts of interest, and in due course shared best-practice examples of how situations have been managed and the types of services that have been developed will be invaluable to commissioners.

• **If not, what additional safeguards could we introduce?**

As above, the present danger is that the regulations, as they stand, will have an inhibiting effect on service developments that would be in patients’ interests.

9. We gratefully acknowledge the contributions of members of the RCGP’s Council and Centre for Commissioning in formulating this response.

Yours sincerely

Professor Amanda Howe MA Med MD FRCGP

Honorary Secretary of Council