

# Choice and Competition

## *Delivering Real Choice*

A report from the NHS Future Forum

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# Delivering Real Choice

## Introduction to the report by the Chair



At its inception in July 1948 the first activity the NHS offered the people of England was an injunction to “*First choose your GP*”. So the NHS began with the offer of choice. In the intervening 63 years, technology and science have delivered healthcare that is extraordinarily sophisticated. Life expectancy is around 20 years longer than it was in 1948, and many people live successfully for decades with chronic and long-term conditions that would have quickly been fatal in the early years of the NHS. Our health has improved and our expectations have evolved in ways that would have been inconceivable then.

But, despite advances in offering choice, still far too few people feel they play a role in choosing their health and social care. Not enough people can choose their GP. Not enough people feel involved in choosing their treatment.<sup>1</sup> At the beginning of life, parents do not have enough choice about where their child is born. At the end of life, the NHS fails to offer people what many of them want; the chance to die at home.<sup>2</sup>

Take the example of Dame Cecily Saunders, the founder of the first hospice charity in the sixties. She was an NHS nurse in an NHS hospital. Cecily saw that the pain of cancer could be tamed by drugs but that intolerable distress could only be eased by care that ranks the medical needs of the patient alongside their emotional and spiritual ones. Today hospices and charities that provide support for the dying are key to delivering end of life care. When the majority of people wish to die at home, why do we not commission them more?

In delivering choice, the NHS will need help from across the public, private and third sectors to secure those real choices that citizens expect. It will need that help to utilise scarce resources to deliver cost effective and better quality services.

Choice is much more than the ability to choose a different provider of elective surgery. It is also about the choice of care and treatment, the way care is provided and the ability to control budgets and self-manage conditions.

All political parties supported the NHS Constitution when it was introduced, which enshrined citizen's rights to choice. As the Constitution states:

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<sup>1</sup> For example, in a Mind survey conducted as part of the NHS Listening Exercise, over a third of mental health service users had not been offered choice of treatment by their GP. The Royal College of Midwives response to this Exercise noted some remaining barriers to choice of maternity services.

<sup>2</sup> *Dying for change*, Demos (2010): reports a YouGov survey which says 66% of people polled want to die at home. Yet 58% die in hospital. This costs the NHS £20 billion. On current trends by 2030 only one in ten will die at home.

*"You have the right to make choices about your NHS care and to information to support these choices. The options will develop over time and depend on your individual needs."<sup>3</sup>*

So our proposals focus on delivering real choice, with competition as a means to securing greater choice in a more cost effective way. We identify the areas where greater choice will improve services, promote integration and increase citizens' rights; and where competition will be one of the tools used to drive choice and efficiency.

## The Reasons for Reform

### 1 Better value for money

The NHS Confederation, in their submission to the listening exercise told us:

*"Demand for healthcare is growing year after year and it is not sustainable to continue increasing the proportion of national taxpayer money that is spent on these services.....the real transformation will come if we change the relationship that each of us have with our own healthcare and change the way in which we use NHS resources."*

We have an ageing population, advances in medical science and growing numbers of chronically ill. Demand is rising. Funding will not increase to meet rising costs. If we are to spend less yet provide the same level of service, productivity must rise. So competition may well have a role to play in driving more cost effective provision?

### 2 Integrated care

The King's Fund told us:

*"A new model of care is needed, less orientated to treating people when they become ill and more focused on prevention, accompanied by a progressive shift in resources away from acute hospitals to providing in and closer to people's homes."*

The 30 per cent of our population with long-term conditions account for 70 per cent of NHS spending.<sup>4</sup> Changing our model of care and treatment through more integration is now an urgent priority. Our system is geared towards sending people to hospital, which is expensive and often inappropriate. We have heard how the patient's experience is often hugely fragmented.<sup>5</sup> How can competition aid that process? How can greater collaboration and integration do that?

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<sup>3</sup> The NHS Constitution for England (2009)

<sup>4</sup> *Helping people help themselves: A review of the evidence considering whether it is worthwhile to support self-management* The Health Foundation (May 2011)

<sup>5</sup> For example, the submission from Mind noted that one in ten people with mental health issues had been assessed ten times in the last year. This was also a recurring theme at events held as part of the NHS Listening Exercise.

### 3 Putting people in control of their health

The Health Foundation told us:

*" while patients report high levels of satisfaction with the health system, a majority also say that they are not as involved in decisions about their health as they would like to be...we must transform what remains a very paternalistic health service and remove the enforced dependency that the current system and culture creates."*

Choice is too limited and citizens are too little involved in their own care and treatment. The health service has so far often failed to deliver on the promise, "no decision about me without me". Yet we know that self-management improves health outcomes and can be more cost effective.

### Managed Competition

Many groups we have listened to in the last eight weeks have expressed a mixture of confusion and concern about competition proposals in the Health and Social Care Bill. There were concerns about the disruption of integrated care initiatives and cooperation, cherry-picking and profiteering.

We have also heard how competition can drive more choice and raise quality. And how more charities and social enterprises are keen to extend their work in health.

Just as no one is suggesting that you can choose which fire brigade to come to your fire, no one is suggesting that you should choose which accident and emergency department to go to when you have a serious accident. The NHS offers a wide spectrum of health and care. For highly specialised services the role of competition is strictly limited. Accident and emergency is a good example of this, specialist services for sick children with multiple needs is another.

Managed competition is a tool of commissioning, employed where it serves the interests of citizens and the choices they wish to make. Different providers will compete for the patient's choice. But competition must take place in a framework that ensures integration and safeguards choice, quality and patient safety.

A recent study by McKinsey<sup>6</sup> on the extent to which competition improves healthcare argues that evidence shows:

*"for highly specialised services competition should be limited or used only judiciously to ensure quality and avoid overdelivery. In contrast, greater competition could be an effective mechanism for improving the quality and efficiency of less specialised services, particularly care delivered outside the hospital."*

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<sup>6</sup> *When and how provider competition can improve health care delivery* McKinsey Quarterly (2010) Dash and Meredith

The role of the private sector has attracted concern. To give this context, the Clinical Forum of the NHS Confederation Partners Network (representing some 45,000 clinicians carrying out NHS work from the independent sector) told us:

*" Although critics have expressed fears that the independent sector could dominate the NHS, it is important to remember that the sector carries out only a very small share of NHS work, amounting to not more than about 5 per cent of acute, primary and community care. We do not expect this figure to increase dramatically or quickly as a result of the government's proposals. This in itself completely belies all suggestions that the reforms amount to 'privatisation' of the NHS, as indeed does the fact that there is no proposed transfer of assets."*

They also pointed out that an opinion survey carried out in 2009 showed that 74 per cent of people agreed they *"don't mind who owns or runs my NHS services as long as the quality of care is right"*. A higher number also agreed that *"the NHS should be free at the point of use for all treatments"*.

There is a well established role that external suppliers already play in the delivery of NHS services which may not be apparent to everyone. GPs, for example, have always been independent contractors yet it does not affect their status as a valued cornerstone of the NHS locally. Similarly, drugs supplied on the NHS account for around 10 per cent of its total spending; and the manufacture, development and research involved in supplying NHS patients with these products could not otherwise be sustained by individual pharmaceutical companies. In short, the fortunes of the NHS, general practice, thousands of small suppliers and an internationally renowned life sciences industry are inextricably bound up one with another.

The response from Mind also pointed out that 20 per cent of mental health service provision now comes from the private and third sectors. Access to psychological therapies has been opened up to 500,000 people due to widening provision to the public and third sectors. But still there is room for improvement and competition will play a role widening that choice.

## **Promoting integration**

A large number of organisations responding to this exercise have stressed the importance of integrated care packages for long-term conditions, at end of life, mental health and complex needs. They have argued for a more collaborative approach between hospital and doctor, between our public, private and third sectors and between health and social care. We have seen evidence from the King's Fund of innovative approaches to integration that work. We have also heard many people saying that competition and integration are opposing forces. We believe this is a false dichotomy. Integrated care is vital, and competition can and should be used by commissioners as a powerful tool to drive this for patients.

Our group has been struck by one key fact about the health service budget – 70 per cent is spent on long-term illness. So this must be a key focus for reform. Attention must shift from a service dominated by care in hospital to care that is community based and integrated around the needs of the citizen.

The many organisations that represent people with long-term conditions have been passionate in arguing for major change for the 18 million of our citizens with such conditions. A policy pamphlet sent to us as part of this process by ten major charities is full of examples of coherent pathways created around third sector organisations, often working in partnerships with independent or NHS bodies.<sup>7</sup> At the moment, these are a small minority of provision because they are simply not commissioned in the mainstream.

Integration is also crucial to securing more cost effective use of increasingly scarce health resources. The Health Foundation provided compelling evidence that effective self-managed care can reduce pressure on services and be more cost effective.<sup>8</sup> We have seen evidence, for example from LSE and Bristol studies, that competition can improve quality and increase choice.<sup>9</sup> The Nuffield Trust told us:

*"The evidence suggests that the strengthening of choice and competition for clinical care (with fixed prices) in the NHS over the last few years has improved quality. On this basis it is an appropriate step to encourage more competition in the NHS (alongside other tools that help promote quality, efficiency and equity)."*

It is clear the health service now needs to drive integration in a way that has simply never happened to date. In practice, current contracting processes, funding streams and financial pressures can actually discourage integration. There needs to be a culture in the service that both encourages innovation and supports collaboration. We also believe competition will play an important role driving change.

There has been real concern that competition could undermine the integration of care or collaboration. But there are still too few examples where NHS organisations have worked with each other to provide that integrated care. If commissioners want to commission integrated care they will only succeed in doing this by creating a new market in integrated care services and stopping the current commissioning of episodic services from different NHS organisations. This will involve existing NHS organisations taking a leadership role in developing integration. But it needs also to involve other providers.

Commissioners should also ensure that competition is generally based on the whole pathway of care. That is why we recommend a framework for choice and competition that will ensure commissioners have duty to promote integration, and ensure competition drives this, not disrupts it.

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<sup>7</sup> *How to deliver high-quality, patient-centred, cost-effective care: consensus solutions from the voluntary sector* collective report from ten charities, published by the King's Fund (2010)

<sup>8</sup> *Helping people help themselves: A review of the evidence considering whether it is worthwhile to support self-management* The Health Foundation (May 2011)

<sup>9</sup> *Does hospital competition save lives? Evidence from the English NHS patient choice reform* Cooper et al (2010); *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service* Gaynor et al (2010)

## Our Proposals

We are recommending significant changes to current health policy, including specific changes to the Health and Social Care Bill. The drive for change in the NHS should be based not on Monitor's duty to promote competition, but on citizens' power to challenge the health service when they do not feel that service offers real choice or good quality.

We recommend that an effective framework for promoting choice and managing competition, as well as ensuring cost efficiency, is established. This new framework must ensure that choice, quality and integration are central to the NHS. It will provide greater clarity on the type of choice that should be offered and the model for applying competition. It will hold the key players to account.

We are also proposing specific safeguards are introduced around the promotion of competition and a stronger role for citizens. This aims to prompt a real change in culture and greater transparency of approach.

### ***Making choice, quality and integration central to NHS***

Drawing from the NHS Constitution's 'right to choice', we recommend that the Secretary of State gives the NHS Commissioning Board a '**Choice Mandate**'. This would set the parameters for choice and competition in all parts of the service, for example promoting more integration and a focus on outcomes. It would also ensure that people are not excluded because they have complex conditions and that health inequalities are tackled.

Based on these principles, the NHS Commissioning Board would publish its plans to deliver choice and outline how competition should be used. It would then report on progress against these plans in terms of health outcomes and effective use of resources. (Further detail in box at p.14.)

Commissioning consortia and providers would then work within this framework to ensure choice and more integrated care become a reality.

Monitor would regulate to ensure the framework protects citizens' interests.

We are also proposing a new mechanism a **Citizens Panel**, part of Healthwatch England, which would hold the system to account by publishing an annual assessment for Parliament on how well organisations have done in delivering the choice mandate.



## *Safeguarding the use of competition*

Our framework would govern the role competition plays. Competition in itself should never be the driving factor. The best safeguard against misuse of competition will be effective commissioning and strong regulation. Consortia must be effective, guard against conflicts of interest and properly engage communities.

We suggest that other safeguards should include the removal of the provision in the Bill for Monitor to 'promote competition' and to clarify Monitor is a sector regulator for health not an 'economic regulator'. Monitor's primary duty should be to protect and promote the interests of patients and citizens. And Monitor will need to ensure that the NHS is able to develop integrated care. There needs to be an effective regulator that tackles abuses that are not in the interest of patients or the taxpayer. We therefore do not advocate that Part III of the Bill be removed, though we do propose significant amendments to the Bill.

It is also important to promote a diversity of providers. We have heard concerns about the concept of 'Any Qualified Provider' but many of these organisations are charities and social enterprises as well as independent providers and are currently providing excellent services that people choose to use. There is a wealth of talent and untapped resource in our country's third sector which can benefit the NHS, so there is a good argument for greater commissioning from alternative providers of care where appropriate. On this basis there is no strong case for changing the policy.

## *Giving citizens more control*

We recommend the Health Bill is amended to give citizens and community organisations additional rights to challenge poor delivery and lack of choice through a '**Right to Challenge**' (currently in the Government's Localism Bill). This new addition to the Health Bill, together with the Citizens Panel, will reinforce the new framework we propose and give more power to citizens to enforce their choice. This will undoubtedly require further detailed work on how this could operate in practice to make sure this approach is the right direction.

**Personal budgets** are very powerful tools in driving choice and greater control and could be particularly effective where people are receiving both health and social care services. We recommend that within five years all those patients who would benefit from a personal health budget should be offered one.

We believe there is also great potential to give NHS staff more control by expanding the use of the '**Right to Provide**'. Giving NHS staff the power to form social enterprises or mutuals will increase the diversity of suppliers but also drive more innovation. We have been told that changes are needed to remove barriers that prevent expansion and the chance for NHS staff to exercise this right. The NHS Commissioning Board should review this.

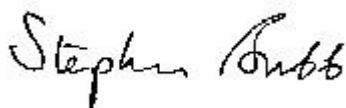
## The Strength of our NHS

This listening exercise has been imperfect and conducted within a very short timescale. There have been criticisms that the professions dominated discussions and the voice of the public was more limited. I have however been convinced of its value and that it could make a very real contribution to delivering effective change to the Bill to enhance the health service. The process has demonstrated the level of warmth and affection for our NHS, its professionalism and commitment to better health for all.

I have spoken to as many people as I could to hear their views on the role of choice and competition and am grateful to those who gave up their time to speak to me. In this, I have been greatly aided by the eleven members of the NHS Future Forum who volunteered to help think about choice and competition. These are eminent people from the NHS, third sector and local government who have been talking to people and thinking about these reforms for months. I have been able to draw on their wealth of knowledge and experience in developing these proposals. Our group has also built on the feedback from events organised by others and comments on the Department of Health website. The fact that the choice and competition issue received the most comments on the website demonstrates the importance of this issue.

There is of course no such thing as a perfect healthcare system; healthcare is too complicated for that. But we believe it is the desire of all who are passionate about the NHS to strive for change which maintains the excellent and improves the imperfect. New approaches to care are needed. These are not necessarily restricted to the NHS itself, but can be partnerships that benefit NHS patients across the private, public and third sectors. This report builds on that desire to further develop a service that responds to, and is informed better by, the citizens who own it whilst retaining its core values.

Finally, I have concluded that it is an error to suppose effective and properly regulated competition threatens the fundamental principle of an NHS that is universal and free at point of delivery. The reverse may well be true; that it helps protect the NHS into the future. We need to move the debate from whether or not competition works to how best to maximise the benefits whilst minimising the risks.



**Sir Stephen Bubb,  
Chair, Choice and Competition  
Chief Executive, Association of Chief Executives  
of Voluntary Organisations (ACEVO)**

## SUMMARY OF RECOMMENDATIONS:

### *Making choice, quality and integration central to NHS*

In order to clarify how choice and competition will work in the NHS and what role the NHS Commissioning Board, Monitor and consortia play we recommend:

1. A **new framework for choice and competition** to ensure that choice, quality and integration are central to the NHS and establish one set of principles to underpin decisions about delivering real choice and using competition. This would be supplemented by legal duties on the NHS Commissioning Board and Monitor to publish plans on how they are delivering choice (see further detail in box on p.14).

### *Safeguarding the use of competition*

Competition has a role in the health service to improve quality and to promote cost effectiveness. To ensure that competition can be tailored to the circumstances of the wide spectrum of services in the NHS, we recommend:

2. Greater clarity on Monitor's role on regulating competition, including the necessary changes to the Health and Social Care Bill to:
  - **remove Monitor's primary duty** 'to promote competition' and be clear that their primary duty should be to protect and promote the interests of the patient;
  - **clarify that Monitor's role should support choice, competition and integrated care** within the model of choice and competition set out by the NHS Commissioning Board
  - remove the references to Monitor as an 'Economic Regulator';
  - maintain the provisions to give Monitor concurrent powers with the Office of Fair Trading. Under current rules, any challenge under competition law would be for OFT to deal with. However, we think that this job would be best done by a dedicated regulator with a greater knowledge of the unique nature of healthcare, including the importance of cooperation through clinical networks and the benefits of integrating services to improve quality.
3. Stronger **safeguards to prevent providers from 'cherry-picking'** where it undermines patient quality or distorts the market.

### ***Allowing citizens more control***

Citizens must have more control over their healthcare, and the current proposals need to be strengthened to achieve this.

We recommend that:

4. Healthwatch England should be given a stronger, more explicit, role in championing the voice of the citizen, not just patients. This should include a **Citizens Panel** to hold the system to account by publishing an assessment to Parliament of how well the system has done on the choice mandate.
5. The **Right to Challenge**, proposed in the Government's Localism Bill, is extended to the NHS to allow citizens and patients to hold their health service to account on choice and quality. Further work should be undertaken to ensure this will deliver real change and then this should be placed in legislation.
6. Within five years all those patients who would benefit from a **personal health budget** should be offered one.
7. The NHS Commissioning Board should promote the current provisions for staff being able to set up social enterprises or mutuals through the '**Right to Provide**' and review how to remove barriers to NHS staff taking up this right.

## Section One

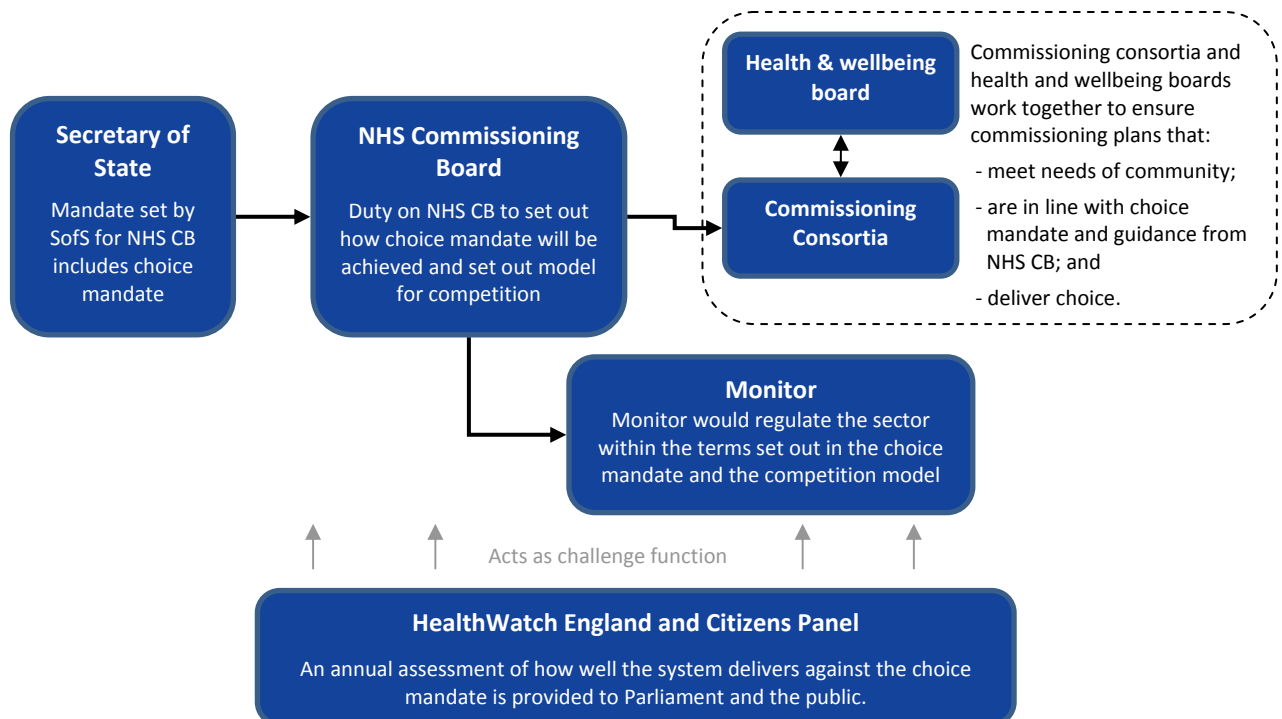
# The Framework for Choice and Competition

We recommend:

A **new framework for choice and competition** to ensure that choice, quality and integration are central to the NHS and establish one set of principles to underpin decisions about delivering real choice and using competition. This would be supplemented by legal duties on the NHS Commissioning Board and Monitor to publish plans on how they are delivering choice.

**Figure 1: The framework for choice and competition: underpinning choice within the system**

This diagram does not attempt to represent the whole system. It focuses on how the framework for choice and competition would apply to different organisations.



Further detail in box on p.14.

## A FRAMEWORK FOR CHOICE AND COMPETITION

The framework will ensure that choice, quality and integration are central to the NHS and establish one set of principles that underpin decisions around improving choice and using competition.

This set of principles would be set out in a **choice mandate**. We suggest these principles include:

- a) Delivering choice
- b) Encouraging collaboration and integration
- c) Market making
- d) Improving outcomes
- e) Personalising care
- f) Reducing health inequalities
- g) Enabling informed citizens.

The framework would ensure that all key players in the NHS are held to account against these principles. We would expect that:

- Drawing from the NHS Constitution's 'right to choice', the Secretary of State would include a choice mandate in his overall Mandate to the NHS Commissioning Board as set out above.
- The NHS Commissioning Board use the principles to set the policy on how to ensure choice is delivered and outline the model of competition to support the delivery of improved choice, quality and integration. The Board should also consider any additional support needed to help consortia achieve the desired aim, for example in encouraging a cultural shift in how procurement is undertaken in the NHS.
- Monitor would use the choice mandate and model of competition set out by the NHS Commissioning Board to regulate and develop the rules around competition.
- We suggest a legal duty on both the Board and Monitor to publish and consult on how they will deliver against the choice mandate and report on progress.
- Consortia would apply the policy on choice and the competition model to their local commissioning decisions to ensure they are delivering real choice. In doing so, commissioners should have regard to the whole of a pathway and their duties to the population as a whole when commissioning.

## The Choice Mandate

Our starting point rests in the ‘right to choice’ in the NHS Constitution:

- **“You have the right** to choose your GP practice, and to be accepted but that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons
- **You have the right** to express a preference for using a particular doctor within your GP practice and for the practice to comply
- **You have the right** to make choices about your NHS care and information to support those choices.”<sup>10</sup>

Building on these rights, this report recommends that the Secretary of State gives a **‘choice mandate’** as the core of the overall Mandate for the NHS Commissioning Board.<sup>11</sup> This will set out the principles that must underpin decisions about delivering real choice and using competition.

We propose seven equal principles with no one taking primacy. Commissioners will also need to take into account the overall financial context in how they apply these principles:

- a) **Delivering choice**
- b) **Encouraging collaboration and integration**
- c) **Market making**
- d) **Improving outcomes**
- e) **Personalising care**
- f) **Reducing health inequalities**
- g) **Enabling informed citizens.**

### *Delivering choice*

‘No decision about me, without me’ must become a reality so that every patient is involved in their care and treatment. There is evidence that patients want choice and not just those from more affluent backgrounds.<sup>12</sup> As this report argues, more needs to be done to ensure patients have real choice, not just choice of provider. More work is needed to promote a more sophisticated view of choice that reflects genuine involvement in care and is open to all.

The definition that arose from a seminar coordinated by the Health Foundation as part of this listening exercise is helpful. They suggested that choice includes:

- Choices to support healthy living;
- Choice of provider and the way in which care is provided; and
- Choice of treatment including self-management support.

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<sup>10</sup> These three rights are taken from The NHS Constitution for England (2009)

<sup>11</sup> The Health Bill includes provision for the Secretary of State to set a Mandate for the NHS Commissioning Board. This report proposes that choice should be a key part of this overall mandate.

<sup>12</sup> *Patient Choice: How Patients Choose and Providers Respond* King’s Fund (2010)

This does not mean all choices have to be provided in all circumstances, but there needs to be a shift away from the focus on simply a choice of providers. The NHS Commissioning Board and consortia will need to ensure they promote choice in a way that is tailored to the specific circumstances.

### ***Encouraging collaboration and integration***

We have been told there is now a historic opportunity to drive much greater integration of care around patients, particularly those with long-term conditions and complex care needs.

When people discussed integration they referred to several different things. We believe integration should cover:

- integration across primary and secondary care – GPs, community services and hospitals working together;
- integration across health, public health, education, and social care;
- integration across public, independent and third sectors; and
- integrated commissioning.

The NHS Commissioning Board will need to support commissioners to design appropriate packages of care and treatment, and Monitor will need to ensure that they are able to do this. There is a wide spectrum of services in our health service and so competition is of more relevance in some than others. Here we see the scope for exciting new ways to promote integrated services that reflect people's needs, whether these are physical or mental health needs. Already on the ground we have heard of developments in services for those with long-term conditions, often headed by forward looking GPs working with third sector organisations or progressive hospital providers. The King's Fund have recently provided compelling evidence of how integration can work.<sup>13</sup>

Commissioners should also seek more opportunities to pool budgets to simplify buying of services across health and social care; as proposed in the Forum's report on Patient Involvement and Public Accountability. For example, there is a real opportunity to improve care by bringing together all the funding to support someone in their last year of life, for disabled children or those with child protection needs. This principle of ensuring care is joined up across health and social care and education reflects the vision of the Government's Green Paper on children with special educational needs and disability currently out for consultation.<sup>14</sup>

The NHS Commissioning Board needs to ensure commissioners and providers develop a mainstream of integrated care, including working with Monitor on how to ensure tariff payments enable, and do not penalise, integration.

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<sup>13</sup> *Where next for the NHS reforms? The case for integrated care* King's Fund (2010)

<sup>14</sup> *Support and aspiration: A new approach to special educational needs and disability* Department for Education (2011)



The regulators will also have a role in enabling integration by setting out transparent approaches to regulation and looking at specific barriers. For example, Monitor and the Care Quality Commission could consider how to ensure providers share information, when it is in the patients' interest and does not undermine patient confidentiality or their control over personal data.

We propose that the NHS Commissioning Board look at developing a number of pilots for integrated pathways, for example in homelessness or children in or on the edge of care, and evaluate these to provide guidance for consortia on best practice.<sup>15</sup>

### ***Case study – Risk of fragmentation of care for a patient with diabetes<sup>16</sup>***

**Scenario:** Mr X is identified as being at risk of Type 2 diabetes via an NHS Health Check programme at his local pharmacy commissioned by the local authority in their public health role. Mr X is told to visit his GP to test for Type 2 diabetes.

Making this work in the new system would require the local authorities to be collaborating with service providers and other commissioners (consortia and the NHS Commissioning Board) to ensure that services are appropriately specified to help ensure people at risk can be effectively supported to receive a joined up service. This coordination may be provided by the health and wellbeing board function, local joint health and wellbeing strategies and needs assessments.

If the services are not joined up, the GP may not have received referral information and therefore would not know if Mr X has been risk assessed already. The GP could therefore duplicate the assessment already undertaken by the pharmacist, which would delay testing for another visit – wasting Mr X's time and NHS resources.

### ***Market making***

Our healthcare system will continue to develop and the NHS will need to make the most of innovative ideas on how to prevent and treat sickness and promote good health. A diverse range of providers is a good way of stimulating innovation – whether this is from within the NHS, from the third sector or independent organisations. People with new ideas need to be able to offer their services, as long as they meet all necessary quality standards. At the moment, these are a small minority of provision because they are simply not allowed into the mainstream. Too often they have been excluded because there is a preference for existing hospital providers, or because of complex procurement rules and short contracts that discourage smaller organisations.

The NHS Commissioning Board and Monitor should work together to ensure there is a level playing field that enables people with new ideas to enter the market. This should include consideration of the potential for stronger support for social enterprise for example examining the role of the existing Social Enterprise

<sup>15</sup> These are two examples of areas where a more integrated approach is needed, but there are others and the NHS Commissioning Board will need to identify priority areas.

<sup>16</sup> Case study based on information provided to the NHS Future Forum by Diabetes UK

Investment Fund and how that could be expanded and whether an 'NHS Bank' could support access to capital as the Nuffield Trust have proposed. The NHS Commissioning Board should examine these ideas and report on them.

The NHS Commissioning Board should consider the support needed for NHS staff who want to exercise their 'Right to Provide'. This should build on the experience of 'Right to Request' where almost £900 million of services per year, representing 10 per cent of total Primary Care Trust community health spend and involving circa 25,000 staff transferred from the NHS to the social enterprise sector.<sup>17</sup> It has led to a range of exciting new social enterprises and mutuals who are providing great examples of good delivery. They told us that the cultural change they have instituted, and the freedom that staff have felt in more flexible ways of working, have improved quality and expanded choice.

However, there are barriers to further expansion: start up capital, insurance indemnities, access to pensions and leadership development. In promoting the current 'Right to Provide', the NHS Commissioning Board should examine these barriers and report on ways in which they can be overcome, as well as providing guidance to encourage more NHS staff to exercise their choice by taking up this right.

#### ***Case study – WRVS – voluntary services in the NHS<sup>18</sup>***

WRVS is committed to helping older people get more out of life by providing practical services powered by volunteers. It helps older people live well at home, in the community and in hospitals.

Within the NHS, WRVS has a chain of approximately 350 general retail and coffee shop services serving 20 million customers in about 260 hospitals. In total, the hospital retail service is a £56 million social enterprise. The surpluses it produces (around £6m) are gifted back to the NHS to pay for patient services and also contribute to the costs of integrated health and social care services for older people in nearby communities.

WRVS relies on volunteers and its outlets provide respite for patients and their families and friends in times of great stress coupled with a range of tangible services including:

- Signposting to specialist services (stroke and dementia charities) and to general statutory and voluntary services (meals on wheels, re-ablement services, benefits advice), including providing strong links to community services;
- Provision of services – the smaller tea bars etc which could never be profitable on a commercial basis or on ward trolley services bringing daily necessities and items for comfort plus a regular, personalised befriending service from a trained volunteer;
- Transport services, both within hospitals and between home and hospital.

WRVS uses its strong community links to create the platform for a range of services that improve the hospital experience for older people and their relatives, reduce hospital readmissions by linking hospital and home based services, contribute financially to patient and community services and provide practical and accessible information to people to make a stressful time more bearable.

<sup>17</sup> Data from Department of Health [www.dh.gov.uk/en/MediaCentre/Pressreleases/DH\\_121692](http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_121692)

<sup>18</sup> Case study based on information provided to the NHS Future Forum by WRVS

Commissioners will need to develop a market that is appropriate to the service that citizens require and takes into account their local area, for example it may not be possible to have multiple providers in a rural area for some services. In some cases the most appropriate model will be using the 'Any Qualified Provider' approach. In other cases, it will be competition to provide an integrated service i.e. competition for the whole market rather than within the market. Commissioners, working with Monitor, will have a role in ensuring people have access to essential services locally and that this is considered in their commissioning plans.

#### *Case study – Wound Healing Clinic, Eastbourne*

- TVCS Ltd was established in 1999 by Sylvie Hampton, previously Tissue Viability Nurse at Eastbourne DGH, and Fiona Collins, previously Senior Lecturer in Occupational Therapy at University of Brighton. Sylvie has an international reputation for healing wounds and Fiona for preventing pressure damage, particularly in the seated patient.
- In January 2008, TVCS opened a Wound Healing Clinic in Eastbourne – the first nurse led complex wound health clinic in the UK specialising in the prevention and management of wounds. They aim to offer patients the right treatment at the right time and in the right place for their wounds.
- As the clinic meets the quality standards required by required by the local PCTs and can demonstrate that they deliver the results the PCT wants for its patients, the PCT can offer patients the choice of being treated at the clinic as well as local NHS providers.
- The Wound Healing Clinic has **both** a high success rate **and** is cost-effective.
- 82 per cent of patients have their wounds healed over a six-week period - one of the highest in the UK. To put this into context, wounds have had an average duration of 3.3 years when patients arrive at the centre.

### *Improving outcomes*

At its heart, the NHS needs to deliver high quality and better outcomes for citizens and their communities. This is central and focusing on system mechanisms must not be allowed to undermine good quality. But we are clear that choice and competition, when tailored to circumstances, can drive better quality. We welcome the Government's changes to the Bill to prevent price competition under tariff. Decisions about care should never be made solely on the basis of price. Commissioners should look at the current picture in each healthcare area in terms of quality, broader health outcomes and choice. We have heard examples where patient care is undermined by commissioners going for the cheapest services and ignoring the wider social added value. Clearly commissioners have a responsibility to secure good value for the taxpayer but this should not be at the expense of quality.

We propose the NHS Commissioning Board should consider how to ensure commissioning decisions in the NHS reflect social value and wider health outcomes – not just price. It will need to give appropriate guidance, for example on how to measure outcomes and to evaluate added social value. It should also report on how it aims to achieve this focus on outcomes. In addition, the Board should work with

Monitor on the pricing system, including extending tariff to help take price out of the equation and ensuring that pricing supports better integration of care and does not ignore added social value.

The Commissioning Board should review the current commissioning systems and the models of 'for the market' and 'in the market' as part of its competition policy to ensure this delivers quality health outcomes.<sup>19</sup>

### ***Personalising care***

People should be able to access services designed around their needs. There must be more control for those who understand their conditions best and services should reflect the fact that patients often have more than one condition, including physical and mental health needs. The NHS Commissioning Board and consortia will need to ensure they commission services appropriately. Health and wellbeing boards will also have a key role in driving personalisation.

We recommend action to promote personal budgets to improve outcomes for some users, particularly at the interface between health and social care where we have heard examples of people feeling that their services are being dictated by organisations that do not understand all their needs and do not talk to each other. We have also heard suggestions that personal budgets are helpful for people with disabilities who know the most about their impairment but often are not given the support they need in dealing with health conditions. As has been shown in the personalisation process in social care, the greater sense of control afforded by a personal budget can in itself be beneficial. We note there are similar discussions occurring as part of the Government's consultation on the provision of assessment and support for children and young people with special educational needs and/or disabilities. We support the principles of joint assessment and transparency of funding arrangements across health, education and social care.<sup>20</sup>

The current pilots of personal health budgets are welcome but do not go far enough and have not received enough support. We believe it is important for the Government now to set out a clear ambition for the role that personal health budgets will play in the future. This ambition will need to recognise that healthcare is complex and personal budgets are not right for everyone. Some people will not want one – they may prefer to leave the decisions in the hands of their GP. But where it is appropriate, it is important that commissioners and providers are geared up to support people in using their budgets.

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<sup>19</sup> Competition 'in the market' is where providers compete to attract patients directly whereas and services are provided under an Any Qualified Provider model. Competition 'for the market' is where commissioners issue a tender for a service they want, and providers compete to provide that service.

<sup>20</sup> *Support and aspiration: A new approach to special educational needs and disability* Department for Education (2011)

So to drive more progress, this report recommends that within five years all those who are eligible for a personal health budget should be offered one. This mirrors the entitlement in social care and will help ensure that all consortia see this as a core part of their role. Taking into account the evaluation of current pilots, delivery should particularly focus on the overlaps between health and social care and on integrated packages of care for long-term conditions.

### ***Case study - Personal health budgets<sup>21</sup>***

Anita has Huntington's disease and she cannot wash, dress herself or swallow properly. Her husband, Trevor, was her only carer and because Anita needed a lot of care he used to get no sleep. He became physically and mentally exhausted, and lost four stone in weight. When Anita's condition deteriorated and she needed 24/7 care, Anita and Trevor discussed the possibility of a personal health budget with a Community Matron. Anita didn't want anyone else to come in to wash her nor did she want to attend a day centre. She wanted to go swimming, as that made her feel better, and do some of the things she used to do such as shopping, the cinema and having her hair done. They decided that the budget would be best spent on carers to fund 49 hours of support. Anita and Trevor didn't want lots of different carers involved, and personal health budgets meant they were able to employ three carers themselves. The carers take her to the theatre, seaside and swimming.

Trevor's view: "Since the personal health budget, Anita's mood is now so much brighter. Her speech is better when she is involved in activities. Anita feels much better in herself and really enjoys spending time with the carers. Anita's psychiatrist has written a letter noting how much improved Anita has become since she has had carers from her personal health budget."

### ***Reducing health inequalities***

Change in the NHS should not be the expense of vulnerable individuals and all players in the system need to take responsibility for reducing health inequalities and tackling the Inclusion health agenda.

Inclusion Health highlights that health inequalities persist and that vulnerable groups experience a range of health needs, which can be exacerbated by social factors. Furthermore, those with multiple complex needs often make chaotic and disproportionate use of healthcare services and experience a range of barriers and issues relating to their access and quality of primary care. For example, on admission to prison 40 per cent of prisoners deny contact with a GP. On release, 50 per cent of prisoners are not registered with a GP and 42 per cent have no fixed abode. We also know that homeless people are estimated to consume eight times more hospital inpatient services than the general population of similar age and make five times more accident and emergency visits.

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<sup>21</sup> Information from the Personal Health Budgets Learning Network - [www.personalhealthbudgets.dh.gov.uk](http://www.personalhealthbudgets.dh.gov.uk)

We welcome the Government's move to establish the National Inclusion Health Board but we have heard concerns about the potential impact on different groups, for example, the Royal College of Paediatrics and Child Health stated:

*"The 11.78 million children in England comprise over 22 per cent of the population and it is essential that the changes envisaged to the NHS and public health result in improvements to their health and wellbeing rather than worsening outcomes and increasing complexity of provision".*

There will be individuals and groups where choice and competition is more limited. For example, children with multiple complex needs such as child diabetes or cerebral palsy, require multi-disciplinary teams and long-term follow up. The NHS Commissioning Board and consortia will need to ensure these groups receive the services they need.

We also heard concerns about whether consortia would be able to commission services for traditionally excluded groups including those with mental health issues, learning disabilities, drug users and homeless people. And whether there would be sufficient joint working between health, public health and social care. It is often people with the most complex needs that place the greatest demand on the system, but where there is significant potential for improvement. As we heard from Friends, Families and Travellers, an organisation representing Gypsies and Travellers:

*"Many inequalities persist in society. All too often initiatives aimed at creating equality of opportunity and at empowerment assist those people who are already have a voice, but leave certain groups untouched, meaning that people become even more marginalised with poorer life outcomes. Unless we can provide basic health information to these people and other chronically excluded people their health outcomes will not improve, we will simply end up picking up the pieces again, but probably with less funding."*

That is why we believe that it is important that consortia have responsibility for commissioning and funding services that cover their whole population, including those not registered. As the Royal College of GPs said to us, *"There must be no possibility of discrimination against patients based on their current or perceived future healthcare needs"*. Consortia will also need to work closely with public health colleagues who will have a key role in play in securing better health for communities.

#### ***Case study – Collaborative working for the most vulnerable<sup>22</sup>***

Since 2008 the two charities St Mungo's and Marie Curie Cancer Care have been working in partnership to explore ways to improve end of life care for homeless people. People who are homeless often have a range of difficulties to face, and appropriate care at the end of life for them is as important as it is for any other group. This partnership between the charities has focused on better understanding the key signs of deterioration in homeless people with advanced liver failure and supporting staff to recognise these signs. By working together they can strive to ensure that all homeless people who are terminally ill experience the best possible care at the end of their lives: care that respects their wishes and is available in a place of their choosing.

<sup>22</sup> Information provided by Marie Curie Cancer Care

To help ensure that consortia are commissioning the appropriate services, it is vital they genuinely engage their local community and other professional bodies in designing services. The Joint Strategic Needs Assessment will help identify these people and local health and wellbeing boards will be an important way in helping to ensure that these groups receive the health and social care services they need. That is why the work of the Forum on Clinical Advice and Leadership and Patient Involvement and Public Accountability is so important to ensure consortia access the right advice.

### ***Enabling informed citizens***

Information is critical to shared decision-making, collaborative care planning and patient choice. The information revolution will drive better information but we believe there is a clear role for the NHS Commissioning Board and Monitor to ensure accessible and reliable information about services. There should also be a requirement on providers to publish data on outcomes. It is essential that citizens are able to exercise real choice based on reliable, accurate and understandable information on providers.

Indeed, information must be accessible to all, including those with complex needs, and that support is available to understand choice if that is required. Recent research by Dr Foster for the Royal National Institute for Blind People (RNIB) has shown that nearly three quarters (72 per cent) of blind and partially sighted people cannot read the personal health information provided by their GP. A similar proportion does not receive information from their hospital in a format that they can read themselves. This undermines their ability to make informed decisions about their own health and care. There may be scope to consider more innovative ways of providing information. This could build on the potential of NHS Choices for example using digital media to deliver personalised messages via mobile phones. As NHS Direct told us:

*“Providing more convenient multi-channel access to health services will encourage people, especially younger ones, to engage with their health and take preventative action earlier.”*

**We believe that if the above principles are applied sensibly then they will help support a health service that delivers more choice and better quality for citizens.**



## Section Two

# Buying better - the role of the NHS Commissioning Board

As part of the framework for choice and competition we would expect that:

The NHS Commissioning Board use the principles in the choice mandate (included in the overall Mandate from the Secretary of State) to set the policy on how to ensure choice is delivered and set the model of competition to support the delivery of improved choice, quality and integration. The Board should also consider any additional support needed to help consortia achieve the desired aim, for example in encouraging a cultural shift in how procurement is undertaken in the NHS. We suggest a legal duty on the Board to publish and consult on how it will deliver against the choice mandate and report on progress.

In delivering against the principles in the choice mandate, we would suggest a specific role for the NHS Commissioning Board to ensure that:

Within five years all those patients who would benefit from a **personal health budget** should be offered one.

The current provisions for staff being able to set up social enterprises or mutuals through the '**Right to Provide**' are promoted and there is a review of how to remove barriers to NHS staff taking up this right.

### *Cultural change*

As part of this exercise, we heard support for the aim of an NHS that is more independent from political micromanagement and encourages a culture of innovation and flexibility.

The change to a more localised system of commissioning with independent oversight by the new NHS Commissioning Board marks a significant change in the way services are bought in our health service. This could herald a much better relationship between citizens and their NHS.

We believe this significant shift must be marked by a new relationship between the centre and the front line. There has been criticism that the current system is too top down and centralised and this discourages innovation and flexibility. So the culture of commissioning and the process of procurement must change. There needs to be a cultural shift to reflect the new relationships with an intelligent Commissioning



Board setting the outcome standards to be achieved by intelligent consortia that are able to ensure better care across their whole population. And with the Board providing ongoing support and guidance on best practice to consortia where needed. Over the next few years, it will also need to take into account the financial challenge facing the service.

### ***Ensuring care is commissioned at the right level***

Commissioning the best care for certain services or pathways can require commissioners to look across a larger population size. For example, there are diseases such as childhood leukaemia that are not sufficiently rare to be commissioned nationally, but are rare enough that smaller consortia will not see many cases. Other services require scale to be able to commission high quality integrated services. For example, it has been suggested that commissioning for end of life care services requires a population of at least 0.5 million people.<sup>23</sup> The NHS Commissioning Board would need to have a role in ensuring that commissioners have the right skills and are collaborating appropriately so that services are commissioned at the right level.

The Board should also not lose connections to the local level. To achieve this, the NHS Commissioning Board may want to develop mechanisms that allow a presence closer to consortia and do not rely on the system being driven from one national location.

We would also expect the focus of the Board to be drawn to where the NHS spends the vast bulk of its budget: long-term conditions. This will mark a major departure from current practice where hospital spend dominates policy and practice.

### ***Promoting the principles of the choice mandate***

To provide greater transparency and certainty for commissioners, providers and the public, we recommend that the NHS Commissioning Board be required to publish and consult on how it will deliver against the choice mandate and report against how it is delivering. This should include a clear model for how competition can be used as a tool to improve quality for patients. For example, the Board may wish to advise on which services should be the priority for opening up to 'Any Qualified Provider' to improve choice and quality of services for patients. We would also expect the Board to issue any necessary guidance to support delivery against the principles in the choice mandate, for example in promoting personal health budgets or removing barriers to the 'Right to Provide' for NHS staff.

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<sup>23</sup> Based on information from Marie Curie Cancer Care

## ***Better procurement***

We feel there is a particular need for clear guidance on procurement to prompt a radical new approach that is much clearer on how commissioners can buy better in a way that avoids unnecessary bureaucracy and where proper account is taken of added social value and the health and social outcomes of tender decisions.

The NHS Commissioning Board should become a beacon of best practice in procurement and foster a culture of intelligent, flexible and high quality buying; not one dictated by over-zealous adherence to procurement rules and dominated by bureaucracy or worries of legal challenge.

We have heard too many examples of where new entrants, smaller voluntary bodies or progressive NHS providers have been blocked by commissioners who either refused to tender or developed complex processes that effectively excluded many providers. And too often procurement processes have ignored the relevance of added social value in how they make decisions. They look at process and not outcomes. The guidance from the Board should also look at the procurement rules in the NHS and local government to ensure there are not barriers to them working together to commission services. The aim should be simple, proportionate processes that allow fair competition from a range of providers, secures the best service for patients, and minimises costs.

### ***Case study – Manual Therapies Back and Neck Service, NHS North East Essex***

- NHS North East Essex wanted to provide greater choice, easier access and shorter waiting times for patients suffering back and neck pain and at the same time address the unsustainably high demand on local spinal services.
- In 2008, all existing providers were contacted and invited to bid to offer patients these services. Patients can now choose from 20 different providers of chiropractic, osteopathy and physiotherapy based throughout the Colchester and Tendring area. There are four chiropractic, five osteopathy and 11 physiotherapy providers to choose from and they all meet NHS standards and agreed prices.
- Patients are given an appointment within two weeks and receive up to four treatments.
- During 2009/10, 2,810 patients used these services and 97 per cent of patients were seen within two weeks of referral.
- Providers are working to locally agreed common referral and clinical protocols and whilst there is competition, there is also cooperation between individual providers and disciplines to ensure service integration for patients.
- Evaluation after the first 12 months of offering patients a choice of any willing provider has identified improved patient access and choice, meaning early treatment and improved outcomes; and reduced primary care consultations, imaging, medication costs and inappropriate referrals to secondary care. Referrals to spinal surgeons have reduced by more than 25 per cent.
- In 2009, this approach was awarded the NHS Alliance 'Acorn Award' for alternative therapy.

## Section three

# Regulating better - the role of Monitor

To ensure competition can be tailored to the circumstances of the wide spectrum of services in the NHS, we recommend:

Greater clarity on Monitor's role on regulating competition, including the necessary changes to the Bill to:

- **remove Monitor's primary duty** 'to promote competition' and be clear that their primary duty should be to protect and promote interests of the patient;
- **clarify that Monitor should support choice, competition and integrated care** within the model of choice and competition set out by the NHS Commissioning Board;
- remove the references to Monitor as an 'Economic Regulator';
- maintain the provisions to give Monitor concurrent powers with the Office of Fair Trading. Under current rules any challenge under competition law would be for OFT to deal with. However, we think that this job would be best done by a dedicated regulator with a greater knowledge of the unique nature of healthcare, including the importance of cooperation through clinical networks and the benefits of integrating services to improve quality.

Stronger **safeguards to prevent providers from 'cherry-picking'** where this undermines patient quality or distorts markets; and

As part of the framework for choice and competition, Monitor would use the choice mandate and the model of competition set out by the NHS Commissioning Board to regulate, applying this model and developing the rules around competition. We suggest a duty on Monitor to publish and consult on how they will do this and report on progress.

### *Supporting an effective regulator*

The role of Monitor and Part III of the Health and Social Care Bill has attracted much attention in the listening exercise, focusing on what is seen as an over emphasis on promoting competition. We heard from several bodies who argued that Part III of the Health Bill, which covers economic regulation, should be removed entirely. We have considered this, based on the submissions and evidence we received. Our view is that there is a need for an effective regulator and a real benefit to having a clear and transparent framework in legislation so there is much greater clarity on how the system works.

However, we do feel that the Bill as currently drafted goes too far. In particular, there needs to be much clearer direction on what Monitor is and is not able to do and safeguards in place to ensure that competition does not become the driving factor. We are therefore proposing three significant changes to the legislation as outlined above.

It remains crucial there is a vigorous regulator that ensures fair play and tackles bad practice. As we heard from the Foundation Trust Network:

*“Choice and quality are fundamental to the effective provision of healthcare and competition is one of the range of tools that an economic regulator will have to improve both. Competition should be demonstrably in the patients’ and taxpayers’ interest and having an economic regulator to oversee competition (and ensure it is open, transparent and challengeable) will be a vital protection for patients and other stakeholders in the context of a plurality of providers”*

There is also a role for the regulator in addressing failing organisations and ensuring continuity of essential services locally. We heard requests for more information on how this would work, for example the King’s Fund said:

*“more clarity is needed about the failure regime for providers to ensure an appropriate balance between allowing poor quality and inefficient providers to exit the market and acting in the public interest to maintain access to essential services.”*

In its role as regulator, Monitor has to be focused on the consumer, on promoting integrated care and treatment in areas such as long-term conditions, and enabling innovative services and market making that are in the best interests of citizens. We also feel that the language of ‘economic regulator’ is misleading, suggesting an organisation like a utilities regulator – a model that is unhelpful and inaccurate.

Based on the revised duties in the Bill and the principles in the choice mandate and the competition model set by the NHS Commissioning Board, Monitor would be able to develop clear rules and make sensible decisions on whether there has been anti-competitive behaviour locally or not. We propose that Monitor is required to publish and engage on how they plan to do this and report on their progress.

### ***Avoiding ‘cherry-picking’ and improving tariff***

We have heard widespread concern about the risk of cherry-picking in the new system. Some people were using the term in different ways, but the definition we most commonly heard was where providers were able to select patients based on factors such as age, co-morbidities or anticipated treatment complexity resulting in less good quality care for patients or unfair advantages for some providers. There was real concern that providers will cherry-pick the profitable patients, leaving the complex and expensive patients to NHS services. For example, if a provider is selecting only joint replacement operation patients with minimal co-morbidities or is

not providing training, then this would be regarded as possible cherry-picking. If this happens, NHS providers could be unfairly disadvantaged and they could find that some clinical services became unviable. This could affect their ability to deliver wider services such as emergency surgery and trauma centres.

Cherry-picking is not a new issue – it is already possible under the current system. We heard from the King’s Fund that *“there were concerns previously with GP fundholding that this would result in cherry-picking. Evaluations found no evidence of this.”* Concerns were also raised at the introduction of patient choice and the development of Independent Sector Treatment Centres (ISTCs). ISTCs were only contracted to treat low risk patients. When patients unexpectedly became high risk they had to be transferred to NHS facilities, but the ISTCs were not necessarily required to pay for this additional treatment, and we heard concerns about the impact this had on NHS providers.

There is a case for allowing providers to tailor their services to help ensure patients get the best possible treatment, get choice of care and have a good experience. But this should not be allowed to disadvantage other providers or undermine care for patients. The key is to minimise the incentives for cherry-picking. Each provider should be paid a fair rate for their service which reflects costs and providers should not be able to turn away patients just because they are too expensive. High quality commissioning will have a vital role in preventing cherry-picking. For example, contracts should be clear about the level of care that the organisation needs to provide either directly or through collaboration with others. In addition, if commissioners are looking across the whole pathway this will reduce the risk of cherry-picking.

We therefore recommend that Monitor, working with the NHS Commissioning Board, should be tasked with preventing cherry-picking from undermining the quality of NHS services or distorting the market. We would expect that this should include further work to ensure that tariff reflects a fair price for the service they have provided and the case mix of patients treated and a requirement on commissioners to act on cases of possible cherry-picking at a local level.

### ***Scope of competition law***

There have been concerns about the applicability of competition law to the NHS, particularly in relation to the role of the European Union (EU). For example, the Royal College of General Practitioners told us of their concern that *“the Bill potentially opens up the whole of the NHS to EU competition law”*. There have been visions of an economic regulator that imposes EU law indiscriminately, with no acceptance of the needs of healthcare, leading to the dismantling of effective services for patients. This is not a vision we recognise.

We have been reassured that the Health and Social Care Bill does not change the application of competition law in the NHS. But from what we heard, our view is that, should a court ever decide that aspects of EU competition law were applicable to

some NHS services, it is important for these decisions to be made by an organisation that has a real understanding of the unique nature of healthcare and the NHS. If the organisation understands health, it will be able to make decisions that recognise the importance of cooperation, for example through clinical networks, and the benefits of integrating services to improve quality whilst tackling anti-competitive behaviour. The existence of a sector specific regulator could provide a strong defence against other bodies, both in the UK and EU, becoming involved in the event of any challenges. In the response to this exercise from the Nuffield Trust, they said:

*"Applying the principles and correct degree of competition alongside other tools that promote equity, access and efficiency within healthcare will require significant analysis, evaluation and experience. This is more likely to come from a healthcare specific regulator than from general competition authorities such as the Office of Fair Trading."*

We therefore think that the Bill should be clear that Monitor is the sector specific regulator and takes concurrent powers to the Office of Fair Trading as a safeguard against competition being applied disproportionately.

### ***Links with Care Quality Commission***

Given the focus of this report, our discussions have focused on the role of Monitor in the new system. However, the Care Quality Commission remains an important part of the regulatory landscape maintaining quality and ensuring that patients can be confident that services are safe. The recommendations in this report are not intended to undermine this role. Given the recent publicity about the effectiveness of the Care Quality Commission regulatory role we believe sufficient resource must back the role it plays in regulating for quality and preventing abuse in the system.

## Section four

# Serving Communities Better

We recommend:

As part of the framework on choice and competition, consortia would apply the policy on choice and the competition model to their local commissioning decisions to ensure they are delivering real choice. In doing so, commissioners should have regard to the whole of a pathway and their duties to the population as a whole when commissioning.

### *Meeting the needs of the local population*

One of the areas where there seems to be a clearer consensus is to bring commissioning decision-making as close as possible to the patient: the stated objective of commissioning consortia. The health and wellbeing board working with local commissioners including consortia, have a crucial role in serving their local community. Commissioning consortia will need to focus on buying better services, which look across care pathways and deliver real choice. They will also have a responsibility to ensure they provide services for everyone in their area, not just those registered with GPs, in keeping with the principle in the choice mandate on reducing health inequalities. This must include services for the most vulnerable and those with complex needs. Commissioners will also need to work within the recognised limited financial resource and take responsibility for the prioritisation of care within it and for the whole of the treatment pathway.

As outlined in the Forum report on Patient Involvement and Public Accountability it is vital that commissioning plans are based on real engagement with communities, including those with more complex needs. Both consortia and health and wellbeing boards will have core roles in ensuring that this happens. Our proposals on the Citizens Panel also ensure that the health and wellbeing boards play a role in assessing how far choice is being delivered locally.

### *Buying better locally*

There is now a real opportunity for significant culture change with intelligent commissioners supported by the NHS Commissioning Board. Choice will only be delivered through local services and the best safeguard against inappropriate use of competition will be effective commissioning. Consortia will be able to commission local services based on the clear set of principles set out in the choice mandate from the Commissioning Board.

Commissioners will be able to work with a wide range of professionals, public and providers to design pathways and would publish a tender with a specification that has patient and professional endorsement. Providers would be able to come

together as a group to bid for that service. This could be opened up to the full range of NHS providers, independent and third sector, including joint ventures and collaborative consortia. This would ensure that small local community groups will be able to continue offering services, often working in consortia arrangements.

#### ***Case study – Boots UK providing services to the NHS<sup>24</sup>***

Boots UK aim to deliver services that are designed to meet the specific needs of customers and patients in their local communities right across the UK. In an average week, 4.8 million people will visit a Boots pharmacy and they will dispense nearly 3.5 million prescriptions. They supply over-the-counter medicines to 1.7 million customers as well as providing general health and wellbeing support and advice.

Local commissioners are also able to buy additional services if they wish, which can then be provided as part of NHS care. These could include:

- medicines-use reviews involving a consultation with a pharmacist for patients with prescribed medicines, especially those for long-term conditions;
- needle exchange and supervised consumption of treatments for drug misusers;
- emergency hormonal contraceptive supply services and Chlamydia testing;
- advice and support needed to help people stop smoking, including more innovative tools for example in larger stores customers are able to have a 'real lung age' test;
- a pharmacist-led professional weight loss programme designed by experts and based on a tested approach that can increase a person's chance of losing weight;
- offering flu vaccination;
- offering healthy heart checks (from June 2011) to help identify those at risk.

#### ***GPs providing services***

In addition to their commissioning functions, GPs and the services they provide remain a vital part of our health service. The GP can be the most important person for many patients in the NHS. Given this critical role, it is important that patients have a say in which GP practice they are registered with. Care will be needed to ensure that people will still be able to access a GP locally if they want to, and that they can have a home visit when needed. The Government is already undertaking work to increase choice and this should continue.

As services are increasingly designed around the patient and move out of hospitals, GPs may want to provide more services for their community. In most cases, this is to the benefit of the population as care is integrated and coordinated by people they already know. However, we heard significant concerns about potential conflict of interest if GPs are able to commission services from their own practice or from companies in which they have an interest. This is an important issue which must be addressed and we support the specific measures recommended in the Forum's report on Patient Involvement and Public Accountability including the proposed role for health and wellbeing boards.

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<sup>24</sup> Based on information provided to NHS Future Forum



## Section five

# Building Citizen Choice

We recommend:

Healthwatch England should be given a stronger, more explicit, role in championing the voice of the citizen, not just patients. This should include a **Citizens Panel** to hold the system to account by publishing an assessment to Parliament of how well the system has done on the choice mandate.

The **Right to Challenge**, proposed in the Government's Localism Bill, is extended to the NHS to allow citizens and patients to hold their health service to account on choice and quality. Further work should be undertaken to ensure this will deliver real change and then this should be placed in legislation.

The current proposals in the Health and Social Care Bill do not provide strong enough accountability on choice. The changes proposed in the NHS Future Forum report on Patient Involvement and Public Accountability will help provide stronger routes for the citizen to hold the health and social care system to account. Building on these, there are two specific proposals in this report on how citizens can hold the system to account where it is not delivering the choice that they are entitled to in the commissioning arrangements in the NHS or where competition is being used badly.

### ***Assessing how choice is being delivered for citizens***

The healthcare system is complex. People can tell if they and their families have been offered choice, but it is hard to know what is happening in other parts of healthcare. And if you are lucky enough to not need the health system for a while – how do you know choice will be there when you want it?

In support of the recommendations in the report on Patient Involvement and Public Accountability, this report recommends that Healthwatch England is given a stronger role in championing citizens, not just patients. In particular, they should be looking at whether real choice is being delivered by establishing a Citizens Panel to assess how well the NHS Commissioning Board, Monitor and consortia are delivering against the choice mandate. They should pay particular attention to voices of marginalised and excluded communities and those whose voices have not always been heard. Given it would be part of Healthwatch England, the Panel could also look at other areas covered by Healthwatch. This assessment should be published annually to Parliament and the public.

This report would also consider the effects of competition. For example it should highlight if the integration of care is being undermined, or vulnerable groups excluded as a result of inappropriate use of competition. This should offer assurances to the public and to the professions who have raised this concern during our listening process. The assessment would build on the local assessment undertaken by health and wellbeing boards.

Healthwatch England would need to consult on what this Panel would look like. We envisage one where a range of national bodies might make nominations. For example, Consumer Focus, the trades unions, or the citizens advice bureau might be organisations to give an independent view. On both Healthwatch England and the health and wellbeing boards, there needs to be a voice for the 11.78 million children and young people who have no vote and cannot influence the democratic process.

### ***The Right to Challenge***

The Government has stated its commitment to securing more control and influence for citizens and to promoting a bigger and stronger society. In the Coalition Programme for Government they committed that:

*“We will introduce new powers to help communities save local facilities and services threatened with closure, and give communities the right to bid to take over local state-run services.”*

As part of this, Government has included in the Localism Bill currently going through Parliament, a provision to enable citizens to challenge service delivery by councils where they believe that delivery is poor and could be delivered differently. The Community Right to Challenge aims to hand the initiative to communities with good ideas, ensure those ideas get a fair hearing, and give them the time they need to prepare effective bids to run services.

We believe that citizens must also be given a right to challenge in health services by amending the Health and Social Care Bill. Many community organisations and the broader third sector argued at the time of the introduction of the Localism Bill that this right to challenge on service delivery should be extended. After all, citizens will have those rights in respect of social care, so it does not make sense to exclude them when the service is provided in health. As this report argues, we want to see more integration of health and social care. If such integration becomes the norm then it would be wrong if citizens were prevented from exercising their rights by disputes over boundaries of providers.

The Right would enable groups of people to come together to challenge a service that was not delivering good quality. The consortia would need to consider this challenge. This would go beyond the quality standards on providers set by the Care Quality Commission and will act as an incentive on providers to improve the quality of their service.

This will undoubtedly require further detailed work on how this could operate in practice to make sure this approach is the right direction. Under the Localism Bill, a local authority can either accept the expression of interest (with or without modifying it) and run a procurement exercise for the service or reject it. The Right may need to be tailored for healthcare, for example we do not envisage this right extended to accident and emergency services for example, even though it is doubtful citizens would see that as an area of challenge. But many of the same principles should be applied. It should promote transparency – all responses to expressions of interest would need to be published with reasons for any rejections. It should look at the social value of the bids as well as the health outcomes that might be achieved. It should ensure that any procurement exercise allows a wide range of organisations, including the challenger, to participate. And it should look at how to reduce bureaucracy associated with the Right. So there would be a need for guidance, probably from the NHS Commissioning Board.

In the brief time allotted for our deliberations, it is not possible or desirable for us to make more detailed recommendations for legislation. However, we are recommending that the Right to Challenge be enshrined in legislation. This would be a powerful signal to citizens that they have a method of ensuring that their choice in service delivery is respected and a channel to challenge when it is not. Our current system provides no such external challenge to poor service delivery and limited choice.

This, together with the establishment of the Citizens Panel, provides that external challenge which can ultimately help build better health and social care. Giving citizens greater power to challenge lack of choice and poor quality will drive change. This will reinforce the cultural change needed to build a health service closer to citizens, based not on a role for Monitor in promoting competition but on citizens' power to challenge.

## Evidence on choice and competition

As part of this exercise, we received submissions outlining some of the evidence that is available on the impact of choice and competition in healthcare. From what we were sent, it is clear that there is limited evidence on the impact of choice and competition and academic evidence can be cited to support each side of the debate. There are difficulties in applying evidence from other countries because of the unique nature of the NHS. It is also hard to distinguish the impact that choice and competition may have had as opposed to other changes in healthcare.

Many of the documents we were sent used the introduction of choice in the NHS in 2006 as an opportunity to examine the impact of choice, and the competition that it brought in, on quality. Two large-scale studies suggested that quality in hospitals exposed to more competition has risen, length of stay has fallen and without any increase in expenditure at hospital level (Gaynor et al. 2010,<sup>25</sup> Cooper et al. 2010<sup>26</sup>). For example, Cooper et al. concluded:

*"In our analysis, we consistently find that higher competition was associated with a faster decrease in 30-day AMI mortality after the formal introduction of patient choice in 31 January 2006. We find that one standard deviation increase in competition was associated with an approximately 1 per cent additional reduction in AMI mortality in the three-year post policy period that we studied. Our results are robust to a number of specifications. Our results are also robust regardless of how we estimate competition... The title of our paper asked whether or not hospital competition saved lives in the English NHS. Our results suggest that they did."*

These studies did not show evidence of increases in health inequalities (Cookson et al 2010).<sup>27</sup>

A research scan undertaken for the Forum by the Health Foundation found some evidence that competition, in some settings, was associated with improved clinical outcomes, reduced costs and improved efficiency. There was some evidence that competition could have negative impacts or mixed effects on access or equity, though many of these studies were based on international experience which may not apply in the English NHS.

There is some evidence that the effectiveness of competition and choice is dependent on clear regulatory frameworks and good information. For example a report from Civitas in 2010 noted that:

*"Currently, so many barriers exist to the operation of a market that it seems wrong to draw any concrete conclusions on its effectiveness. Barriers, for example, have meant that providers are able to operate as monopolies dictating terms to PCTs, rather than competing for PCT business."<sup>28</sup>*

<sup>25</sup> Gaynor et al (2010) Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service NBER Working Paper No 16164, July 2010.

<sup>26</sup> Cooper et al 2010 Does hospital competition save lives? Evidence from the English NHS patient choice reform Working Paper 16/2010 LSE Health January 2010

<sup>27</sup> Cookson (2010) *Effects of Health Reforms on Health Care Inequalities*, Draft Report to the Department of Health: Health Reform Evaluation Programme. November 2010

<sup>28</sup> Civitas (2010) Refusing Treatment: The NHS and market-based reform October 2010

There is also evidence that price matters. Research based on the NHS in 1990s showed that when hospitals were able to negotiate prices there was a fall in clinical quality in more competitive areas. (Propper et al, 2008)<sup>29</sup> In studies looking at staff views on the introduction of competition there is some evidence that staff see this as costly and disruptive (Health Foundation research scan).<sup>30</sup>

### **Patient views on choice**

From what we saw, there was some evidence that people want choice but it depends on what choices are offered. There were clear indications that people were interested in more involvement in treatment decisions:

- over 95 per cent of people feel that they should have choice over the hospital they attend and the kind of treatment they receive (NATCEN 2009)<sup>31</sup>
- in a survey – 75 per cent of respondents said choice was either ‘very important’ or ‘important’ to them; older respondents, those with no qualifications and those from a mixed and non-white background were more likely to value choice. This was in contrast to GP perceptions that it was younger, more educated patients that wanted choice (King’s Fund, 2010)<sup>32</sup>
- nearly half of hospital inpatients and 30 per cent of outpatients said they were not involved in decisions about their care as much as they wanted to be (CQC, 2009)<sup>33</sup>
- a survey of those with long-term conditions showed that 87 per cent were interested in more actively managing their chronic conditions (DH 2005)<sup>34</sup>
- a 2008 study found that choosing between hospitals or primary care providers was not currently a high priority for the public but patients did, however, want to be more involved in individual decisions about their own treatment and generally participated much less in these decisions than they would wish (Fotaki et al 2008)<sup>35</sup>
- a hospital close to home or work was selected by 38 per cent of patients offered choice as the single most important factor when choosing their hospital (DH 2010)<sup>36</sup>

Even where there were clear indications that people valued choice, the evidence around whether people exercised this choice was mixed. However, this focuses on choice of provider, rather than the broader definition of choice:

- when offered a choice, 35 per cent of patients chose their local hospital and 65 per cent chose an alternative provider (with a shorter waiting time) (Burge et al 2005)<sup>37</sup>
- in the King’s Fund study, most patients chose their local provider (69 per cent of those offered choice) but when patients were presented with a hypothetical situation, in 45 per cent of cases they chose a non-local provider (King’s Fund 2010)
- since the introduction of ‘Free Choice’ over 300,000 NHS procedures have been performed by independent providers under the Extended Choice Network.

<sup>29</sup> Propper et al (2008) Competition and Quality: Evidence from the NHS Internal Market 1991-9 Economic Journal 118(525): 138-70

<sup>30</sup> Health Foundation (2011) *Competition in Healthcare: Research Scan* sent to the NHS Future Forum

<sup>31</sup> NATCEN (2009) *Trends in Attitudes to Healthcare 1983 to 2007* National Centre for Social Research Report based on results from the British Social Attitudes Surveys

<sup>32</sup> King’s Fund (2010) Dixon et al Patient Choice: How Patients Choose and Providers Respond

<sup>33</sup> CQC (2009) National Patient Surveys and CQC in-patient survey 2006-2009

<sup>34</sup> DH (2005) Public attitudes to self care: baseline survey

<sup>35</sup> Fotaki (2008) What benefits will choice bring to patients? Literature review and assessment of implications Journal of Health Service Research

<sup>36</sup> DH (2010) National Patient Choice Survey

<sup>37</sup> Burge et al (2005) London Patient Choice Project Evaluation: A Model of Patients’ Choices of Hospital from Stated and Revealed Preference Choice Data, Rand Europe/King’s Fund/City University



