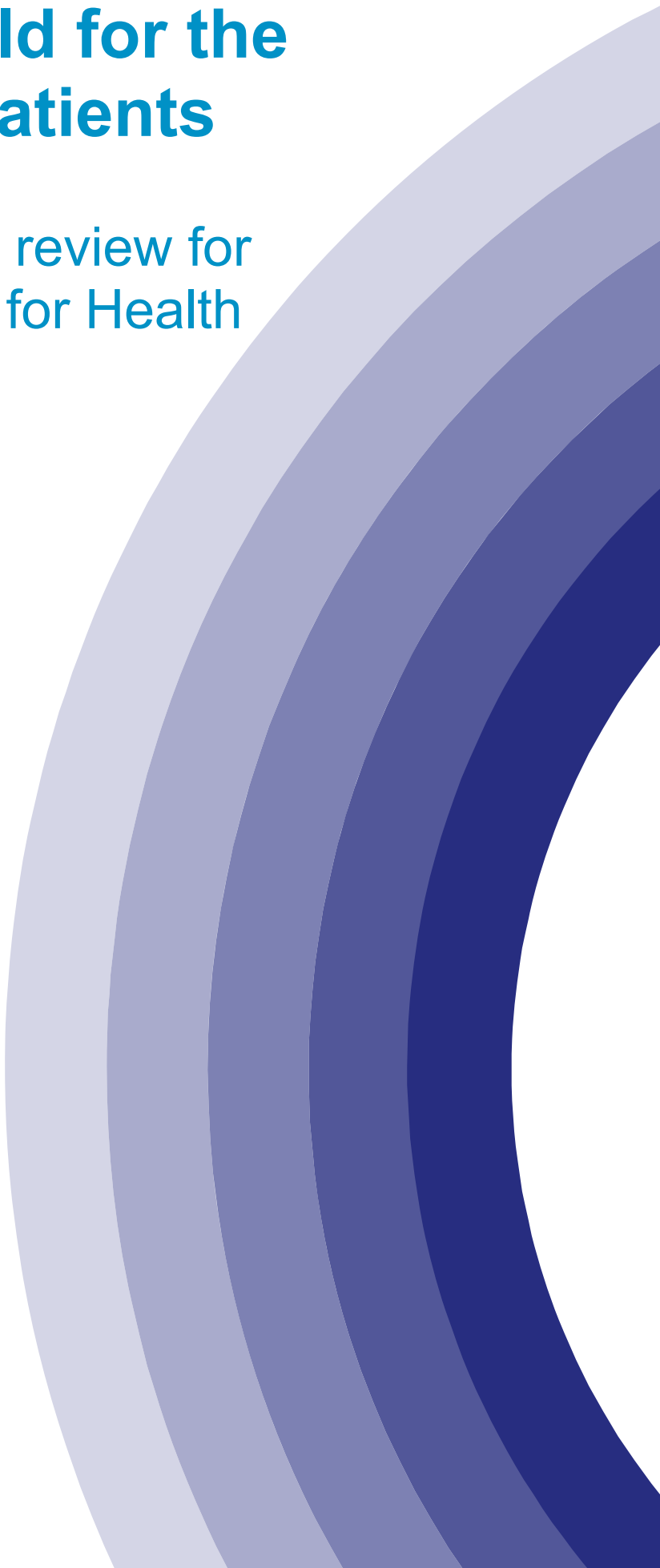
Monitor

A fair playing field for the benefit of NHS patients

Monitor's independent review for the Secretary of State for Health

March 2013



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A fair playing field for the benefit of NHS patients

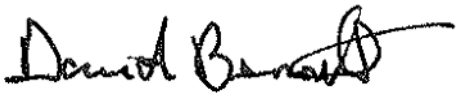
This is the first major report to be published by Monitor in its new role as sector regulator for health. It addresses the extent to which all potential providers of NHS care have a fair opportunity to offer their services to patients.

We have approached the Review from a singular perspective: are there unfair aspects of the health care playing field the removal of which would improve patient care? We have taken no view as to whether any particular type of provider – public, voluntary or private – would be best placed to meet patients' needs in any given circumstance. Our concern has been simply to identify any barriers that might be preventing the provider best able to meet patients' needs from doing so.

This focus on what makes a difference to patients reflects our overall duty to 'protect and promote the interests of people who use health care services'. It will inform everything that Monitor does.

As we have undertaken this first major review we have also sought to exemplify our overall approach to regulation. We have sought to be evidence-based and objective throughout our analyses, and consultative throughout our processes.

A key conclusion of our Review is that it is often how commissioners go about their job that determines the extent to which patients get access to the best possible provider of the care they need. As responsibility for commissioning undergoes major change, I want to make it clear that we see Monitor's role as supporting them to do the best job they can for the people who use the NHS.



David Bennett

Chair and Chief Executive

Executive Summary

On 21 May 2012, the Secretary of State wrote to Monitor asking us to undertake "an independent review of matters that may be affecting the ability of different providers of NHS services to participate fully in improving patient care." His letter also set out the Government's aim that "NHS services are commissioned from the best providers, with competition based on quality." Monitor's Fair Playing Field Review, undertaken in response to the Secretary of State's request and presented in this document, is intended to inform the statutory report on this issue that the Secretary of State must lay before Parliament in March 2013.

We consider the provision of NHS-funded care as a playing field on which the players are the wide variety of health care providers offering or seeking to offer services to NHS patients. If the playing field were fair, there would be nothing to prevent providers with the best services from reaching patients, regardless of the type of provider. We have sought to understand whether there are any systematic distortions in the playing field preventing this from happening.

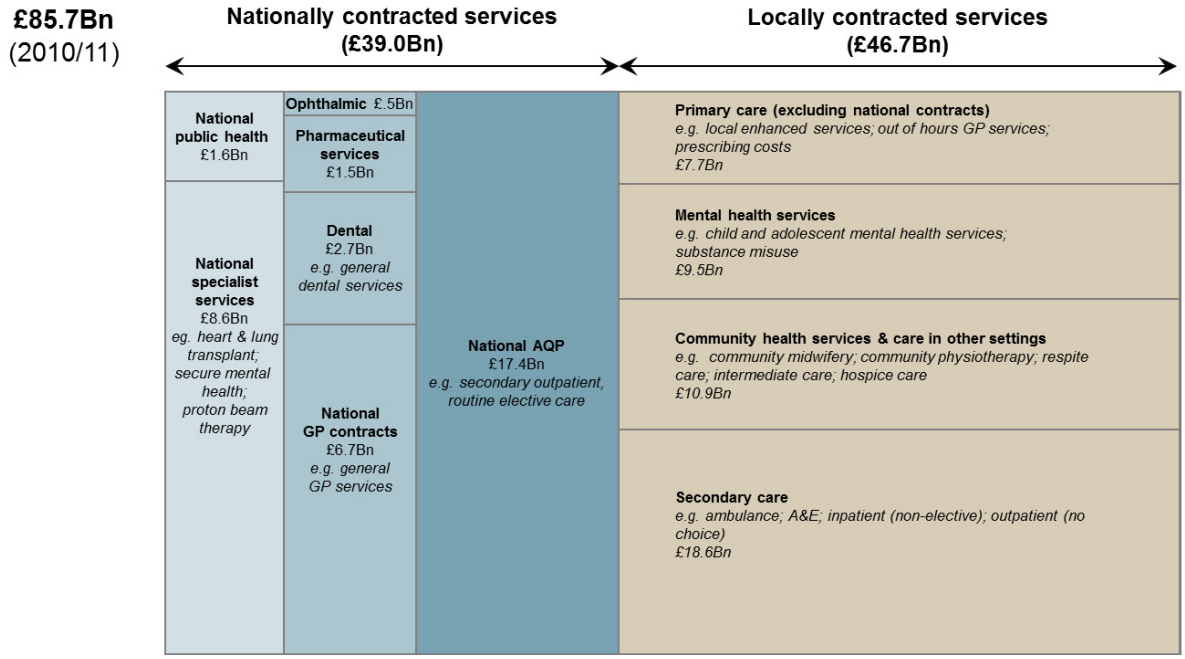
In assessing the importance of any distortions we have focused on the ultimate impact they have on patients. This is consistent with Monitor's primary duty to protect and promote the interests of patients.

Throughout this work we have treated all types of provider equally; there is no assumption that certain types of provider might be better able to meet the needs of patients than other types.

Defining the health care playing field

About £86 billion of the annual NHS budget is assigned to local and national commissioners tasked with commissioning the best quality clinical services possible for the patients they represent. The variety of patients' conditions and the range of services they require, from specialist surgery through to routine care in the community, have produced a number of different segments, both local and national, which together make up the overall NHS playing field (Figure 1).

Figure 1. The NHS playing field



Responsibilities for selecting and reimbursing providers vary by segment. For instance, for many elective procedures, a patient can choose 'Any Qualified Provider' (AQP) from anywhere in the country. The provider will be reimbursed by the patient's local commissioners. On the other hand, specialist services for rare diseases will be both commissioned and reimbursed centrally, by the NHS Commissioning Board from April 2013.

Local and national commissioners responsible for spending in the different segments have for many years been able to purchase care from providers of different types – NHS trusts, NHS foundation trusts, private providers, charities, social enterprises and voluntary providers – and of different sizes, ranging from large hospitals providing acute services in cities through to small charities running hospice services in rural areas. Providers also divide into incumbents and non-incumbents.

Playing field distortions

This review concentrates on distortions to the playing field that have, or potentially have, a significant impact on patients and are beyond the control of providers affected by them. To understand the distortions, we took evidence from providers of every type, size and geographical setting, including those already serving NHS patients and those seeking to serve them. We also listened to commissioners of health care services across the country.

All of the providers experience aspects of the playing field that they believe are unfair distortions. However, in line with Monitor's core duty "to protect and promote the interests of people who use health care services", we weighed the evidence according to its impact on patients.

We found three types of material distortion:

1. **Participation distortions.** Some providers are directly or indirectly excluded from offering their services to NHS patients for reasons other than quality or efficiency. Restrictions on participation disadvantage providers seeking to expand into new services or new areas, regardless of whether the providers are public, charitable or private. Participation distortions disadvantage non-incumbent providers of every type.

2. **Cost distortions.** Some types of provider face externally imposed costs that do not fall on other providers. On balance, cost distortions mostly disadvantage charitable and private health care providers compared to public providers.

3. **Flexibility distortions.** Some providers' ability to adapt their services to the changing needs of patients and commissioners is constrained by factors outside their control. These flexibility distortions mostly disadvantage public sector providers compared to other types.

Participation distortions

Commissioners play a critical role in ensuring patients' care needs are met as well and as efficiently as possible. With limited resources to meet the population's growing health care needs, commissioners need to be increasingly rigorous in identifying the highest quality, most efficient and best coordinated care available.

During the course of the Review, we heard many examples of innovative commissioning. Some commissioners are working with an incumbent provider to improve services. Others are introducing new providers, either instead of or alongside the incumbent, to change the way services are delivered, for instance, by moving care from a hospital setting into the local community. We met providers of all types keen to reach more patients, including groups of independent community midwives, general practitioners delivering primary care, charitable providers running hospices, social enterprises offering mental health services, private providers of specialist care and public providers of general acute services.

However, we also found widespread examples of commissioners failing to consider alternative providers where that might have been appropriate. Similarly, we found examples of commissioners running unnecessarily complex procurement processes. In such cases, commissioners give incumbents an advantage over alternative providers, whether public, private or charitable, and patients may finish up with a poorer service than they could have received.

We recognise that commissioners operate under considerable pressures beyond their control. Commissioning bodies have been restructured five times in 16 years. By 2014 administrative spending on local commissioning will have been reduced by 45 per cent, relative to spending in 2010. Both the amount commissioners can

spend on health care each year and the prices in the NHS tariff are unpredictable. Commissioners frequently lack good information on quality and are understandably wary of the impact of change on the continuity, coordination and quality of care.

Our recommendations on participation distortions aim to complement current changes and support commissioners so that they can deliver benefits to patients without disrupting patient care. Specifically, the recommendations are intended to develop:

- a more stable and supportive commissioning environment, to help commissioners think and act strategically;
- better evidence, case studies and tools for commissioners, to help them identify the best solutions for patients; and
- better aligned incentives for commissioners, with a greater voice for patients.

Cost distortions

We learned of many circumstances in which some types of provider face externally imposed costs that do not fall on others, although stakeholders raised this problem less frequently than participation issues. We found two cost issues that affect patients and which are not currently being addressed: differences in access to rebates for Value Added Tax (VAT) and the variation in cost of capital faced by different types of provider. On these issues we recommend changes to remove the distortions, subject to some further work.

Several of the other cost distortions raised by providers are already being tackled, and we suggest complementary measures in some cases. The remaining cost issues that providers raised turned out, on examination, not to affect patient services, and we recommend making no changes in these areas.

Cost distortions not being addressed

VAT. Current VAT rules represent a material playing field distortion. Under the **'**Contracted Out Services' scheme, public sector providers claim VAT rebates worth a substantial amount in total on contracted out services, such as legal or laundry services. However, it appears that they may no longer be eligible for all of this rebate because of changes in the health care sector. Private and charitable providers cannot claim VAT rebates on any of their contracted out services and this sometimes affects their decisions about supplying services. We recommend the Government reviews whether certain public providers remain eligible for VAT refunds and considers extending rebates to services provided by the charitable sector, where they would be eligible. We recommend that the Government re-invests any resulting net saving in the NHS.

Cost of capital. Many providers raised the differential cost of capital faced by different providers. Private and charitable providers borrow (and in the case of private providers, raise equity) at rates that reflect the lender's risk of not recovering

the capital. Public providers, however, do not. We recommend that risk is priced into the cost of capital for all providers.

Cost distortions already being addressed

Pensions. Private and some charitable providers serving the NHS cannot generally offer continued access to the NHS Pension Scheme to staff transferring to them from a public provider. Instead, these providers must offer a broadly comparable private pension, which costs them more than the NHS Scheme costs public employers. These additional pension costs deter some providers from bidding for contracts.

The Government has made a commitment to allow NHS staff who are members of the NHS Pension Scheme to retain their membership if they are transferred to a non-public health care employer. However, to remove this distortion fully, all staff working in NHS-funded health care services should have access to the NHS pension scheme, not just those currently working for the public sector. We recognise this presents practical challenges. However, we recommend that the Government works to overcome them.

Clinical negligence indemnity. The Clinical Negligence Scheme for Trusts (CNST), overseen by the NHS Litigation Authority, is open only to public sector providers. Contributions for CNST indemnity do not fully reflect the risks of individual providers, which creates a distortion among providers in the Scheme that have different levels of risk but pay the same rate for their indemnities. There may also be distortions between public providers in the Scheme and other providers who cannot gain access to it. Some NHS foundation trusts also complain that, while they can in theory buy private insurance should this appear lower cost for them, in practice they find it hard to leave the CNST. This creates a further potential distortion of the playing field. The Government has already laid regulations to open the CNST to charitable and private providers. We recommend that the Department of Health and the NHS Litigation Authority also improve the pricing of risk within the CNST and minimise barriers to joining and leaving the Scheme for all types of provider.

Education and training. Responses to our initial request for evidence suggested that the requirement to provide education and training for clinical staff disadvantaged public providers because independent sector providers are able to recruit trained staff without incurring the costs of training them. However, since the aggregate funding of provision of education and training appears to match the aggregate costs, this is not a distortion between types of provider. Nevertheless, the current system for funding undergraduate and postgraduate education and training does create a distortion amongst providers within the public sector. This system pays more per trainee to some large, established public sector hospitals than to other public sector hospitals. Health Education England is responsible for reforming clinical training arrangements to ensure funding reflects the underlying costs, which should remove this distortion.

Case mix. Public sector providers argue that other types of provider benefit from treating patients with less complex needs for the same prices that public sector providers receive for treating patients with more complex needs. Forthcoming changes to NHS pricing aim to ensure that, in future, providers' receipts will reflect the true costs of provision more accurately, including reflecting case mix better. This should remove this 'cherry picking' distortion, although new pricing arrangements will take some time to implement.

Cost issues that do not affect services to patients

Corporate taxes. Charitable and private providers are liable for three corporate taxes – corporation tax, capital gains tax and stamp duty – from which public providers are exempt. However, this situation does not result in important distortions; the low incidence of corporate taxes means we do not have evidence of any impact on patients arising from differential liabilities.

Flexibility distortions

Public sector providers face a number of restrictions on their flexibility that other types of provider do not face. These include: mandatory service obligations; the power of the Secretary of State to direct NHS trusts; rigidities in the public sector workforce; and the higher likelihood of intervention by the Government. These restrictions are exacerbated for public sector providers by the uncertainty they face as to how the Government or national bodies with oversight of public sector providers will exercise their authority. This is different to the more general political uncertainty that all types of provider face.

Most of our recommendations to promote flexibility are directed towards Government, the NHS Commissioning Board and regulators. We recommend that they: clarify their roles and the limits of their discretion; promote autonomy and accountability among providers, including by completing the move to an all-foundation trust sector for high quality public providers; and encourage public providers to take advantage of flexibilities they already have.

Chapter 1: Introduction

This chapter describes the origins and purpose of this review, explains our approach to carrying it out for the benefit of patients, and our methodology.

1.1 Origins and purpose

The Health and Social Care Act 2012 requires the Secretary of State for Health to present a report to Parliament assessing:

"the treatment of NHS health care providers as respects any matter, including taxation, which might affect their ability to provide health care services for the purposes of the NHS."

This requirement was introduced as an amendment to the legislation supported by Lord Patel of Bradford and other peers. They introduced the amendment because of concerns that health care charities do not compete against other health care providers on a 'fair playing field'.

The Secretary of State asked Monitor to carry out an independent review of these matters to fulfil his duty under the Act. In his request, he stated that:

- the Government's aim is to ensure that NHS services are commissioned from the best providers with competition based on quality;
- the purpose of the Review is to identify matters that might undermine this aim;
- the Review should be broad in scope and based on an inclusive process of engagement with stakeholders, including health care providers of different types and sizes; and
- Monitor should produce recommendations on where potential issues need to be explored further and, where possible, how any matters that harm patients' interests could be addressed.

The scope of the Review is all NHS-funded care in England.

1.2 Our approach

We consider the provision of NHS-funded care as a playing field on which the players are the wide variety of health care providers offering or seeking to offer services to NHS patients. If the playing field were fair, there would be nothing to prevent providers with the best services from accessing patients, regardless of the type of provider. We have sought to understand whether there are any systematic distortions in the playing field preventing this from happening.

In assessing the importance of any distortions we have focused on the ultimate impact they have on patients. This is consistent with Monitor's primary duty to protect and promote the interests of patients.

Throughout this work we have treated all types of provider equally; there is no assumption that certain types of provider might be better able to meet the needs of patients than other types[1].

The rest of this section describes what we mean in the Review by the concepts 'playing field', 'distortions' and 'types of provider'.

1.2.1 The playing field: NHS-funded care in England

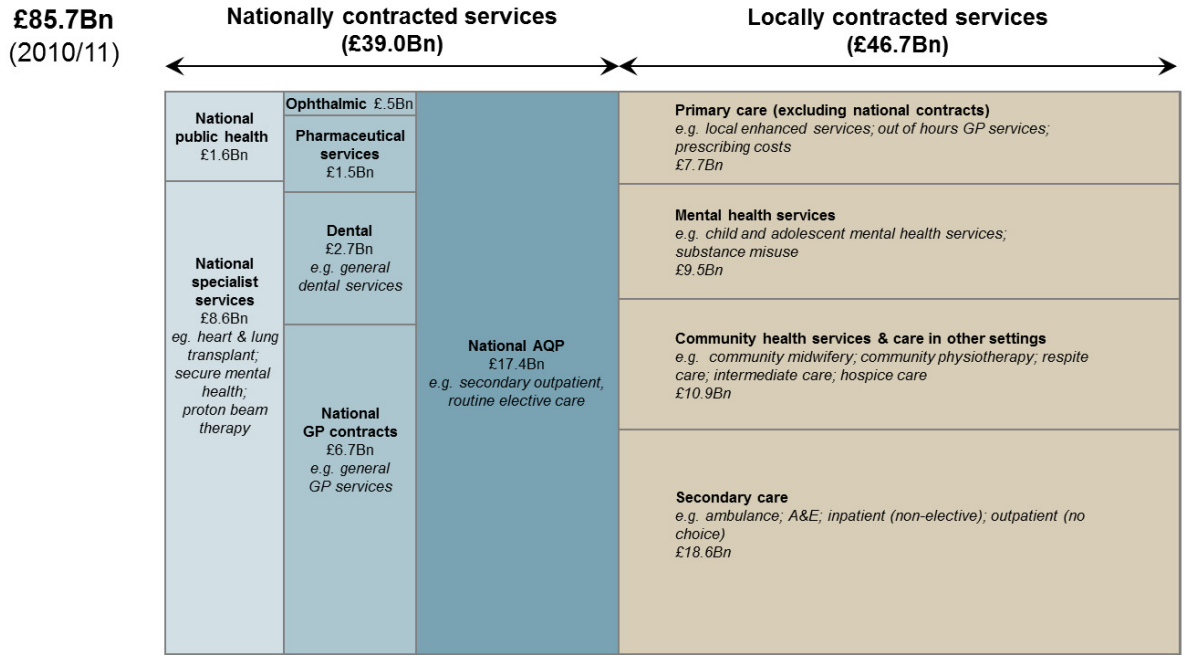
The NHS in England currently spends about £86 billion a year on providing primary, secondary and specialist clinical care. The way in which health care services are commissioned varies, from complex specialist surgery purchased at a national level to routine community care contracted by local commissioners. Figure 1 shows the range and value of nationally and locally contracted NHS services.

Commissioners have for many years been able to purchase care from providers of several different types, including NHS trusts and foundation trusts, private providers, social enterprises and voluntary and community sector providers (VCS). Providers range in scale from large hospitals providing acute services to small charities providing care to patients in community settings.

Responsibilities for selecting and reimbursing providers vary by segment. For instance, for many elective procedures a patient can choose 'Any Qualified Provider' (AQP) from anywhere in the country. The provider will be reimbursed by the patient's local commissioners according to a nationally set tariff. On the other hand, specialist services for rare diseases will be both commissioned and reimbursed centrally, by the NHS Commissioning Board, from April 2013.

[1] This is consistent with the requirement set out in the Health and Social Care Act that Monitor "must not exercise its functions for the purpose of causing a variation in the proportion of health care services provided for the purposes of the NHS that is provided by persons of a particular description if that description is by reference to- (a) whether the persons in question are in the public or (as the case may be) private sector, or (b) some other aspect of their status." The Health and Social Care Act 2012 Section 62 (10)

Figure 2. The NHS Playing Field



The Health and Social Care Act 2012 (the Act) introduced a number of changes to the playing field which are now being implemented. These include the creation of the NHS Commissioning Board (NHS CB), clinical commissioning groups (CCGs) and health and wellbeing boards, as well as changes to Monitor's role.

From April 2013, the NHS CB will be responsible for commissioning specialised services, primary care services, offender health care, and support for members of the armed forces.

The NHS CB will also be responsible for authorising and overseeing clinical commissioning groups, which will take over many of the local commissioning functions previously held by primary care trusts (PCTs). These include the commissioning of community health services, maternity services, elective hospital care, rehabilitation services, urgent and emergency care including A&E, ambulance and out-of-hours services, and health care services for children, people with mental health conditions and people with learning disabilities.

CCGs may choose to buy in support from external organisations, including NHS commissioning support services and private and voluntary sector bodies, although responsibility for commissioning decisions will remain with CCGs.

Newly formed health and wellbeing boards will have strategic influence over commissioning decisions across health, public health and social care through their role developing Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. Health and wellbeing boards must include one locally elected

representative, a representative of the local Healthwatch organisation and of each local clinical commissioning group, and the local authority directors for adult social services, children's services and public health.

Monitor has taken on a new role as sector regulator, with duties that affect both providers and commissioners. Our new provider licence is the main tool with which we will regulate all providers of NHS services, replacing the terms of authorisation through which we regulated only NHS foundation trusts. Monitor will license foundation trusts from April 2013 and other eligible providers of NHS-funded care from April 2014.

The licence contains obligations for providers of NHS services that allow Monitor to fulfil its new duties in relation to: setting prices for NHS-funded care in partnership with the NHS CB; enabling integrated care; safeguarding choice and preventing anti-competitive behaviour that is against the interests of patients; and supporting commissioners in maintaining service continuity when providers are in difficulty. It will also enable Monitor to continue to oversee the way that NHS foundation trusts are governed.

Alongside the licence, Monitor is responsible for issuing guidance and enforcing the Procurement, Patient Choice and Competition regulations set down by the Department of Health.

Undertaking the Review as these major structural reforms take effect means the evidence we have collected reflects a situation that is already changing. We have tried to take this into account in our findings and recommendations. Some of the current reforms are designed to address issues raised in this report. Where this is the case, our recommendations seek to work with the grain of wider Government policy. In other areas we make recommendations for additional changes or further work.

1.2.2 Playing field distortions

Our first step was to collect evidence from stakeholders to find out what factors providers experience as unfair distortions of the playing field. We considered as distortions only those where the evidence suggests:

- the factor may have a differential impact on different types of provider; and
- the impact is beyond the control of providers affected.

We considered carefully whether the endowments that providers start out with on the playing field could be distortions. Such endowments might include good quality estate or a favourable location, strong capital reserves, or an extensive international network. We concluded that endowments could not be distortions because providers of all types may have (or may develop or acquire) endowments of any type.

Similarly, if a provider has a comparative advantage over other providers because it has taken good decisions, we do not treat those advantages as distortions. To illustrate, having recruited excellent staff reflects a good decision, not a distortion.

Having identified actual distortions, we then considered the potential impact of distortions on patients in terms of their access to services, their choice of services, patient outcomes (including the effectiveness and safety of services and the quality of the patient experience) and value for money. We examined further only those distortions shown by this analysis to have a material impact on patients.

In order to understand the impact a distortion has on patients we sought to understand how the distortion affected provider decision making. If a distortion did not change a provider's decisions on whether to offer a service or the quality of the service then it would not have an impact on patients.

The evidence we received showed that providers experience three main types of distortion.

The first is distortions that impede a provider's ability to participate at all in the delivery of health care services, that is, their ability to "get on to the field". We call these **participation** distortions.

Providers who are able to participate in the delivery of care may then face two other types of distortion. **Cost** distortions may affect a provider's decision to offer a service or their decision on the quality of service to offer. They might arise, for example, from differences in taxation or the cost of capital.

Flexibility distortions include reporting requirements or service obligations that fall on one type of provider but not another. These also affect provider decisions about service provision.

1.2.3 Types of provider

There are a number of ways to classify types of provider of NHS-funded services, including by form of ownership, size, geographic coverage, incumbency, type of specialisation, or sector of health care covered. Among these different classifications, two emerged as particularly helpful for the Review: form of ownership and incumbency, meaning the distinction between incumbent providers in an area or service and those seeking to enter or expand into new areas or new services.

Participation distortions**,** that is, distortions that may prevent a provider from getting on to the playing field at all, give **incumbents** an advantage over **potential new entrants** into an area or service. Cost distortions and flexibility distortions generally advantage or disadvantage providers distinguished by their type of ownership, which we break down as:

- **public providers,** comprising publicly owned and run providers, including NHS trusts and foundation trusts in acute, mental health, ambulatory and community settings;

- **private providers,** comprising acute, mental health, community and primary care providers that are privately owned, owned by shareholders or partnerships; and

- **voluntary and community sector providers (VCS),** comprising charities and other forms of local voluntary and community organisations that have specific social objectives, such as Community Interest Companies.

Providers do not always fit into just one type. For example, an NHS general practice, although formally a private provider, may be treated for some purposes as a public provider, for example, in relation to the NHS Pension Scheme. Similarly, while some social enterprises and mutuals may be charities, others are private sector providers.

1.3 Methodology

We gathered extensive evidence from stakeholders and undertook both qualitative and quantitative analysis to determine which of the potential distortions stakeholders told us about had a material impact on patients, and what recommendations would best address those distortions.

1.3.1 Gathering evidence

We collected and analysed views from a large number of stakeholders from across the sector to find out what factors stakeholders perceived as potential distortions to the playing field and why (see Figure 3).

- In June 2012, we sent out a 'call for evidence' and received 71 responses;

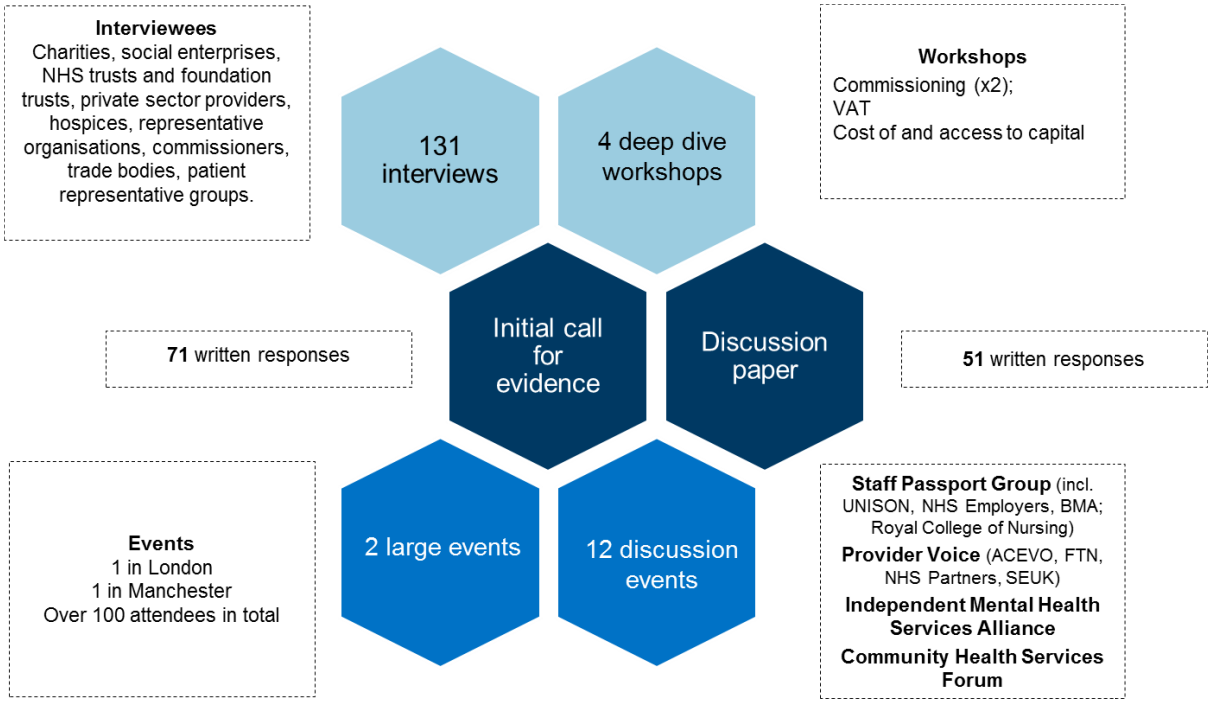
- We conducted 131 interviews and discussions over the course of the Review;

- In November 2012, we published a discussion document and received 51 responses;

- We held four workshops and two events attended by more than 150 stakeholders in total; and

- 12 discussion events.

Figure 3. Engagement with stakeholders



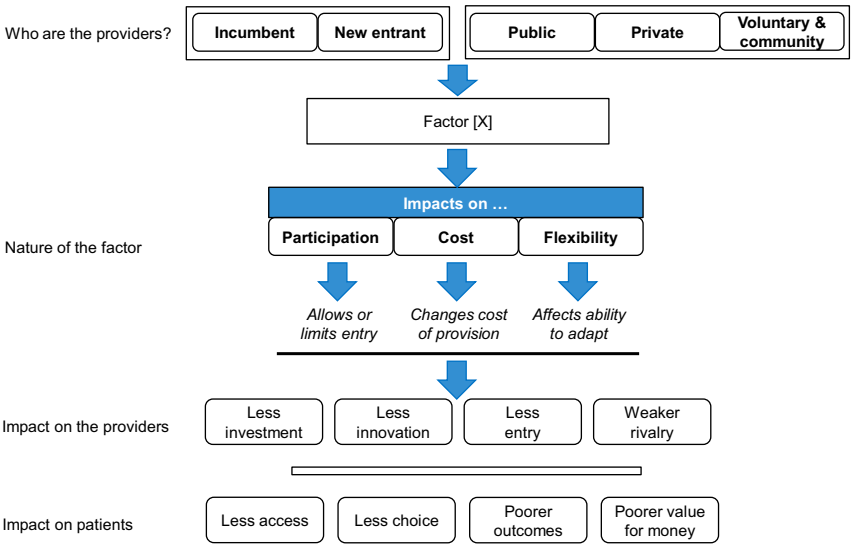
1.3.2 Assessing the impact of distortions on patients

There is no established theoretical framework for determining how a distortion experienced by providers might have an impact on their decision-making NHS funded patient care. The relationship between distortions and patient care are complex and may differ in different circumstances. For instance, different providers may respond differently to the same distortion. To illustrate, some charities told us that their primary goal was to deliver a given service, so they might choose to continue delivering that service even if a potential distortion means they have to deliver it at a loss for a period. Similarly, the same distortion may have a different impact on patients in different service contexts. For example, if a participation distortion impedes a new entrant from offering a service, the extent to which patients are affected will depend on the quality of the incumbent provider.

Recognising these constraints, we developed a framework to identify the link between distortions and patient impact (Figure 4)[2].

[2] For a more detailed account of our methodology please visit www.monitor-nhsft.gov.uk/FPFR

Figure 4. Impacts on patients



We undertook quantitative modelling where possible, for example, in the case of taxes, pensions and cost of capital. We drew on data from a wide range of providers, using the modelling to compare the impact of a given distortion on different types of provider and for some illustrative services.

The modelling gave us some indicative ranges for the impact of particular factors. It also helped us understand the drivers of variations in the impact of distortions by provider or service. However, unlike other such reviews, we have not tried to add up the effects of the distortions that we quantify in order to create an aggregate numerical measure of their overall impact. This is for two reasons. First and foremost, our quantitative analysis forms only one part of the evidence informing our findings and recommendations. Providing aggregate quantitative measures in some areas but not in others risks focusing attention on what can be quantified rather than what is important. Second, we are also concerned that aggregate measures disguise the interaction between individual distortions. Such interaction may mean that the overall impact of several distortions is more or less than a simple sum of their individual impacts. For example, the strength of the local labour market may influence both pay and benefits.

1.3.3 Potential distortions considered

Figure 5 below provides an overview of the 19 potential distortions we examined during the course of the Review. These are grouped by the three categories of distortion identified earlier in this chapter.

Figure 5. Potential distortions

Category	Factor
Participation	Strategic planning
	Procurement
	Choice
Cost	VAT
	Cost of and access to capital
	Pensions
	Indemnities (clinical negligence)
	Education and training
	Corporate taxes
	Pay and employee benefits
	Market forces factor (MFF)
	Mix of patients (cherry picking)
	Payment timings
	Information technology
	Research and development
Flexibility	Constraints on inputs
	Burdens imposed by external requirements
	Changing services
	The policy environment and central control

Early in the Review, we considered three additional factors as possible distortions: central procurement support, the NHS brand and climate change. In each case our analysis suggested that, while important issues, they were not fair playing field distortions:

- Central procurement support was not raised without our prompting by any of the stakeholders we consulted. The discussions that we did prompt suggest it is available to all types of providers of NHS services without undue discrimination between providers of different types.

- The NHS brand is an important and widely recognised symbol of quality and NHS values. It too can be used by all providers if they meet specific criteria relating to the provision of NHS care. There are some differences concerning which logo can be used and how, but no provider raised those as significant issues.

- Climate change imposes costs on the NHS. These range from health care conditions exacerbated by climate change to the reporting of carbon saving, investment and other measures imposed on providers by attempts to mitigate or adapt to climate change. These impacts of climate change apply - albeit in slightly different ways - to all providers of care. They were not raised as an issue by stakeholders. However, we discuss the related issue of emergency planning rules in our discussion of flexibility distortions.

Chapter 2: Conclusions and Recommendations

This chapter sets out the conclusions and recommendations of the Review. The recommendations themselves are numbered in the boxes below. The first two recommendations prepare the ground for those that follow.

1. **The Government should set out a plan for implementing the recommendations and for judging progress towards a fairer playing field.**
2. **The Government should implement these recommendations in a way that maintains the overall level of spending on patient care.**

2.1 Participation

In Chapter 3, we describe how opportunities for providers to participate in the delivery of health care services may be unduly limited by the processes commissioners use to procure services.

We find that at the **strategic planning** stage and when developing **procurement strategies**, commissioners often fail to give due consideration to all available options. We also find that when new opportunities arise for providers to offer their services, non-incumbents may be disadvantaged, either due to poorly designed and implemented **procurement processes** or, where patients have a **choice** of provider, due to a lack of information on the range of available providers.

These limits on the opportunity for, and ability of, some providers to participate in the provision of NHS services mean that patients may not have access to the provider best placed to meet their needs.

In examining the reasons why opportunities are being unduly limited, we identify three root causes:

I. A lack of stability and support

Constant changes to the commissioning system create a strain on commissioners' capacity. When considered alongside short-term budget settlements, this leaves commissioners more likely to have a short-term outlook and less likely to think strategically about the long-term benefits of change.

II. A lack of evidence, case studies and tools

Commissioners are frequently uncertain about the effects of changing current patterns of provision on the continuity, coordination and quality of care. The costs of change can seem significant and the benefits speculative. Commissioners lack evidence on how change has been successfully implemented elsewhere, and high-quality information to allow them to compare different providers or models of care.

III. Misaligned incentives

Commissioners tell us that the point at which they are most likely to encounter challenge to their procurement strategy is when trying to bring about change. This makes retaining the status quo the easier option, even when an incumbent is underperforming. This is reinforced by a lack of opportunity for patients to support the case for change and for other providers to know when contracts are being awarded so that they can offer alternative services where appropriate.

Our recommendations are designed to address each of these three issues and are organised accordingly.

Greater stability and support to enable commissioners to think and act strategically

Longer funding settlements

An uncertain financial outlook can make it difficult for commissioners to plan ahead and make strategic decisions. Reducing that uncertainty would be good for commissioners, providers and patients.

Annual fluctuations to the national tariff leading to uncertain costs for commissioners have been highlighted in previous research[3] undertaken for Monitor. We plan to address this in our future role setting prices for NHS-funded services.

Commissioners' funding settlements are decided on an annual basis, leading to uncertainty about future revenue streams. A longer-term settlement is desirable, although we recognise any change to the settlement term would need to align with the timetable for deciding budgets for the Department of Health and NHS CB[4].

3. Commissioners should be given a more stable financial outlook. The NHS Commissioning Board should fix commissioners' funding settlements for periods longer than one year from April 2016 and Monitor should aim to reduce year-to-year tariff volatility.

Flexibility to determine appropriate lengths of contract

Fixing provider contract lengths at one year causes uncertainty for both commissioners and providers. One-year contracts may be appropriate in some circumstances but they can make it difficult for providers to raise capital and form

[3] Evaluation of the reimbursement system for NHS-funded care (PwC, 2012) http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/our-publications/about-monitor/monitors-new-role/evaluation-the-re

[4] The Department's current budget settlement runs through until 2015. The Government has committed to a one year settlement for 2015/16. This means that April 2016 is the earliest date from which longer term settlements could be introduced.

strategic partnerships. They may also indirectly increase other costs, for example, the cost of rented facilities.

4. **The NHS Commissioning Board should encourage local commissioners to use their new flexibilities to offer contract lengths longer than a year where appropriate.**

Clear rules and expectations

Local commissioners are best placed to decide how best to secure and improve local services, subject to a framework of rules. These rules were set out in the Procurement Guide published by the Department of Health in 2010 and have been carried over into the new Procurement, Patient Choice and Competition regulations.

Where commissioners have identified a need for change to improve the care patients receive, it is particularly important that they consider all available options. These options can include the introduction of an alternative provider through a competitive process, or managing or varying the contract of the incumbent. The commissioner should pursue those options most likely to improve the quality of care delivered to patients, including the opportunity to deliver better integrated care. However, we heard that many commissioners are unsure how the current proposed rules affect their options.

5. **The guidance documents issued by Monitor and the NHS Commissioning Board on the procurement regulations should set clear expectations for commissioners on their approach to procuring services. Guidance should emphasise the importance of considering all available options for improving patient services, including enabling the delivery of better integrated care. This is particularly important when an incumbent provider is underperforming.**

Commissioner transparency

Where commissioners decide to commission new services or when existing contracts come up for renewal, patients and current and potential providers should be given the opportunity to discuss with commissioners how those services can best be delivered. However, information about forthcoming contracts is not always publicly available and therefore discussions about how services should be delivered frequently rely too heavily on input from incumbent providers.

Publishing information about forthcoming contracts would give patients and providers more opportunity to participate in those discussions. This would help commissioners identify the best solutions for patients. In some instances the best solution may be extending the contract of an existing provider without a competitive process. However, the opportunity for patients and other providers to input into commissioner

thinking is important in those instances too (although Monitor will be mindful of the risk of trivial or inappropriate challenges to commissioners by alternative providers and will work with commissioners and providers to minimise this risk).

6. **To ensure patients and providers know about forthcoming contracts and can take part in discussions about how services may best be delivered, the NHS Commissioning Board should require commissioners to publish information about their intention to enter into new contracts, including extensions of existing contracts, on Supply2Health.**

Commissioning support services

The Review has highlighted the need for capacity and capability building in commissioning. In the current context of shrinking administrative budgets and new commissioning organisations, it is particularly important that commissioners have effective support. Supply of commissioning support is currently dominated by Commissioning Support Units, which will be hosted by the NHS Commissioning Board until no later than 2016.

7. **The NHS Commissioning Board should implement in full its published plans for developing the supply of commissioning support and ensure this meets the needs of commissioners. The NHS Commissioning Board should develop and publish performance metrics for all providers of commissioning support.**

Bundling

Commissioning a range of services from a single provider through one 'block' contract will sometimes be the best way to secure efficient, effective and coordinated care. In such cases, commissioners must be able to determine the appropriate price for the bundled set of services. In other circumstances, bundling may exclude smaller providers who are well placed to provide one element of the service bundle.

Getting bundling decisions right is critical to delivering integrated care to patients. Our evidence suggests that the current NHS pricing system may be a barrier to commissioners' ability to make the best bundling decisions, particularly in relation to community and mental health services. Improving the pricing system entails developing standardised currencies (descriptions of what is being purchased for a given price) and better data on providers' costs.

8. **The NHS Commissioning Board and Monitor should accelerate the development of standardised currencies and better cost data in areas where the lack of both is limiting commissioners' ability to bundle or unbundle contracts as appropriate. Monitor should publish a plan by October 2013 setting out how it will improve cost collection in community and mental health services and assess the feasibility of patient-level costing for all acute care.**

Reserves and working capital

Commissioners need to limit their exposure to the financial risks faced by providers. However, some providers - in particular charities and social enterprises - told us they are unable to bid for contracts because commissioners request what those providers perceive to be disproportionate levels of reserves and working capital.

9. **Monitor and the NHS Commissioning Board should publish guidance to help commissioners determine the appropriate levels of reserves and working capital to require from providers, in particular charities and social enterprises, by April 2014.**

Better evidence, case studies and tools to help commissioners identify the best solutions for patients

Information

In determining the best way to secure and improve services, commissioners must assess the risks, costs and benefits of different options. Often the costs of using choice and competition as a tool to improve services appear significant, while the benefits appear more speculative.

Commissioners should be able to access the best evidence and understand what has worked well and what has not. They should be able to identify when competition might be an appropriate tool for improving services and understand how they can identify and manage any risks to continuity and coordination of care.

Developing better information on quality and costs for all areas of care is central to meeting these objectives. Previous efforts to develop better information and metrics on quality have often focused on secondary care. Future work should extend to other areas, including primary care. It should also consider how to take account of contributions providers make to social value, consistent with the requirements of the Social Value Act 2012.

10. **Monitor and the NHS Commissioning Board should collect and share evidence of the risks, costs and benefits of different approaches to procurement including the use of choice and competition. A website with the first set of resources should be operational by October 2013.**

11. **To help commissioners make decisions based on quality, the Department of Health should publish a plan by December 2013 to make a step change in the development and use of quality metrics. The plan should reflect the experiences of service users and take account of contributions to social value.**

Role models

In future, the NHS CB will be directly responsible for commissioning some clinical services. Monitor and the NHS Trust Development Authority (TDA) will also have indirect roles in commissioning services as they facilitate service reconfiguration at distressed or failed providers. In these roles, all three national bodies have the opportunity to demonstrate best practice procurement.

12. **The NHS Commissioning Board should demonstrate best practice procurement when it commissions services directly. Monitor and the NHS Trust Development Authority should likewise demonstrate best practice when they procure services in instances of provider distress and failure.**

Patient choice

The NHS Constitution sets out the rights of patients, including those to choice. In addition, commissioners are responsible for considering where choice should be extended locally.

Where patients do have a choice of provider, they should be made aware of their options and supported in making informed decisions. However, information on the extent to which choice is being offered to patients is no longer gathered systematically. This reduces the ability of commissioners and others to judge how well choice policy is working.

Commissioners also need access to evidence on the risks, costs and benefits of extending patient choice to other areas, in particular in community-based services.

13. **The NHS Commissioning Board and Monitor should measure and publish information by April 2014 on the extent to which patients are offered a choice of provider in line with their rights set out in the NHS Constitution.**

14. Monitor should work to develop evidence on the risks, costs and benefits of extending local choice for patients, particularly in community-based services. This should start from April 2014.

General practice and associated services

Questions were raised during the course of the Review about the extent to which the commissioning of general practice and associated services in particular is operating in the best interest of patients. Issues raised included:

- the rules for setting up a general practice;
- the different contractual terms under which practices operate;
- the perceived reluctance of PCTs to commission new services against the wishes of existing local practices and Local Medical Committees;
- perceived conflicts of interest that may in future prevent clinical commissioning groups from commissioning services from new entrants; and
- concerns about a lack of choice of general practitioners for patients.

15. Monitor should issue a call for evidence by June 2013 to help determine the extent to which the commissioning and provision of general practice and associated services is operating in the best interests of patients.

Better aligned incentives

Accountability

Commissioners told us that they are most likely to encounter scrutiny and challenge when trying to change current patterns of service delivery and/or award new contracts.

As a result, some commissioners are less likely to make changes to the way services are delivered and, when they do, are more likely to run overly complex and risk-averse procurement processes. This operates against the best interest of patients if it allows incumbents to continue to provide poor quality services.

We also heard that patients and their representatives often struggle to be heard and want more opportunities to provide input into commissioners' decisions.

The new commissioning system introduces changes intended in part to address these issues. Health and wellbeing boards will have an important role in strengthening the voice of patients and ensuring that commissioning plans adequately reflect local priorities across both health and social care. The NHS CB, the Department of Health and Monitor will all have responsibilities to hold commissioners to account.

16. **The Department of Health should commission an independent evaluation of the effectiveness of the commissioning system for NHS services, starting by April 2014. This should include an evaluation of whether health and wellbeing boards are performing their role effectively and what additional capabilities they might need.**

17. **The NHS Commissioning Board should publish by October 2013 how it will provide assurance that clinical commissioning groups are fulfilling their statutory functions and what actions it will take if a local commissioner underperforms. The Department of Health should publish by December 2013 how it will provide similar assurance in relation to the NHS Commissioning Board's own commissioning functions.**

18. **Monitor should clarify how its intervention powers for commissioners will be used alongside those of the NHS Commissioning Board.**

2.2 Costs

We investigated circumstances in which some types of provider face externally imposed costs that do not fall on others. Two cost issues – Value Added Tax and cost of capital - represent distortions that have an impact on patients and we recommend further work to understand how best to address them.

Some other cost distortions raised by providers have a major impact on patients but are already being tackled. These are in the areas of pensions, clinical negligence indemnity, the pricing of education and training, and the pricing of clinical services. In these areas we highlight principles that need to inform efforts to make the playing field fairer.

Providers raised a number of other cost issues, including corporate taxes, which we found, on investigation, not to warrant action.

Value Added Tax

NHS providers do not charge commissioners VAT on their NHS services. This means that providers cannot usually recover VAT paid on their purchased inputs. However, since it may be more cost effective for the Government if public providers outsource a service when it is cheaper to do that (net of VAT) than to provide it in-house, the Government created rules to allow public sector providers to reclaim VAT on some contracted out services. The resulting VAT refund to public providers amounts to about an additional £1 billion a year of public spending on health services.

This refund for public sector providers gives them a cost advantage over other providers because it allows them to offer services at lower cost than they would

otherwise have faced. We have seen examples where other types of provider have lost contracts to public providers because of the rules allowing VAT refunds to public providers on contracted out services. However, under the VAT rules, where a VAT refund on inputs would significantly distort competition, providers are no longer eligible to claim the refund on those inputs.

VAT refunds on contracted out services are intended to encourage public sector health care providers to make the most efficient resource decisions when choosing inputs. For the same reason, where they do not conflict with the VAT rules, the Government should consider extending the VAT refunds on contracted out services to charitable providers of NHS-funded care.

19. The Government should review whether certain public sector providers remain eligible for VAT refunds and should report on the case for extending VAT refunds to some charitable NHS-funded health care providers by the Budget in 2014.

Cost of and access to capital

Some VCS providers told us they did not have the same access to capital as public and private providers. We note that there are a number of new initiatives already under way that will help to alleviate this problem[5], for example:

- The Government is developing financial instruments that VCS providers may use such as social bonds and social capital investments; and
- Big Society Capital, funded largely by dormant bank accounts, was set up in 2012 to develop the market for social investment.

In addition, stakeholders pointed out that public providers can generally access capital at lower than commercial rates.

We have reviewed the cost of the different sources of capital available to different types of provider. Public providers largely access public sources of funds at rates set by government, while private providers largely access private sources of funds at rates that are set by financial markets. Our analysis suggests that there may be an advantage to public providers for some types of funding. More notably, lending to private or VCS providers regularly varies by individual provider according to their level of risk. Lending to public providers by government largely fails to differentiate between the risk levels of different providers. This creates a distortion where providers with a similar level of risk face different costs of capital.

20. The Department of Health should publish how and when it will implement a risk-reflective cost of capital for public sector providers, by April 2014.

[5] Recommendation 9 in this Chapter may reduce the need for capital; this is discussed further in Chapter 3.

Pensions

The NHS pension is currently available to public sector staff, some social enterprises and General Practitioners. It is subsidised by the Exchequer and this gives rise to a cost distortion as not all employees involved in the provision of NHS-funded services have access to the scheme.

When staff move from a public provider under TUPE regulations they are guaranteed a 'fair deal', which obliges their new employer to give them a broadly comparable package.[6] Although some providers, for example, some social enterprises, can offer access to the NHS Pension Scheme, those that cannot face the higher costs of offering comparable benefits. The Government is tackling this distortion by making a commitment to allow staff who are members of the NHS Pension Scheme to retain their membership if they move under TUPE regulations to another provider of NHS-funded care.

When a private or charitable provider develops a new service, it does not currently have access to the NHS Pension Scheme. This creates a disadvantage for these providers when they operate in tighter labour markets requiring that they offer NHS-equivalent pensions, particularly when recruiting older and senior clinical staff. In theory, the obligation to offer the NHS pension represents an offsetting disadvantage to public providers in weaker labour markets. In aggregate, it appears that at present this is a cost distortion that disadvantages private and charitable sector providers of new NHS-funded clinical services.

Removing this distortion would require giving staff supporting the provision of new NHS-funded services access to the NHS pension. However, ensuring that only such staff gain access to the scheme presents practical challenges. The Government therefore needs to identify and try to solve any practical impediments to extending the Pension Scheme. This approach will have no effect on the pensions of existing NHS staff.

21. The Government should rapidly extend access to the NHS Pension Scheme for all staff moving from a public provider to provide NHS-funded clinical services elsewhere. They should also continue work on the practicality of extending access to the NHS Pension to any employee providing NHS-funded clinical services. A decision should be announced by June 2013. Private and charitable providers should face the same employer contribution rate for the NHS Pension Scheme as public sector providers.

[6] TUPE stands for Transfer of Undertaking (Protection of Employment Regulations).

Indemnity for clinical negligence

The NHS Litigation Authority currently provides a clinical negligence scheme for providers in the public sector (the CNST). As a risk-pooling scheme, it is intended to smooth annual fluctuations in pay-outs to members but not to transfer risk from some members to others. However, pay-outs to some members consistently exceed their contributions, indicating that the scheme does not price risk accurately. The scheme is often available to these members at a lower cost than commercial alternatives, giving them a cost advantage.

On the other hand, public sector providers have difficulty exiting from CNST. This is a drawback for those public providers in the scheme whose risks are disadvantageously priced.

The NHS Litigation Authority is trying to tackle both these problems. The Government has also laid regulations to open access to CNST to most private and charitable sector providers by April 2013.

22. The Department of Health and NHS Litigation Authority should improve the pricing of risk and should minimise barriers to joining and leaving the CNST for all types of provider.

Education and training

Many stakeholders voiced concern that the private or charitable sectors are able to employ clinical staff without facing the cost of training them. Conversely, other stakeholders saw as a disadvantage to the private and charitable sectors their lack of access to public funds for training and the other benefits training brings, for example, in recruiting clinical staff. The Review found no evidence of disadvantages to patients arising from the different treatment of the public, charitable and private sectors with respect to education and training.

However, within the public sector the current system of funding undergraduate education and training provides higher levels of remuneration to large, established hospitals than to small, less-established hospitals. This gap reflects historic patterns of provision and not differences in the value of the training services those hospitals provide.

Health Education England, which will take on its full functions from 1 April 2013, will be creating a new system of tariffs to cover all formal undergraduate and postgraduate professional training, similar to the national tariff for clinical services.

23. Health Education England should ensure that the tariff system for funding clinical education and training is cost-reflective.

Pricing of clinical services

Public providers often offer a broad range of services reimbursed through the NHS tariff. The price for some services in the tariff is set at a level above the actual cost of providing that service (for most providers) while some other services are priced at a level below the actual cost of provision. In general, non-public providers offer a narrower range of NHS-funded services and treat a narrower range of patients, often with simpler conditions. Some providers complain that this allows non-public providers to 'cherry pick' those services and/or those patients that are reimbursed through the tariff above the actual cost of provision. Basing the tariff on the actual costs of provision will help to resolve this issue but will take significant time. From April 2013, Monitor and the NHS Commissioning Board will have responsibility for developing the national tariff, which will include developing the April 2014 tariff and working to improve future tariffs. Monitor's role includes calculating efficient prices for the national tariff. Commissioners have the flexibility to reduce the price paid to providers whose contracts include exclusion criteria for patients who are more expensive to treat, though this flexibility is currently rarely used.

24. Monitor should set out a timetable by the end of this year for establishing more cost-reflective reimbursement of NHS-funded care. Commissioners should specify the case mix covered by contracts and reduce the price paid to reflect any exclusion criteria.

Corporate taxes

Private providers are liable to pay corporation tax on profits, and other corporate taxes. Charities and public providers do not pay corporation tax on revenues generated from providing NHS-funded clinical care, or other corporate taxes. In theory, this could make a difference to patients if it meant some providers were choosing not to invest in providing services because of their higher costs. However, the low incidence of corporate taxes in practice means there is unlikely to be an impact on provider decision making and therefore there would be no benefit to patients in extending corporate taxes to public providers or removing corporate taxes from private providers.

25. The Government should not alter the current corporate tax arrangements for public, private or charitable providers.

2.3 Flexibility

Flexibility distortions arise as a result of external constraints that limit the flexibility of providers to respond to changing patient needs or the changing requirements of commissioners. These constraints do not have an equal impact on all providers.

Providers told us of a range of constraints that affected their flexibility: difficulty securing access to some types of staff and facilities, burdens created by externally imposed requirements; barriers to changing services; and the impact of the general policy environment and extent of central control.

Flexibility distortions concern public providers more than other providers since public providers face a number of restrictions on their flexibility that other types of provider do not face. These include: mandatory service obligations; the power of the Secretary of State to direct NHS trusts; rigidities in the public sector workforce; and the higher likelihood of intervention by the Government or other national bodies. These restrictions on flexibility are exacerbated for public sector providers by uncertainty about how the Government or national bodies with oversight of public sector providers will exercise their authority. This is different to the more general political uncertainty that all types of provider face.

Certainty

Some private sector providers expressed concern about the effects of political uncertainty regarding their role. Although this may have an impact on patients, it is inevitable that different governments will have different views about the delivery of public services. A more tractable source of uncertainty is the manner in which a government exercises available levers for influencing public providers, particularly in relation to the central bodies responsible for oversight of the system.

The Review found that a lack of clarity concerning the roles of central authorities in the health care system makes public providers less innovative than they might be if the roles were clear to all and strictly adhered to.

26. The Department of Health, the NHS Commissioning Board and Monitor should act in a way that is consistent with the legislative framework in the Health and Social Care Act 2012. Rather than acting as managers of providers, the Department of Health should act as steward of the health and care system, the NHS Commissioning Board should provide leadership and support to commissioners and Monitor should regulate the sector, protecting and promoting patients' interests.

NHS trusts

NHS trusts have less flexibility than other public sector providers because they are subject to a range of controls, for example, the obligation to obtain government clearance for their capital spending decisions. The additional flexibility that NHS foundation trusts gain with foundation trust status improves their ability to respond to changing patient needs and is more generally in patients' interests. However, it is also in patients' and taxpayers' interests that NHS trusts face a rigorous assessment

process to become foundation trusts and that patient safety is guaranteed throughout this process.

27. The Government should promote the policy of increasing provider autonomy and accountability, which includes moving towards an all foundation trust public sector.

Staff pay and conditions

Staffing accounts for a large percentage of the costs of any health care provider and the productivity of staff can make a significant difference to patient care. Foundation trusts have the flexibility to tailor staff terms and conditions to local circumstances and to use systems of reward to manage staff performance. Although some foundation trusts are beginning to explore departing from current arrangements, few have done so. In some circumstances, this puts them at a disadvantage to private and charitable providers with more flexible arrangements.

28. Providers should use existing pay flexibility wherever this is in the interests of patients.

Provider transparency

Historically, public providers have faced higher levels of scrutiny than other providers, including requests for information under the Freedom of Information Act. This degree of scrutiny can improve accountability to patients and promote good practice. Freedom of Information requirements have been extended through the standard NHS contract to private and charitable providers. However, it is not clear that this is operating effectively as yet, and other aspects of transparency do not apply across all types of provider.

29. The Government and commissioners should ensure that transparency, including Freedom of Information requirements, is implemented across all types of provider of NHS services on a consistent basis.

Mandatory service obligations

Mandatory service obligations were widely reported by stakeholders as placing public sector providers at a disadvantage to other providers, for example, because they limit the freedom of public providers to adjust themselves to changing circumstances. Some disadvantages arising from mandatory services may be corrected by their designation as Commissioner Requested Services (CRS) under the new health care provider licence scheme starting from 1 April 2013. This will

place both public and non-public providers of CRS under the same regulatory regime.

However, some stakeholders question whether the new regulatory approach will be proportionate and whether the barriers to changing services are too high. These barriers include service obligations imposed by commissioners, the existence of cross subsidies across services and political constraints. Following discussion with the Foundation Trust Network, Monitor is undertaking a short review of the operation of the licence in 2014, including the operation of CRS.

30. Monitor should consider barriers that public sector providers face when reconfiguring services as part of its planned review of the Commissioner Requested Services arrangements in April 2014.

Chapter 3: Findings – Participation Distortions

3.1 Introduction

This chapter concerns distortions that directly limit a provider's ability to participate in the provision of services to patients[7]. These distortions disadvantage providers who would like to offer new services to their existing patients or new services to new patients, as compared with existing or 'incumbent' providers of those services. Providers of every type can be either incumbent or non-incumbent.

For stakeholders, participation distortions were the most important identified by the Review. Participation distortions are important for patients because there may be high-quality providers who could be providing their care but who are not being given the opportunity to do so. If such providers are denied the opportunity to offer their services, the potential they have to improve the quality, efficiency and effectiveness of patient care may be lost.

While some providers seeking to provide new services may be charities, mutuals, social enterprises, or private providers, would-be bidders for contracts very often include non-incumbent public sector providers as well. For example, in 2010, the Whittington Hospital successfully bid for a contract to provide a TB diagnostic screening service commissioned by Wandsworth PCT.

> While many public sector providers see themselves as a "local hospital, first and foremost", others tell us that "When we get offers to provide national stuff, we go for it…Perhaps our biggest opportunity is to move into primary and community care as that is where the growth is."

Opportunities for all providers to provide services are created by commissioners, who purchase care on patients' behalf. This chapter therefore starts with an overview of commissioning and describes how commissioners aim to secure the best services for patients. It then presents our findings on the relationship between individual commissioning tasks and participation.

3.1.1 Overview of NHS commissioning

Commissioners play a central role in the health care system. In purchasing care, they assess the needs of patients, monitor the adequacy of current provision and consider the best way to bring about continuous improvements to patient care.

[7] For more detailed findings and analysis about participation please see www.monitor-nhsft.gov.uk/FPFR

It is a difficult job. With limited resources to meet the population's growing health care needs, commissioners need to be increasingly rigorous in identifying the best solutions for patients.

During the course of the Review we heard many examples of innovative commissioning. In some cases, commissioners are working with an incumbent provider to change the way services are delivered. In others, commissioners are introducing new providers, either instead of or alongside the incumbent, sometimes because the incumbent is underperforming, but often because commissioners have taken the initiative to think afresh about how best to meet the needs of patients. For example, they may be moving care from a hospital setting into the local community or increasing the choices available to patients.

However, we also found widespread examples of commissioners failing to give adequate consideration to all available options, including failing to canvass the views of patients. Where this is the case, commissioners may not be choosing the best provider for their patients.

Many providers feel disadvantaged by commissioning practices. Thirty-nine per cent of respondents to our discussion document said that commissioning was among the most important fair playing field issue for their organisation. Commissioners themselves recognise flaws in the current commissioning system. But they also told us about several ways in which the system does not currently support them to think and act strategically.

Many stakeholders also referred to the structural changes to commissioning currently taking place (a number of which have been designed to address issues we highlight in this chapter) and the impact these changes may have. Our assessment of whether opportunities for providers to participate in the provision of health care are unduly limited is, necessarily, based on a picture of the sector before these changes. Where appropriate, we refer to current or planned initiatives, although this is covered more comprehensively in Chapter 2.

3.1.2 Securing the best services for patients

Commissioners are tasked with determining the best way to secure services for their local population, subject to a framework of rules[8]. Their options include extending and varying existing contracts, negotiating with a new provider, opening contracts to competitive tendering or widening the range of local qualified providers that patients can choose from.

Recent research undertaken by the NHS Commissioning Board and Monitor on choice and competition in the NHS shows that less than 3% of the £46 billion budget

[8] These rules were set out in the Procurement Guidance published by the Department of Health in 2010 and remain unchanged in the Regulations published in March 2013.

that local commissioners spent on commissioning clinical services in 2010/11 involved the use of a competitive tender or local Any Qualified Provider (AQP) to secure services. There are significant differences by geographic area. For example, 8% of services provided in the East of England are open to competitive tender or local AQP, while the equivalent figure for London is 0.7%, a greater gap than might be expected even recognising differences between the regions.

This does not prove that competitive tendering is not being used everywhere it should be, as in many cases competitive tendering will not be the most appropriate tool for improving services. For example, where an incumbent is clearly best-placed to deliver high-quality care, there would be little to gain from putting services out to tender. However, it does raise concerns amongst providers as to whether commissioners are giving adequate consideration to their full range of options.

In order to determine whether the opportunities for non-incumbent providers to offer services may be unduly limited, we examined the approach commissioners take to procurement. We identified three key aspects of their approach:

- **Strategic planning and developing a procurement strategy:**
    - strategic planning: How the process through which commissioners assess local needs and current provision, and identify and assess the ways in which needs could best be met in future, operates; and
    - procurement strategy: How the process of determining an approach to procurement, given the outcomes of strategic planning, operates. This includes how the decision of whether to extend or vary the contracts of existing providers, or whether to introduce additional providers, either instead of or alongside existing providers, is made.
- **Procurement processes:**
    - how planned procurement processes are implemented.
- **Patient choice**:
    - whether the support needed to enable NHS patients to make good choices is provided.

We find that improvements could be made in each of these three areas so as to enable patients to access the provision most suited to their needs.

3.2 Strategic planning and developing a procurement strategy

Providers told us of a number of difficulties they encounter at the strategic planning stage of commissioning that may be hindering the best providers from participating in patient care. We conclude that limitations in both strategic planning and the development of procurement strategies mean commissioners may, in some

instances, be failing to identify the best solutions for patients. But we also recognise that commissioners need more stability, evidence and support to overcome those limitations. Current reforms offer an opportunity to provide commissioners with all three.

3.2.1 Strategic planning

Strategic planning involves assessing local needs and current provision, and identifying the best way of meeting those needs, including considering alternatives to current provision. It is a critical stage in determining the opportunities for high-quality providers to extend their provision to new services and/or patients. If commissioners do not systematically review how effectively a current provider is meeting patient needs and whether alternative providers might meet them better, then they may miss opportunities for improving patient care. The consequences of supporting underperforming providers are highest in a context where the quality of care can vary widely.

We found that some commissioners are, often inadvertently, reinforcing the status quo at this stage of the commissioning process by failing to give adequate consideration to all available options. This may unduly limit the opportunities for high-quality providers – whether public, private or VCS – to offer services.

Many stakeholders from all sectors share this view. Some told us they believed they would have been able to offer higher-quality services than the incumbent in several situations where commissioners had been unwilling to allow them the opportunity.

> "There's a default assumption that the public sector should provide all services – tenders tend to only come out when there's been a major failure with the provider or a specific need for something the public sector can't provide." (VCS provider)

While the view cited above was common among many contributors to the Review, it is not the case that all commissioners are reluctant to consider new providers. Commissioners cited a number of other factors that may constrain their consideration of alternative providers.

For example, in many cases commissioners may simply lack the necessary **capacity** to consider alternative providers.

> "In reality, we can only conduct a small number of competitive procurement exercises each year." (Commissioner)
>
> "If we took everything to the market for full procurement that we possibly could, the level of resource needed to manage this would be massively in excess of what we have available." (Commissioner)

"We know what is expected. But with constant restructuring and all of the pressures we are under, most of our attention is focused on the local acute. Then we realise that other contracts are running out, at which point we look to extend them just to keep things ticking over." (Commissioner)

A lack of **capability** amongst commissioners was also highlighted in this Review and by previous research as contributing to their difficulties in 'engaging the market', an important step in developing a broad provider base from which to identify high quality provision.

"A number of commissioning skills were highlighted as needing development, including contracting and contract management, market analysis and market management, project management skills, and the ability to build mature commercial relationships." (The King's Fund, Building High-Quality Commissioning, 2010)

Commissioners may also be unsure of the **risks and rewards** of changing current patterns of provision. In some cases preserving the status quo will appear the easiest option.

"There is a cartel nature with some NHS providers [...] they can stop things happening that they don't like. They can be powerful lobbyists with significant influence – it's hard to stop commissioners caving in to that." (Commissioner)

"Commissioning has a problem of demand, not supply […] The problem is that commissioners don't see any upside in developing these capabilities. They won't be thanked for running more professional procurement processes, in fact sometimes it may leave them open to challenge." (Think tank)

It may not be the case that commissioners are simply "caving in" to institutional or political interests whenever they opt to retain the current provider. In many cases commissioners are understandably concerned about the impact that introducing new providers, either alongside or instead of the incumbent, may have on local services.

The most obvious opportunities to improve services by introducing alternative provision will often be in cases where the quality of current provision is low. However, poor service quality from a provider often goes hand-in-hand with poor clinical and financial governance. This is seen in the fact that commissioners report concerns about the impact on the **stability** of an already fragile incumbent provider of transferring some services to an alternative provider. The new regime designed to help commissioners protect essential services when providers are in situations of distress or failure should help alleviate this problem.

Some commissioners also reported concerns about the impact of introducing alternative provision on the delivery of **integrated care**. However, some providers told us that, in many cases, a range of providers is precisely what is required in order to deliver an integrated package of care tailored to patients' needs. To illustrate, one charity told us that:

"The delivery of hospice care to meet palliative care needs is an example of a part of the healthcare system that has for many years operated as a mixed economy, in which charitable providers work in close partnership with the public, private and voluntary sector to ensure that patients have access to the best quality care."

In future, Monitor and the NHS Commissioning Board will have specific duties to enable and promote integrated care. The establishment of health and wellbeing boards should also help ensure that commissioners' decisions support the delivery of integrated care by providing a route for patients' views to feed into the commissioning process alongside the views of the local authority, which will be responsible for commissioning social care and some public health services. Patient groups tell us that patients are not currently cons ulted sufficiently about commissioning, either when current needs and provision are being assessed or when new services are being commissioned. This is important in ensuring that commissioners are selecting the providers that best meet patients' needs.

"Decision-makers have stopped talking about personal budgets, but that is how you will see a real difference. For people themselves, good support is more than just health care, and they can often say what makes a difference to their health and quality of life and what doesn't." (Patient representative group)

"We need better feedback loops with patients to support the case for change." (Patient representative group)

Finally, commissioners told us that a lack of good, comparable **information on quality** contributes to the difficulty of assessing whether an alternative provider may improve the quality of services.

"A lot of people think there is a science to it [evaluating different providers], but there really isn't. If only it were that easy." (Commissioner)

"A lack of good quality information – on quality as well as costs – means that in many areas commissioning is a largely relationship-based and data-free activity." (Think Tank)

3.2.2 Developing a procurement strategy

In developing a procurement strategy, commissioners must decide how to package the services they are purchasing. High-quality providers can be prevented from getting on the playing field if, in order to do so, they need to offer an extensive range of services, some of which are beyond their capability. This situation might arise if there are:

- **restrictions or deficiencies in pricing** – for example, a single tariff for multiple services that could be efficiently supplied separately may lead commissioners to purchase all the services in one bundle;

- **deficiencies in commissioning** – for example, a lack of provider engagement may mean commissioners lack knowledge of who could supply the services separately; or

- **restrictions imposed by incumbents** – for example, an incumbent provider may use its bargaining power in one service to refuse to supply that service unless the commissioner agrees to buy other services as well.

Bundling of services was identified by 15% of respondents to our discussion paper as one of the most important to their organisation[9].

> "Bundling constricts the ability to enter the market, often with little benefit. You have to form a joint venture or else not compete at all." (Private sector provider)
>
> "Questions have been raised about whether the traditional approach to tariff structures and tariff-setting has the effect of reinforcing current practices, pathways and incumbent providers at the expense of potential new entrants and those seeking to offer innovative services which do not neatly fit the various tariff templates." (Representative body)

There are different ways of bundling services together. In practice, the most common is block contracting. Although using block contracts does not necessarily imply that a commissioner is only able or willing to buy one activity or service in combination with another, we were told that the two often coincided.

Lack of evidence means it is not possible to determine the extent to which bundling currently acts for or against the interests of patients. For instance, in some cases deficiencies in pricing may make it reasonable and in patients' interests for commissioners to use block contracts. In addition, there are circumstances in which bundling can work in the interests of patients by supporting integrated care offerings or clinical inter-dependencies.

However, it is clear that bundling services together where they could be better supplied separately is likely to exclude some providers from offering services even when those providers are best placed to meet patients' needs. For example, a number of hospices told us that some commissioners purchase large blocks of community-based services through one contract with a single provider, excluding smaller, expert providers of high quality end-of-life care. While in some cases this can be resolved by sub-contracting arrangements, palliative care organisations we spoke to argued that poorly implemented sub-contracting arrangements or poor contract management by commissioners can result in less satisfactory outcomes for patients. For example, they told us that in some instances, prime contractors use sub-contracting as a way of "handing-off" more difficult-to-treat patients to charitable providers, rather than reaching an objective assessment of where all patients should best be cared for. Similar concerns were raised in relation to mental health services.

[9] As we point out below, unbundling is not always better for patient's interests than unbundling'.

Contracting with a single 'prime' contractor may be a good option for commissioners, especially considering the strain on commissioners' capacity to run multiple procurement exercises. But this will only be the case if commissioners are putting in place appropriate governance arrangements and adequately holding prime contractors to account for service quality[10].

The evidence uncovered here reinforces the need for work by the NHS Commissioning Board and Monitor on the role of the reimbursement system in reducing the risk of inappropriate bundling, and on how the system influences commissioner and provider behaviour. This work should also help commissioners to identify areas in which services might be bundled together to improve the integration and coordination of care.

3.3 Procurement processes

Large elements of procurement processes are nationally mandated. However, local commissioners do have some discretion over the design and execution of procurement processes and are allowed to tailor processes to local needs. How commissioners use this local flexibility can impact on different providers' ability to participate fairly in the procurement. This may in turn affect patients' access to the best available care.

Many organisations told us they are disadvantaged by procurement processes. We heard about problems caused by:

- the administrative burden of the tender process;
- the length of the tender process;
- delays in tendering processes;
- over-specification of contracts, with an emphasis on processes instead of outcomes;
- under-specification of staffing and facilities;
- working capital and reserves requirements;

- short contract lengths; and
- biases and conflicts of interest.

Commissioners and providers gave us examples of **disproportionately burdensome tender processes**. These can cause particular problems for smaller providers with fewer staff and resources to devote to preparing bid documents.

[10] Some stakeholders told us they expect to see an increase in sub-contracting in future years in the NHS, partly driven by a desire by commissioners to introduce new providers without creating an additional strain on their capacity. There may be a case in future for the development of a code of conduct to manage such arrangements, similar to the Merlin Standard developed by the Department for Work and Pensions, which sets out a standard of behaviour to which prime providers are expected to adhere in their relationship with their subcontractors.

"We are so good at overcomplicating things. The process needs to be legally sound, but it sometimes feels the same approach is used for a small service as taking over the running of an acute hospital." (Commissioner)

Some smaller providers told us that they had problems investing the necessary time and resources in very **long, drawn-out procurement exercises**. For example, one procurement process for a Recovery at Home service took a total of 22 months to complete. Commissioners in an equivalent area had procured a very similar service at the same time using a simple specification, having already engaged informally with providers. That tender process took "approximately 20 days".

There have been **delays in procurement processes** for selecting services for local AQP lists. Following an engagement with patients, health care professionals and providers, the Department of Health said that primary care trusts (PCTs) should have identified three or more community services for local AQP by 31 October 2011 and have implemented AQP for those services by September 2012. At the end of December 2012, only 13 PCTs were delivering the three AQP services. Such delays can have a particularly adverse impact on the business planning of non-incumbent providers, who may have raised capital, rented facilities or recruited staff in the expectation of an opportunity to attract patients from the pre-announced dates.

Commissioners need to gather insights from current and potential providers as well as from patients to understand how a service might best be designed, commissioned and delivered. However, people told us that they were concerned that commissioners rely too much on incumbent providers to help them **define service requirements** and place too much emphasis on **processes instead of outcomes.** This makes the current provider and current model of provision likely to prevail when commissioners consider their options[11].

Providers also told us that commissioners do not always make all of the required information available in time for them to come to a judgement about the feasibility of bidding to provide a service. Examples of **under-specification of contracts** include failing to make available in a timely manner information about the potential costs associated with TUPE staff[12] or the facilities available to deliver the service.

Charitable providers, social enterprises and mutuals say they often struggle to meet **requirements of working capital and reserves**. We have not been able to determine the extent to which these requests are in fact disproportionate to the scale of activities involved. However, many providers perceive that they are. Guidance to help commissioners determine appropriate levels may be beneficial. Working capital requirements are a particular issue for social enterprises that have 'spun out' from

[11] This point was reinforced by charities who told us that commissioners don't usually take into account the contribution they make in terms of social value.

[12] The Transfer of Undertakings (Protection of Employment) Regulations (TUPE) protects employees' terms and conditions of employment when a contract is transferred from one provider to another. TUPE arrangements are discussed in more detail in Chapter 4.

PCT provider arms "with few assets and a very limited formal trading history" (Social enterprise).

> "[There is] an inherent discrimination against social enterprises in the current tendering process because of the requirement to hold 10% of contract value in the case of failure." (Social enterprise)

We also heard about problems arising from the **length of contracts.** Currently, commissioners are free to determine appropriate lengths for contracts when procuring a service through a competitive tender. However, commissioners may only extend existing contracts by one year at a time, regardless of how well the incumbent is performing. Standard contracts for AQP last three years. These restrictions on contract lengths have an impact on providers' ability to plan, may increase their costs, (for example of renting facilities), and can undermine the delivery of sustained coordinated care to patients. They also increase the costs for commissioners. These restrictions are due to be lifted from April 2013, after which commissioners will be free to determine appropriate lengths for all contracts. Commissioners need to be made aware of that change and encouraged to use that flexibility appropriately[13].

> "The contracts are so short, which favours incumbents. Any alternative provider would need a minimum period to make the capital investment pay off." (Private sector provider)

Finally, we heard from many providers who believe that some commissioners are **biased** against their participation in favour of incumbent providers, especially where there are long-standing relationships between commissioners and the local incumbent. This concern has been raised most frequently in relation to the commissioning of primary care contracts, where **conflicts of interest** may also arise.

3.4 Patient choice

NHS patients in England have extensive rights set out in the NHS Constitution to make choices concerning their care, and to information concerning those choices. Local commissioners are able to extend the areas over which patients have choices beyond those set out in the NHS Constitution.

In those areas where patients are able to choose from a range of providers, the ability of a provider to participate in serving patients depends largely on the extent to which patients are aware of their choices. Unless they are aware, incumbents will

[13] While longer contracts can be beneficial to service quality, they will not always be the answer. As commentators have pointed out, "Moving to new models of provision will require new models of contracts…and a more strategic approach to procurement…. [But] long contracts can [also] mean parties are stuck with each other and care needs to be taken not to remove incentives for improvement" Nigel Edwards and Robert Breedon, 'The NHS needs to think long term about contracts', HSJ, 26 Feb 2013.

continue to attract patients even when those patients might be better served by another provider. Participation is also affected by the extent to which commissioners choose to extend the services where patients are able to exercise choice.

3.4.1 Patient awareness of choice

In a survey of 5000 people conducted on behalf of the Department of Health in 2011, over 80% of respondents said they wanted more choice over where they are treated in the NHS. Nearly three-quarters of respondents said they wanted more choice over who provides their care.

However, not all patients know about the choices already available. In the same survey, less than 50% of respondents were aware that they could choose which hospital to go to for non-emergency treatment[14]. There is also some regional variation. The Department of Health's 2010 National Patient Choice Survey[15] showed that in some PCT areas, 70-80% of patients recalled being offered choice of hospital for a first appointment, compared to 10-20% in other areas[16].

Overall, the extent to which patients are being made aware of their choice of provider is difficult to assess. Until 2010, the Department of Health commissioned an annual National Patient Choice Survey, which has since been discontinued. Not all patients want to exercise choice and many will need the advice of expert advisors (most often GPs) to do so. However, given the role that awareness of choice of provider can play in ensuring that patients are able to reach the provider best placed to meet their needs, it would be beneficial to gather and publish information on the extent to which patients are aware of, and are exercising, their choices.

We heard from stakeholders that local commissioners sometimes diminish patient choice by seeking to influence referral patterns. Some try to direct patients to 'cheaper' providers, motivated by a desire to fill block contracts, and by Market Forces Factor (MFF) payments.[17] Previous studies reached similar findings.

> 'We saw many examples of PCTs excessively constraining patients' ability to choose.' (Review of the operation of "Any Willing Provider" for the provision of routine elective care, Co-operation and Competition Panel, 2011).

Within this context there is some evidence that the situation is improving in secondary care. A report for the Nuffield Trust by the Institute for Fiscal Studies, in 2012, reviewed the impact of patient choice between 2003 and 2011 and found that

[14] http://mediacentre.dh.gov.uk/2011/10/11/the-public-wants-more-choice-of-nhs-care/
[15] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_116958
[16] Some variation is to be expected, particularly where it is more difficult to facilitate a range of choices for patients, for example in rural areas with smaller populations.
[17] MFF payments are discussed in more detail in Chapter 4.

GPs were, on average, referring to 50% more providers in 2010/11 than in 2006/07.[18]

3.4.2 Extending patient choice

Local commissioners can help to extend patient choice in their areas by adding to the number of qualified providers on their local AQP lists or by adding to the list of services that may be provided by an AQP provider.

Evidence gathered in the Review suggests that some commissioners may be slow to realise the benefits of extending the areas where choice is available to patients, particularly for community-based services. This may be driven by a number of factors, including a strain on commissioners' capacity while CCGs prepare for authorisation. However, as more services move from being delivered in hospitals to being delivered in the community, further research to consider which services may be well-suited to extended choice through local AQP would help inform commissioners' decisions.

3.5 General Practice and associated services

Questions were raised during the course of the Review about the extent to which the current model for commissioning and delivering GP and associated services is operating in the best interests of patients. This subject cuts across each of the three areas we have looked at in this chapter.

The concerns we heard related to:

- the rules for setting up a general practice;
- the different contractual terms under which practices operate;
- the perceived reluctance of PCTs to commission new services against the wishes of existing local practices and Local Medical Committees;
- perceived conflicts of interest that may in future prevent clinical commissioning groups from commissioning services from new entrants; and
- concerns about a lack of choice of general practitioners for patients.

Further evidence is needed to establish the true nature and**3.6 Conclusion**

The Review considered whether opportunities for providers to participate in the delivery of health care services are being unduly limited by the processes commissioners use to procure services.

[18] This increase was driven in part by the establishment of Independent Sector Treatment Centres http://www.nuffieldtrust.org.uk/publications/choosing-place-of-care

We find that at the **strategic planning** stage and when developing **procurement strategies**, commissioners often fail to give due consideration to all available options. We also find that when new opportunities arise for providers to offer their services, non-incumbents may be disadvantaged, either due to poorly designed and implemented **procurement processes** or, where patients have a **choice** of provider, due to a lack of information on the range of available providers.

These limits on the opportunity for and ability of some providers to participate in the provision of NHS services mean that patients may not have access to the provider best placed to meet their needs.

In examining the reasons why opportunities are being unduly limited, we identify three root causes:

I. A lack of stability and support

Constant changes to the commissioning system create a strain on commissioners' capacity. When considered alongside short-term budget settlements, this leaves commissioners more likely to have a short-term outlook and less likely to think strategically about the long term benefits of change.

II. A lack of evidence, case studies and tools

Commissioners are frequently uncertain about the effects of changing current patterns of provision on the continuity, coordination and quality of care. The costs of change can seem significant and the benefits speculative. Commissioners lack evidence for how change has been successfully implemented elsewhere, and high-quality information to allow them to compare different providers or models of care.

III. Misaligned incentives

Commissioners tell us that the point at which they are most likely to encounter challenge to their procurement strategy is when trying to bring about change. This makes retaining the status quo the easier option, even when an incumbent is underperforming. This is reinforced by a lack of opportunity for patients to support the case for change and for other providers to know when contracts are being awarded so that they can offer alternative services where appropriate.

Our recommendations, set out in Chapter 2, are designed to address each of these three issues.

Chapter 4: Findings - Cost Distortions

This chapter assesses distortions that impose costs on some types of provider but not others[19].

Cost distortions generally advantage or disadvantage providers by their type of ownership. In general, we distinguish between three types of ownership – public, private, and voluntary and community sector. However, some provider types, such as social enterprises or mutuals, span more than one of these categories. Therefore, where appropriate, we look at the impact of distortions on these providers separately.

We investigated twelve factors that may cause cost distortions. We found that two of them - Value Added Tax and providers' cost of capital – create distortions that have an impact on patients, but both require further work in order to understand how best to address them.

Some of the other distortions also have an impact on patients but are already being tackled. These relate to pensions, clinical negligence indemnity, the provision of education and training, and accurate reimbursement for clinical services. In these areas, we emphasise that it is important that the proposed solutions are realised.

Stakeholders also raised a number of other cost issues which we found, on investigation, to warrant no action. These include corporation tax.

4.1 VAT

The VAT rules vary in how they are applied to public sector providers, charities and private sector providers. Providers of NHS-funded health care services do not charge commissioners VAT on the services they provide, but they do incur VAT on some of the inputs they purchase. Public sector providers can claim a rebate on the VAT charged on inputs classified as 'contracted out services' (COS), while other providers do not have access to this rebate. VAT rules do appear to distort opportunities to provide services to patients.

We also note two other issues raised by stakeholders. First, medical equipment bought with charitable funds by not-for-profit providers is zero-rated for VAT. The zero-rating is aimed at supporting charities in meeting their charitable objectives. In principle this may cause a distortion between these providers and for-profit providers. However, we have not been able to establish whether this distortion has a significant impact on patients and have not received any stakeholder submissions raising concerns about this issue.

[19] For more detailed findings and analysis about cost distortions please see www.monitor-nhsft.gov.uk/FPFR

Second, some drugs and other items are zero-rated for VAT when they are supplied outside a hospital setting. This creates an incentive for providers to offer items in a different setting, benefiting providers who have alternative distribution channels. Because all provider types are able to choose the setting of care, this does not constitute a distortion to the playing field for the purposes of this review. However, it is perceived as unfair by some stakeholders. It could also lead to inefficient provision as a hospital may pay a third party to administer drugs to the patient in their home solely to avoid the VAT liability, even though this incurs the additional costs of employing a homecare provider.

From our discussions with providers and the submissions to this review, we accept that cost differences arising from the VAT rules on contracted-out services affect the services available to patients. In some cases, providers' decisions on how and whether to provide health care services may be affected. In other cases, the effect of the VAT rules has been for providers to lose bids for contracts because of their higher costs when, VAT aside, they might have won the contracts.

The impact of any distortion caused by the rebate of VAT on eligible contracted out services depends on a provider's type and the extent of its contracted out services. Some told us that differential treatment for VAT was important to their organisations: it ranked among their most important issues for just over 10% of respondents to our discussion document.

> "Irrecoverable VAT makes services more expensive to the commissioner than if they use the NHS organisations, therefore this is a disincentive to commission or a barrier for providers to enter." (VCS provider)

We carried out some modelling to estimate the scale of cost disadvantages providers without access to the COS rebate might face. The modelling indicates irrecoverable VAT costs may add 1% to 3.5% to such providers' total operating expenses, depending on the structure of their costs. The modelling has some limitations. Nevertheless, when the results are added to the evidence from case studies and representations made by stakeholders, it is reasonable to infer that the VAT rules disadvantage some providers to a material extent, depending on the nature of the services they offer.

The COS rules are designed to assist efficient provision of services by preventing VAT from biasing public sector providers in their decisions to 'make or buy' certain contracted out services. As such, they should benefit users of health care services. This means that simply removing the COS rebate would replace a fair playing field distortion with a distortion to the efficiency of public sector providers: those providers might decide to keep in-house services such as legal and accounting even when outsourcing would (VAT aside) be better value and therefore better for patients.

Nevertheless, the distortions arising from VAT rules are potentially significant and may have a negative impact on patient care. Further work to understand them is justified. In the first instance, a distortion arises where the application of existing

rules has not kept pace with changes in the provision of health care services. In particular, where non-public providers are prevented by the operation of the VAT rules from offering services to patients, the existing rules imply the public sector should not be entitled to a rebate (as the rebate should not apply if the service provided is subject to alternative provision). However, where there are no alternative providers, legislation, though not the current rebate scheme, allows the option of a VAT rebate to charitable providers of services. The lack of such a rebate raises the cost to charities of delivering services.

4.2 Cost of and access to capital

All providers of health care need capital funds to finance their operations. Different types of providers have access to different types of fund, on different terms and at different rates. We set out the range of sources of capital available to different types of provider in Figure 6.

Figure 6. Sources of capital[20]

		NHS trust	Foundation trust	Private sector	VCS
Public capital	Grants				
	PDC				
	DH/FTFF loans				
Private capital	PFI				
	Bank loans				
	Bonds				
	Equity				
	Donations				

Providers told us that access to capital was important for their organisations and it ranked in the list of most important issues for 13% of respondents to our discussion document.

[20] Green shading means that a provider can and does access the source of funding. Orange shading indicates that providers can access this funding source but they do not make significant use of it. Red shading means that a provider cannot access the source of funding.

"Social enterprises in the health care sector have been established without a financial trading history which can significantly limit their access to capital as well as leave them at a disadvantage when competing with major private sector companies." (Representative body)

"The development of the social investment bank needs to progress more rapidly to provide access to capital for non-NHS providers of care such as hospices." (VCS provider)

We note that there are a number of new initiatives already under way that will help to alleviate this problem, for example:

- The Government is developing financial instruments that VCS providers may use such as social bonds and social capital investments; and
- Big Society Capital, funded largely by dormant bank accounts, was set up in 2012 to develop the market for social investment.

We received fewer representations on the cost of capital, with 8% including it among their most important issues in response to our discussion paper. There was a mix of views on whether the public sector had the lowest cost of capital, mainly due to perceptions that those public sector organisations with Private Finance Initiative schemes faced high charges.

"Public sector providers benefit from the strength of government backed covenants which results in a lower cost of capital when compared to independent sector providers." (Private sector provider)

"Traditional sources of capital view our operations as of higher risk, particularly when faced with the standard NHS contract tenure of 3 years. Typical market reaction is to increase the cost of capital, in some cases putting such capital out of reach of smaller providers." (Social enterprise)

Public providers largely access public sources of funds at rates set by government, while private providers largely access private sources of funds at rates that are set by financial markets. Our analysis suggests that the gap between the two rates in aggregate may represent an advantage to public providers of around 1% to 2% of operating costs. More notably, lending to private or VCS providers regularly varies by individual provider according to their riskiness, whereas lending to public providers by government largely fails to differentiate between the riskiness of different providers. This creates a distortion where providers with similar levels of risk face different costs of capital.

4.3 Pensions

Employees of public providers have access to the NHS pension scheme. Public providers contribute 14% of pensionable pay to the NHS pension plan for each of their enrolled employees. To fund a broadly comparable pension in the private sector we estimate would require an employee contribution of between 22% and 27%.[21] The NHS pension plan is thus subsidised by the Exchequer.

If a private sector or VCS provider were to win a bid to take over an existing NHS service then, under TUPE rules, it would be required to offer a broadly comparable pension to those staff transferring. This would cost the new employer more to provide than it would another public provider taking on those staff. This extra cost is compounded by uncertainty about the value of the pension transfer, which may mean that the acquiring provider would also have to make a lump sum payment to top up pensions at the point of transfer. Some private providers told us that these additional costs they face under TUPE rules are often 'a deal breaker'.

More generally, wherever private or VCS providers must offer terms similar to those of NHS providers to employees, they face significantly higher costs. These may add 3.5% to 7.5% to a provider's cost base, depending on the size of its employment costs relative to other costs.

This was raised as a significant issue by a number of stakeholders.

> "Pensions…is the number one problem in trying to attract new suppliers. It can make a 20 to 30% difference, which really can outweigh any efficiency of a new provider." (Commissioner)

However, one representative body argued that non-public providers are not always disadvantaged. For example, where private providers do not have to match the public offer because of local labour market conditions, they may choose an alternative pension scheme that is not so costly. There is evidence that private providers do make use of this flexibility in such circumstances where, typically, private providers pay contributions that vary between 4% and 7% of pay.

We conclude that pensions are a potentially significant distortion. They clearly represent a hurdle to providers bidding to take over services where they would have to maintain the same level of pension benefits as a public sector provider. Recent announcements by the Department of Health suggest that changes to the 'fair deal' scheme on pensions are set to allow former NHS staff who TUPE transfer into VCS and private providers continued access to the NHS Pension Scheme. This would resolve the distortion depending on the terms of that access (including the employee contribution rate).

[21] The equivalent private contribution depends on a number of actuarial assumptions about the profile of the workforce and so the range reflects different scenarios for the workforce, as well as input from stakeholders about their costs. For more detail please see www.monitor.nhsft.gov.uk/FPFR.

In those situations where a TUPE transfer is not involved, the cost distortion can operate in both directions. In tight labour markets, non-NHS providers are disadvantaged as they have to offer NHS-equivalent pensions but face the full cost of doing so. In less tight labour markets, non-NHS providers may be advantaged because they can offer cheaper pensions. At present it appears that, in aggregate, non-NHS providers are disadvantaged.

4.4 Indemnities (clinical negligence)

All providers need to make appropriate indemnity arrangements to cover claims for clinical negligence. The Clinical Negligence Scheme for Trusts (CNST) currently offers indemnity for all public providers against clinical negligence claims. Private and charitable providers do not in the main have access to CNST[22] and have to obtain private insurance cover. If it were the case that, in some circumstances, private indemnification was cheaper than CNST, the resulting distortion could be removed by also making it straightforward for members to exit the scheme.

Access to CNST was not raised as a major issue by many stakeholders. About 5% identified it as important to their organisation. We considered two potential distortions in relation to CNST.

First, we investigated whether public providers' access to CNST created an advantage to them. We sought to compare CNST and the most comparable private insurance options, although differences in the way that CNST and private insurance operate make the comparison difficult. However, any difference looks set to become much less important as the Department of Health has laid regulations that will make access to CNST available to most independent sector providers[23].

Second, we examined the contributions made by different public providers to CNST. These vary widely across providers in ways that are not clearly tied to their risks. The main determinant of CNST contributions is whole-time equivalent (WTE) staff numbers. This may result in public providers with otherwise similar risk profiles facing different costs for their clinical negligence indemnity. However, the NHS Litigation Authority, which operates CNST, appears to be moving to correct this.

4.5 Education and training

Stakeholders observed that 'the delivery of integrated and high-quality care depends upon a solid programme of medical education'. A number of responses to our initial

[22] There are some arrangements whereby non-public providers can use commissioners' access to CNST in order to access it themselves. These "back-to-back" indemnities are used in some areas of care (e.g. under Any Qualified Provider arrangements).
[23] Some self-employed staff will not have access to the scheme. As individuals rather than provider organisations they fall outside the scope of this review. http://www.legislation.gov.uk/uksi/2013/497/made

request for evidence and discussion paper expressed concern about aspects of the future provision of education and training. These included two significant potential distortions related to NHS funded clinical care provision. One concerns the funding of education and training and the other concerns the opportunity to deliver it.

Most of the Government's education and training budget is allocated to public sector providers. There is no requirement that stops non-public providers from providing education and training and, in theory, the ability to deliver clinical training is open to all suitable providers. However, some providers experience difficulty when they try to deliver training in practice. One large charitable sector provider told us it had struggled to access trainees despite being recognised as a high quality provider.

> "We are the largest provider of joint replacements in the region. They will let us do the operations but we can't train the staff that perform those operations! I think what is going on is that the local acute don't want to let the trainees go as they use them to help deliver services on the cheap." (Charity)

Some stakeholders complained that state funding for the training and education of doctors and nurses in England subsidises independent sector providers, since they are able to access highly trained staff without contributing to the costs of their training. In fact, this concern would also apply to any NHS organisations that are not themselves providing education and training. In fair playing field terms, this funding arrangement would only disadvantage those health care providers that carried out education and training over other types of provider if their training and education costs were not reimbursed adequately. In this case, health care providers that carried out training and education would be subsidising those providers that did not.

Some stakeholders are also concerned that the funds allocated for education and training overcompensate some providers. If that were the case, this would also be a distortion of the playing field.

The Department of Health has calculated an average cost tariff of about £35,000 a year for each undergraduate clinical placement, with only limited variation around this average. It also believes that this figure is just under the average reimbursement (a difference it is seeking to correct). This means that there appears to be no cost advantage for those providers that do not provide education and training. However the reimbursement per undergraduate varies across trusts from £10,000 to £90,000 a year[24], confirming that there are distortions among those that provide education and training.

The second possible distortion in this area arises from the reputational benefits gained from providing education and training, which are not available to any provider that finds it cannot provide education and training. This benefit was acknowledged by a large public sector teaching hospital, which told us that offering education and training made recruiting and retaining the best staff much easier.

[24] "Introduction of tariffs for education and training" Impact Assessment, January 2013

The lack of transparency concerning the costs and allocation of funds makes both difficult to analyse.

> "The current arrangements under which providers are paid by the NHS for education and training are anachronistic and anomalous … and there is an almost total lack of transparency about how [funds are] spent[25]." (Health Committee, May 2012)

We think it is reasonable to conclude on the evidence available that some public providers are over-compensated for the training and education activities they provide and some public providers may be under-funded. However, the extent to which the current education and training funding arrangements creates distortions *between* types of provider is unclear.

A new body, Health Education England (HEE), is responsible for developing a policy for allocating funding more transparently to new Local Education and Training Boards (LETB). HEE is developing cost-reflective tariffs covering all main areas of education. It intends to make training funds available to all providers of NHS-funded services that are capable of delivering high quality training, regardless of their form of ownership, and to reimburse them for training according to the new tariffs. These changes will take some time to implement in full but, if successful, should resolve both the possible distortions that result from current arrangements for funding and delivering training.

4.6 Corporate taxes

Private sector and some VCS providers can be liable to pay corporate taxes that public providers need not pay.

The Review examined three taxes: corporation tax, stamp duty land tax (SDLT) and capital gains tax (CGT). Of the three, the stakeholder feedback concentrated on corporation tax and so SDLT and CGT are not discussed further here[26].

Stakeholders raised a variety of issues concerning corporation tax. Some thought different treatment of providers might increase the prices charged by private sector providers and social enterprises. Two VCS providers suggested this was a particular issue for social enterprises.

> "As [private and some VCS providers] pay corporation tax, commissioners say that '£1 of money to them is less than £1 worth of services to the patient." (Social Enterprise)

[25] Health Committee. 23 May 2012. Education, Training and Workforce Planning, Volume 1
[26] For more detail please see www.monitor-nhsft.gov.uk/FPFR

Any significant difference in taxation for different providers might affect patients in two ways. First, it might mean that high-quality providers that have to pay corporation tax may not be able to win contracts to provide their services to patients. Second, it might mean that some providers may be limiting investment in particular services because of their higher costs.

In practice, many public providers do not earn surpluses and so would not pay any corporation tax even if they were to become liable. Of those that might have tax to pay, we estimate their tax payment would at most amount to 0.9% of their operating costs and would probably be much less.

Analysis of the accounts of a number of private sector providers covering primary, community and acute care suggests that few earned a profit in their most recent complete financial year. Of those providers that did pay corporation tax, the amount they paid was in most cases low in relation to their operating costs.

While the different liability for corporation tax of different providers could, in principle, affect services provided to patients, we have not seen enough evidence to justify recommending a change to corporation tax rules.

4.7 Pay and benefits

Ten per cent of respondents to our discussion document said compensation was one of the most important issues for their organisation. Generally, the concerns they raised were about the constraints that rules on pay and benefits place on public providers.

> "Trusts now have a pressing need for the NHS to start discussing the different ways we could set pay, terms and conditions." (Representative body)

The employee pay and other benefits (such as annual leave or sick pay) for public providers are negotiated centrally and agreed in the 'Agenda for Change' (AfC). The AfC is negotiated by unions, employers and government.

NHS trusts and foundation trusts are able to depart from AfC terms and conditions but in the main they offer the standard terms, conditions and pay scales. One possible exception is in the South West, where nineteen trusts are taking part in the South West Pay Terms and Conditions Consortium. This was set up in June 2012 to consider the pay and conditions for NHS staff in South West England.

Some private and VCS providers told us that they benchmark their pay and benefits packages against those offered by public sector providers and that they need to match these to recruit staff. Others said that their offer depends more on local labour market conditions.

While many public providers feel there is a strong case for more flexibility in rules on pay and benefits, it is not clear that the levels of pay and benefits offered between provider types reflect a fair playing field distortion.

4.8 Reimbursement for NHS-funded services

National and local reimbursement arrangements determine how providers are paid for the NHS-funded services they supply. In this section we focus on three mechanisms that are used to pay providers for acute, mental health and community services: Payment by Results (PbR) and adjustments; block contracts; and local tariffs[27].

Under PbR, providers are paid for each service they perform. The amount they are paid is based on the estimated average cost for performing that particular service and similar services. This average is calculated from a set of reference costs supplied by providers. Centrally determined additional payments are made for a range of purposes including to reflect variations in local market costs (the market forces factor), to reflect higher levels of specialism and to reflect higher quality.

Under block contracts, providers are typically paid for making available an amount of capacity irrespective of how much is used. These payments are often set with reference to historic funding levels.

Local tariffs can involve payments for treating an episode, a spell of treatment or an entire treatment pathway. These payments are set through local negotiation. Sometimes reference costs are used as a starting point in these negotiations.

It is critical that providers are fairly remunerated for the services they deliver. In practice, this means that the prices paid to providers should reflect the efficient costs of providing services. Where the prices paid to providers do not reflect efficient costs – for example as a consequence of treating a 'non-average' mix of patients – there is a risk that some providers will be over-remunerated and some providers will be under-remunerated for the services they provide. This can lead to too much supply of some services (inefficient entry and expansion) and too little supply of others (inefficient exit and contraction). Both would be against patients' interests.

Therefore, good reimbursement mechanisms – supported by high quality cost information and robust commissioning – are central to the effective provision of health care services and a fair playing field. Accordingly, a significant amount of work is on-going to improve the way that providers are reimbursed for the health care services they provide.

Stakeholders raised two potential fair playing field distortions arising from the way NHS services are paid for:

[27] For more detail please see www.monitor-nhsft.gov.uk/FPFR

- the way that PbR tariffs are adjusted for the '**market forces factor'** might distort the playing field; and
- that some providers might be over- or under-compensated for the **mix of patients** they actually treat (sometimes referred to as 'cherry picking').

4.8.1 Market forces factor

This issue was raised by 4% of respondents to the initial call for evidence and 10% of respondents to the discussion paper ranked it as among the most important potential distortions that their organisations face[28]. Respondents were concerned that imperfections in the way that MFF is calculated could mean that some providers are over- or under-compensated given the actual costs they face.

> "The existing MFF structure appears inconsistent and illogical. Almost all NHS staff are now paid in accordance with the nationally mandated Agenda For Change pay structures. Local variation in this respect therefore does not arise." (Public sector provider)

While it may be possible to improve the way the MFF is calculated, it is unlikely to systematically disadvantage one type of provider over another. The way it is applied means that all providers receive the same (accurate or inaccurate) MFF for a given area. Nevertheless, there are good reasons to continue work to ensure that the prices paid for NHS-funded services accurately reflect unavoidable cost differences of treating patients from different areas.

4.8.2 Mix of patients

Under PbR, the prices paid to NHS providers are, in general, intended to reflect the average cost of providing a service. But differences in the characteristics of patients mean that some are more costly to treat than others, for example, due to complications or comorbidities.

There is evidence of significant differences in the costs of treating patients whose treatment fall under a single PbR tariff. This raises the possibility that some providers will be under-compensated and some providers will be over-compensated by PbR. The certainty of receiving an average price combined with the possibility of treating below average cost patients may also incentivise providers to target low-cost patients and avoid high cost patients ('cherry picking').

Five per cent of people responding to our discussion document listed this issue as one of the most important for their organisation.

[28] This included concerns that MFF distorts referral patterns which are considered further in Chapter 3.

"Incorrect cost allocation, even when it adheres to national guidance, disadvantages providers who undertake a more complex case-mix than the average. This is because of the tendency for trusts to apportion ward based costs of nurses, medical staff etc. to patients on an average basis rather than by reference to the greater nursing and medical input the more complex patients inevitably receive. The averaging of costing leads to a less refined national tariff and therefore an under-reimbursement of specialist work and a relative over-reimbursement of routine work." (Public sector provider)

There is evidence that private sector providers tend to treat relatively more lower cost patients than public sector providers, sometimes as a result of agreeing exclusion criteria with commissioners. Additionally, some public providers told us that, "typically we deal with the hard cases when things go wrong in private providers."

In theory, the flexibility to agree exclusion criteria with commissioners is available to all providers, including public providers[29]. This flexibility is important for ensuring that patients receive safe and effective care, with patients with the most complex needs treated by providers with the requisite range of services and expertise. Commissioners have flexibility to agree a lower price for providers with exclusion criteria in their contracts to reflect the adjusted case mix.

While there is some anecdotal evidence of individual providers without appropriate exclusion clauses in their contracts selecting 'cheaper' patients to treat and sending more complex and costly cases to other providers, we are not aware of this taking place systematically. Rather, the evidence suggests that the distortion relating to case mix arises because there are inevitable variations in the case mix of different providers and this is not reflected in the national tariff. This remains an important problem as it means that some providers, most often (but not always) public providers, will be systematically under-reimbursed relative to others.

The evidence we have gathered therefore reinforces the need for the work on improving the reimbursement system that the Department of Health, Monitor and the NHS Commissioning Board are currently undertaking. In particular, a proper understanding of the costs of services subject to tariff is required to address the concerns outlined above. If prices reflected the actual costs of cases treated, rather than the average, distortions would be removed. Monitor has recently issued initial guidance to providers about how to allocate the cost of their services to individual patients as a first step in making the tariff more cost reflective.[30] Our approach will evolve as the quality of cost data improves.

[29] In practice many public providers are subject to service obligations. These are discussed in Chapter 5.
[30] http://www.monitor-nhsft.gov.uk/costingguidance

4.9 Other matters

The Review also considered the following factors that may affect costs:

- the timing of payments received by different providers, to understand whether certain providers receive money due to them later than others. If so, they may incur higher operating costs to the detriment of patients;
- the IT infrastructure and access to IT required to carry out NHS services. There was some concern among stakeholders that access to the NHS IT spine needed to carry out NHS services (the so-called N3 connection) was not fair across different types of providers; and
- whether access to R&D funding was different for different types of provider.

Our analysis of the stakeholder submissions we have received and the available evidence suggests that none of these are fair playing field issues that also have a significant negative impact on patients.

We analysed payment timings and could not find evidence of systematic differences in the timing of payments by provider type. We have seen evidence that there is a potentially significant regulatory burden associated with getting an initial N3 connection for organisations starting to provide NHS care. However, that burden may be necessary to protect patient confidentiality and sensitive medical records. It is an issue that should be kept under consideration but is not a priority for this review.

Finally, the wide range of R&D funding is available to all providers with the capability to act as a research sponsor. As such there does not appear to be any fair playing field issue associated with access to research funding.

Chapter 5: Findings - Flexibility Distortions

5.1 Introduction

Flexibility distortions may affect a provider's ability to respond to changing patient needs or the changing requirements of commissioners. This chapter examines externally imposed constraints on the flexibility of providers that do not equally constrain all provider types[31].

Providers told us of a range of flexibility constraints, which fall into four groups:

1. difficulty securing access to some types of staff and facilities. We refer to these as **constraints on inputs**;
2. **burdens imposed by external requirements**, such as the requirement to respond to Freedom of Information requests;
3. barriers to **changing services**; and
4. **the policy environment and central control**.

Public providers were generally more concerned by constraints on their flexibility than other provider types, although private providers were concerned by constraints on inputs. Public providers are more affected by externally imposed requirements and barriers to changing their services than other types of provider. They are also more affected by government priorities and changes to those priorities on a day-to-day basis, although all providers are affected by uncertainty about longer term government policy.

One public provider told us that because foundation trusts are 'directly accountable to the public' there was a level of intrusion in, and concern surrounding, their decisions that was not mirrored by the scrutiny of private or charitable providers. However, other stakeholders suggested that constraints on public sector providers arose not from flexibility distortions but from weak leadership.

There may be some truth in both perspectives. In practice, we have found it difficult to distinguish the internal constraints created by the institutional culture of public providers from the externally imposed constraints of particular rules and obligations affecting them. Our recommendations in Chapter 2, therefore, propose measures intended to reinforce the freedoms that public providers already have and to encourage them to make use of their freedoms.

The rest of this chapter sets out our findings on each of the four groups of flexibility constraint.

[31] For more detailed findings and analysis about flexibility please see www.monitor-nhsft.gov.uk/FPFR

5.2 Constraints on inputs

Private sector providers expressed concerns about constraints on access to staff and facilities. It is not clear that these constraints constitute a significant fair playing field distortion. Individual cases may warrant future action by Monitor to enforce the provider licence.

5.2.1 Access to staff

The particular concerns we heard related to the use of medical consultants. For example:

> "The NHS is the only significant employer of secondary care consultant grade medical staff. The NHS has therefore been able to use this market power to restrict consultants from providing services to independent providers." (Provider)
>
> "Virtually all English consultants are employed by the public sector. It is not easy for the private sector to recruit." (Provider)

Our conversations with stakeholders suggested that the career opportunities offered by large public providers, accompanied by access to the NHS pension scheme, make public providers more attractive full-time employers to NHS consultants than other types of provider. This means that independent providers often rely upon part-time or loaned staff. However, we consider the attractiveness of large public providers to employees an endowment[32] and therefore not a distortion of the playing field.

If public providers improperly restrict their staff from working for other employers in their non-contracted hours, then this would be a barrier to the participation of alternative providers. The Co-operation and Competition Panel (CCP) investigated this issue in 2009. It ruled that only in specific circumstances were these kinds of restriction in patients' interests. Since then, no formal complaints about this issue have been brought to the CCP, and only 3% of respondents to our discussion document considered constraints on inputs to be a major issue[33]. The recent absence of complaints about this issue suggests it is not material to providers, although we will keep the level of complaints under review.

[32] For a definition of endowments see Chapter 2 of this document

[33] Stakeholders raised many general problems about a lack of flexibility in pay and benefits and the constraints these impose on providers, mostly those in the public sector. We cover these types of concerns in Chapter 4 of this report and make a recommendation on pay flexibility in the flexibility section of Chapter 2.

5.2.2 Access to facilities

Stakeholders expressed divergent views on this issue. Some of those seeking to enter new areas highlighted the problems they face in acquiring buildings and facilities when bidding against an incumbent.

> "[The public sector] has an advantage in terms of barriers to entry in being the incumbent provider. From a commissioning point of view, a solution is for greater commissioning control or ownership of capital in the delivery of services, for example buildings." (Private provider)
>
> "When tendering for contracts the NHS providers have a distinct advantage, having access to NHS buildings, well placed within local communities, whilst we have to source and refurbish new premises, all at market rates." (VCS provider)
>
> "Social enterprises in general, but specifically those created through the Right to Request process, do not own either the land, building, equipment or assets they use to provide their service. […] The agreement and management of so many leases is lengthy, time consuming and expensive […] Not owning assets means that social enterprises lack strength on their balance sheets when compared to other NHS providers." (Provider)
>
> "There are community hospitals that are empty but because the trusts own them we can't get access." (Private sector provider)

Others were more positive. For example, one noted that there is available capacity "in many GP and NHS community buildings and on some hospital sites."

Incumbent providers with endowments of land and facilities inevitably find it easier to offer services to patients than providers without such endowments. The latter's lack of access to facilities is only likely to have a negative effect on patients when it prevents their entry to, or expansion in, a service or location. Stakeholders told us that many of the services they want to offer could be provided at a number of different facilities. They often choose to locate in or next to publicly owned facilities because of the benefits of clustering, not because of a lack of alternatives.

We would need further evidence to establish that a lack of access to facilities constitutes a significant distortion to the playing field. As with access to staff, further work by Monitor in this area could be triggered by a complaint supported by evidence that lack of access to facilities is working against the interests of patients.

5.3 Burdens imposed by external requirements

Around 10% of respondents to our discussion document listed regulations and obligations constraining the way services can be delivered as one of the most important issues for their organisation. Public sector providers feel more

disadvantaged by these constraints than other types of provider. The matters they raised include[34]:

- complying with Monitor's provider licence;
- transparency requirements;
- reporting requirements;
- complaints procedures; and
- procurement obligations.

5.3.1 Complying with Monitor's provider licence

Monitor's licence serves two broad purposes. First, it provides the basis for governance (that is, shareholder-like) oversight of publicly owned foundation trusts. Second, it provides the basis for enforcing rules in areas such as cooperation, competition and pricing for all providers (except NHS trusts and smaller providers, which are exempt).

The Review encountered three different types of concern about the licence from a fair playing field perspective[35]:

- First, that it was being introduced for foundation trusts before other providers, 'putting foundation trusts at a disadvantage'.

- Second, that providers, including NHS trusts and smaller providers, would be exempt from the licensing regime altogether; and

- Third, that the foundation trust governance conditions placed higher burdens on foundation trusts than other providers.

While it is true that foundation trusts will be licensed one year before other providers, this is unlikely to affect patients negatively. For a difference between providers to have an impact on patients it must affect the decisions that providers and commissioners make. Because a year is too short a period to affect strategic decision making, it seems reasonable to conclude that the staggered introduction of the licence will make little difference to patients.

It is also true that NHS trusts that have not yet achieved foundation trust status are exempt from holding a licence until they do. However, in the interim the TDA will oversee governance of NHS trusts, and the Department of Health and the TDA have agreed that NHS trusts will be required to comply with the other standards and rules set out in the licence just like other providers This exemption for NHS trusts, therefore should not create a fair playing field distortion between providers.

[34] Emergency planning was also raised but the arrangements for it created no differences on the basis of provider type.
[35] Concerns about the approach to commissioner requested services in the context of the licence are examined later in this chapter under barriers to service reconfiguration.

The Department of Health has also exempted providers from the licence if they have an annual NHS turnover of £10 million or less.[36] It has taken this step to ensure that regulatory resources are focused most appropriately and that the burdens of regulation are proportionate. However, a review of the exemptions criteria in 2016-17 will consider whether there is a sufficiently consistent approach to exemption across provider types. Monitor will be in a position to judge the implications of the exemptions regime for the playing field after that review is completed.

Stakeholders were most concerned about the third issue, that foundation trust governance conditions placed higher burdens on foundation trusts than other providers. The foundation trust governance conditions are designed to allow Monitor to act on behalf of the Department of Health to protect the taxpayers' interest in public providers. These conditions do not introduce significant new burdens, since they replace the standards of governance previously required under the terms of authorisation, that is, we continue to act in a shareholder-like role. However, because this aspect of the licence applies only to public providers, it creates a clear difference in the requirements imposed on foundation trusts versus other provider types.

It is our view that this does not represent an unfair distortion of the playing field that has a negative impact on patients for two reasons. First, although it is true that governance oversight does vary by provider type, all providers are subject to some form of oversight. Indeed, the shareholder oversight of an operating unit in the private sector might be as or more burdensome than that of a foundation trust. Second, an independent assessment of the likely effects of introducing the provider licence[37] found that the costs of complying with these governance conditions are likely to be outweighed by the benefits to the foundation trusts resulting from likely improvements to performance, which then benefit patients.

5.3.2 Transparency requirements

Public providers to whom we spoke did not raise transparency as a major issue, but where it was raised the focus was on the problems and costs resulting from the Freedom of Information Act 2000 (FOI).

> "We do find, as I believe most other bodies do, the compliance with FOI regime extremely arduous, and fruitless much of the time." (Public sector provider)

The costs they identified include legal advice and the amount of chief executive time consumed by FOI. They also noted that anxieties about FOI could inhibit staff from communicating openly with each other internally, creating some inflexibilities in decision-making.

[36] https://www.wp.dh.gov.uk/publications/files/2013/03/130227-Licensing-consultation-response.pdf
[37] PwC (2012), 'Impact Assessment – the new NHS provider licence', September, p. 113.

Unlike public providers and general practitioners, most private and VCS providers are not directly subject to FOI requests. The new NHS standard contract does contain a requirement for all NHS-funded providers to supply information to commissioners who are subject to FOI requests. However, some stakeholders were sceptical that this requirement would be implemented in such a way that all provider types would face the same transparency obligations.

5.3.3 Reporting requirements

As well as FOI, public providers have some other reporting requirements that other providers do not face, including the submission of reference costs and financial planning information. These appear to impose some additional costs but not to constrain flexibility unduly. The NHS Confederation has concluded there is "little difference between the burdens faced by public and independent health providers".[38]

5.3.4 Complaints

Stakeholders observed that complaints by patients about private and charitable providers do not fall under the jurisdiction of the Parliamentary and Health Service Ombudsman. This could create a fair playing field issue if it means that some providers have fewer requirements with which to comply, where compliance with those requirements would be in the best interests of patients. In fact, the Ombudsman's jurisdiction does extend to all NHS-funded care, including that delivered by private and VCS providers, but in the case of providers which rely largely on grants and private donations the jurisdiction of the Ombudsman is unclear. We have not produced recommendations on this issue as it is expected that the on-going review of complaints procedures will help resolve it[39].

5.3.5 Procurement obligations

Public sector providers are required to secure external services through a competitive process, including advertising in the Official Journal of the European Union (OJEU), when the lifetime value of the contract exceeds 400,000 euros. In our workshops with stakeholders we encountered evidence that the time and costs of this process result in some providers doing things in a sub-optimal way, or not doing them at all. However, the ultimate impact on patients is not clear and, in any case, the intention of these requirements is to ensure that such procurements achieve best value, which should always be in patients' interests.

[38] NHS Confederation and IHAS (2009), 'What's it all for? Removing unnecessary bureaucracy in regulation', p. 18.
[39] http://www.dh.gov.uk/health/2013/03/nhs-complaints/

5.4 Barriers to changing services

Distortions arising from the constraints public sector providers face when they contemplate changing or stopping services were seen by 8% of respondents to our discussion document as one of the most important issues facing their organisation. The particular barriers that stakeholders raised in discussions were the obligations on providers to continue to deliver certain services and the limits on their freedom to change services.

Foundation trusts are currently obliged to supply a set of mandatory services, while private and VCS providers are not. With the introduction of the provider licence, mandatory service obligations will be replaced by obligations to provide commissioner requested services (CRS). These obligations may be placed on any type of provider, which will, in principle, remove the differential treatment by provider type. However, this change will take a number of years to implement and some stakeholders fear that inappropriate incentives or skills among commissioners mean that the differential treatment may never be fully corrected. In order to guard against this risk Monitor has committed to review the operation of CRS next year.

However, although foundation trusts can apply to have mandatory services de-designated, and will be able to do the same for CRS, many argue that because they are the de facto provider of last resort for many services, there is no point – and indeed it would not be appropriate – to ask for this obligation to be lifted.[40]

> "Even if the concept of [commissioner requested] services were removed, existing providers may feel a moral or social duty to continue to provide an uneconomic service, particularly if there is no alternative provider available as this would lead to a gap in NHS provision." (Public sector provider)
>
> "Probably the most significant distortion to a fair playing field is…the requirement…to provide emergency care, frequently running at a loss." (Public sector provider)

Even where public providers do seek to stop or change the way services are delivered, they told us that they must meet more onerous legislative requirements to make those changes and than other providers.

> "Rightly, it would not be viewed as appropriate for politicians to intervene in the business decisions of private companies providing NHS services, or VCS providers. However, for NHS providers reconfiguration issues can quickly become the subject of intense political debate…This can place NHS providers at a competitive disadvantage." (Representative body)

In practice, the requirements for public and other providers are not significantly different. However, the aggregate burden on the public sector is much greater, mostly because they provide nearly all services which are seen as 'essential'.

[40] Monitor has never received a request from a foundation trust to reduce its obligations.

We find that there is not a significant distortion of the playing field in regard to the stopping or changing of service provision that causes direct harm to patients. Public providers are subject to greater burdens and inflexibilities in this area, but this fundamentally stems from their position as the dominant providers of essential services. Were this to change, the burdens and inflexibilities would fall elsewhere.

Nevertheless, the requirement – actual or de facto – to continue to provide services, even when loss-making, may lead to patient harm, as may the difficulties arising when providers seek to change service configuration. Such harm would arise if, for example, it led to inefficiencies in service provision continuing rather than being addressed. This would absorb resources that otherwise could be used to provide more or better care. There may also be harm if desirable increases in specialisation are prevented. However, these are not fair playing field issues, although they should be examined.

5.5 The policy environment and central control

Central government has a stronger influence over public providers than over other types of provider. However, uncertainty about the direction of policy constrains the flexibility of all providers.

5.5.1 The influence of the centre over public providers

The role of central government in the governance and financing of public providers places unique restrictions on them.

> "Despite all the other distortions to the playing field we face, I would not switch to running a public provider." (Private sector provider)
>
> "In the public sector there were a room full of people telling me what I couldn't do." (Private sector provider)

The Government has greater scope to influence NHS trusts than foundation trusts. NHS trusts are currently accountable to Strategic Health Authorities (SHAs) and will shortly be accountable to the TDA. Both have significant influence over the operations of NHS trusts including through performance management, making senior appointments and approving capital projects. Both the SHAs and the TDA are subject to direction by the Secretary of State for Health.

Foundation trusts were created to devolve decision making from central government to local organisations and communities. Foundation trusts:

- cannot be directed by government and have greater freedom than NHS trusts to decide their own strategy and the way services are run; and

- are able to retain their surpluses and borrow to invest in new and improved services for patients and service users.

Foundation trusts are accountable to their local communities through their members and governors and to Monitor, through our shareholder-like role. All providers are accountable to commissioners through their contracts.

However, the Department of Health has historically exercised some influence over foundation trusts through a range of policy initiatives (such as the deep clean programme to reduce MRSA), ad hoc schemes (such as critical infrastructure reviews) and funding decisions. Foundation trust chief executives are also subject to policy influence as accounting officers. As such, they are subject to rules created and enforced by HM Treasury. For example, they require Treasury approval for any non-contractual payments to departing staff and are required to take a 'whole public sector' perspective on value for money matters.

Foundation trusts have told us that they do not feel free to operate independently of political pressures:

> "A key barrier to change is the level of political interference at a local and/or national level. If an MP is campaigning for or against something then the drive to see the change through lessens, which is not the case in the private sector." (Representative body)

By transferring powers from the Department of Health to the NHS CB and Monitor, the Health and Social Care Act (2012) reduces government influence. However, some stakeholders have expressed concerns that 'the centre' will continue to exercise discretion over notionally autonomous public providers. Stakeholders were also anxious about the way new national bodies with authority over health care would 'flex their muscles'.

> "The same people are doing the same jobs with different labels." (Provider).

It is clear that NHS trusts and foundation trusts are exposed to higher levels of central involvement in their decision making compared to other types of provider. Unless the Act is implemented in full, this distortion may endure. Our recommendations are therefore designed to ensure that the decentralising intentions behind the roles and responsibilities assigned to new and existing institutions are honoured.

5.5.2 Policy uncertainty

Five per cent of stakeholders listed policy uncertainty as a major concern in response to our discussion document. Stakeholders voiced this concern particularly in the context of investment decisions.

"Policy instability is a real issue for our parent company. It makes it very difficult for them to go ahead with longer-term investments in the sector." (Private sector provider)

"… the roles of the NHS Commissioning Board and of CCGs should be clarified… in order to maintain the confidence of all providers. For example, the policy around 2007 to allow any willing/ qualified provider to provide NHS-funded elective surgery, combined with a tariff and patient choice, has given private and charitable providers confidence to make long-term investments…" (Public sector provider)

Different governments will inevitably have different views about the appropriate way to deliver public services, creating policy uncertainty. This uncertainty affects all providers, some more than others. In particular, it affects public providers, because they are subject to more central influence, and it affects new entrants, because investment decisions are more likely to affected by uncertainty.

5.6 Conclusion

The extent of the effects of flexibility distortions on providers is hard to determine. None of the externally imposed restrictions on providers' inputs, requirements and service changes examined in this chapter emerge as a significant distortion in isolation. However, their cumulative effect may reduce flexibility more significantly, especially among public providers. The policy environment also constrains the flexibility of public providers more than other providers, although to what degree is unclear.

Even among public providers it is not clear to what extent perceived constraints are external, rather than self-imposed. Strong leaders of some public providers are acting with fewer apparent constraints than others, and driving up standards of care and efficiency. What is clear is that NHS trusts have less flexibility than foundation trusts.

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