A fair playing field for the benefit of NHS patients

Supplementary paper

March 2013

Stakeholder Engagement

Fair Playing Field Review - Stakeholder Engagement

Introduction

The work conducted by Monitor for the Fair Playing Field Review took place over a period of 10 months to March 2013. During this period we engaged with over 200 organisations across the health care sector and beyond.

This document is sets out the rationale for and our approach to engaging with stakeholders.

The importance of stakeholder engagement

In keeping with the request from the Secretary of State for Health[1], Monitor placed engagement with stakeholders at the heart of our approach to conducting the Review. We recognised this was important for a number of reasons.

Identifying potential distortions. The remit of the Review was to examine any matters that might affect the ability of providers to provide health care services for the purposes of the NHS. However, the set of matters to be examined was not specified in advance. Previous reviews indicated some issues that would need examining, as did the campaigning by charities that led to this review. However, we recognised that developments since previous reviews, not least the changes introduced by the Health and Social Care Act (2012), meant that former issues may have changed and new ones developed. It was essential for us to be open-minded and listen to views from across the sector if we were to generate a comprehensive list of issues to examine.

Understanding stakeholder perceptions. Of the many issues raised by stakeholders during the course of the Review, not all proved, in our judgement, to represent distortions to the fairness of the playing field. We felt that some issues, while legitimate areas of concern or debate, fell outside of the remit of the Review. In other cases, further examination suggested that current arrangements either did not systematically distort the playing field or, if they did, had no negative impact on patient care.

Stakeholders sometimes had very different perspectives on the nature of particular issues. Listening carefully to those different perspectives has allowed us to respond to the issues that matter to stakeholders, and to explain which issues fall within the

[1] See “A fair playing field for the benefit of NHS patients”, Chapter 1 – Introduction, at http://www.monitor-nhsft.gov.uk/fpfr

remit of the review and which of those, in our view, have a material impact on patient care.[2]

Understanding how issues vary by setting. The Review has covered a very wide set of issues. In total, we examined 19 different areas, ranging from the cost of capital and the rules governing access to the NHS Pension Scheme to service obligations on public providers and strategic planning by commissioners. We have examined the impact of current arrangements in each of those areas on the ability of different types of provider to participate in the delivery of health care services across the whole spectrum of different settings for NHS funded care in England. That spectrum includes independent midwives delivering obstetric care in local communities, general practitioners delivering primary care, charitable providers running hospices, social enterprises offering mental health services, private providers of specialist care and public sector providers of general acute services. We recognised that the impact on providers and patients of the 19 areas we examined would vary by health care setting and by provider type. Only be talking to a wide range of stakeholders would we understand the nature of that variation.

Understanding the impact of distortions. We recognise that different providers behave differently in response to the issues we have examined. This is an important reason why talking directly with stakeholders has been essential in seeking to understand both the impacts and the root causes of distortions.

For example, the cause of a cost distortion is often simple to identify as it is usually a rule or set of rules, such as those governing access to the NHS Pension Scheme or the system for reimbursing clinical care. However, evaluating the impact of differential access to the NHS Pension Scheme on providers entails understanding how pensions affect the ability of providers to recruit and retain staff, which can vary by provider type. Similarly, we observe some providers treating fewer patients with complex needs than others. Only by talking to commissioners and providers have we been able to understand whether this reflects a fault in the referral system that allows some providers deliberately to avoid taking on more expensive patients, or a fault in the pricing system, which is failing to reward providers sufficiently for treating patients with complex needs that they could meet. Likewise, one provider may react differently to a given distortion from another as a result of their different objectives. Such differences can be important in understanding the nature of a distortion's impact on providers' decisions about when to enter, expand or withdraw from a

[2] For example, one issue that was raised by stakeholders was the perception that medical education and training is delivered by public sector organisations while non-public sector providers profit from employing trained staff without contributing to the cost of their training. We found that there were two linked, but distinct issues here. The first was the question of staff trained by the NHS going on to deliver non-NHS funded care (for providers of any type). While recognising this question is one that concerns stakeholders, it is one that falls outside the remit of the Review. The second was the question of whether those providers who are delivering medical education and training are being fairly reimbursed. This did fall within the remit of the Review and we found that in fact there is a distortion that exists mainly between public providers of different sizes.

service, and thus that distortion's impact on patient care. For example, if a provider's primary objective is to maximise its return to shareholders, faced with a service that is just breaking even, it may seek to shift resources to delivering an alternative, more profitable service. However, if a provider sees its objective as to provide a particular service in a particular geography, it may continue to do so even if it could get a better return (or perhaps even add more value) elsewhere. We discuss this in more detail in our methodology paper. In practice, we find that most providers need to balance a range of objectives, but this was something we understood better through talking with providers.

Understanding the root causes of distortions. In other areas, our engagement with stakeholders was important to understand the causes of distortions. For example, in discussing barriers to participation in the delivery of health care, we identify a number of commissioner behaviours that play an important role, such as a lack of engagement with a broad range of providers and service users when planning services. It is only by speaking directly with commissioners that we were able to better understand the pressures under which they operate and that in turn contribute to those behaviours. This has allowed us to be more focused in developing our recommendations. The same is true when discussing flexibility distortions, and the factors which can make it difficult for public sector providers to think and act strategically.

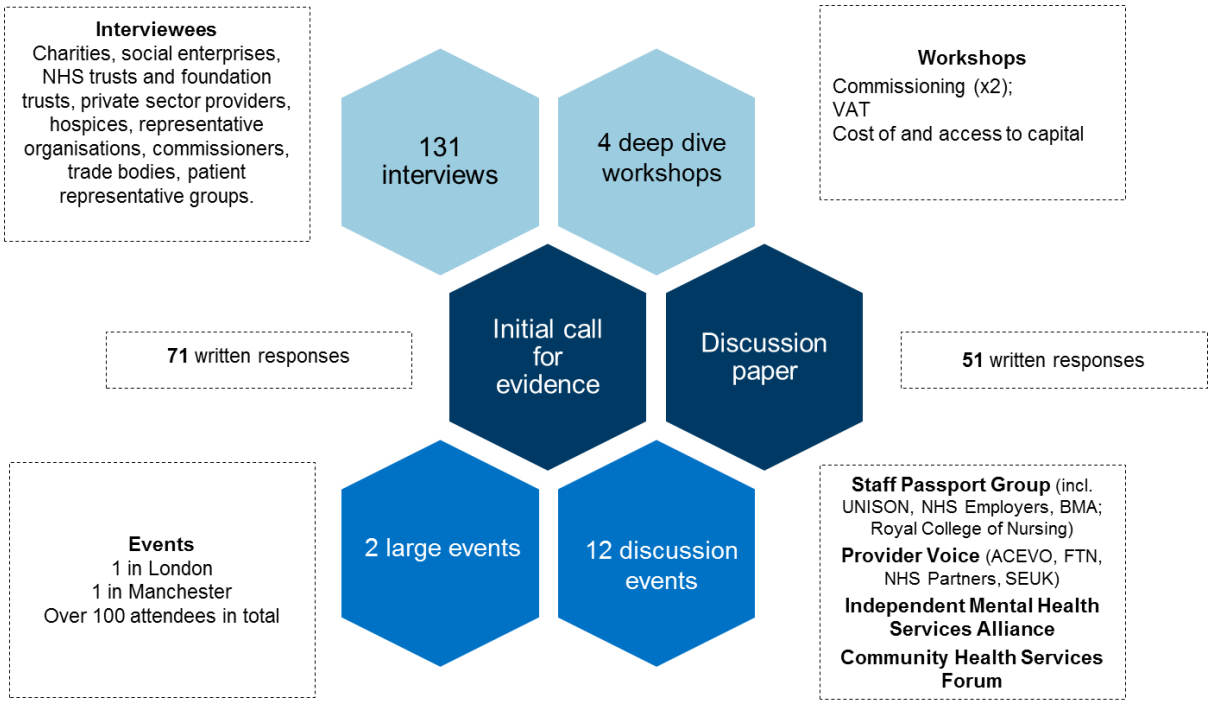
Engagement routes

We sought to reach a wide range of stakeholders from across the sector, including:

Providers of all types	Commissioners	Policy makers	Clinicians
Staff representative groups	Patient representative groups	Researchers	Other representative and campaign groups

We created a number of different fora for hearing from and talking with stakeholders, as set out below:

Figure 1. Engagement with stakeholders



1. Call for evidence

We began the Review with a call for evidence published on Monitor's website on 12 June 2012 and publicised in various health care publications. The call for evidence outlined the purpose and remit of the Review, and was used as an important source for generating our initial long list of issues. We received 71 written responses.

2. Interviews

We followed up the call for evidence with a programme of interviews with stakeholders, which continued right up until the end of the Review. While initial interviews were used to test whether we had identified the right set of issues, as our work progressed our interviews became more focused explorations of particular areas, including potential recommendations. We met people from each of the stakeholder categories described above, including providers

- of all types – public providers, private providers, charities, social enterprises and mutuals;
- delivering, or seeking to deliver, a range of services, including mental health services, planned elective care, primary care and palliative care
- operating in community-based or hospital settings

While the precise set of issues raised by stakeholders varied by provider type, the issues raised most often during early interviews were commissioning, pensions, VAT, cost of and access to capital, and reimbursement (for clinical care and for

education and training). In other words, most of the issues fell into our 'participation' and 'cost' categories of distortions. Over time, we began to ask non-public providers if, given the cost distortions they felt advantaged public providers, they would choose to swap places. The majority said that they wouldn't, which opened the door to understanding the various issues we look at in the main report chapter on flexibility distortions – many of which disadvantage public provider.

In total, we conducted 131 interviews, the majority of which took place face-to-face and all of which took place on a confidential basis to encourage open responses.

3. Discussion paper

On 8 November 2012 we published a discussion paper on the Monitor website. The aim of the discussion paper was to share the results of the initial call for evidence and pose some specific questions to the sector. We received 71 written responses.

4. Deep dive workshops

Commissioning was the subject that had invited most comment from stakeholders following the call for evidence and our initial interviews, particularly from providers. As a result, we considered related issues in some detail as part of the review, and conducted two workshops with commissioners – one to gain an understanding of commissioners' perspectives on issues raised by providers, and another to test our emerging findings and draft recommendations.

We also organised workshops with providers to better understand issues relating to VAT and cost of and access to capital.

Discussions at workshops allowed us to develop a richer understanding of those issues than we had gained from reading initial submissions. For example, while recognising some of the issues raised by providers, commissioners explained the impact of constant restructuring of the commissioning system and their legitimate concerns about changing patterns of provision and the impact this could have on continuity and coordination of care.

Similarly, while expected private and VCS providers to protest and their inability to access cheap capital from government sources, a much stronger theme to emerge from that access to capital workshop was requests by commissioners for what providers perceived to be disproportionate levels of reserves and working capital when bidding for contracts.

5. Large events

In December 2012, we issued open invitations for two half-day events, one in Manchester and one in London, attended in total by over representatives from over 100 organisations, including commissioners, providers, policy makers, patient representative bodies and researchers.

At each event we presented our emerging findings, held an open question and answer session and facilitated roundtable discussions in which all attendees could participate.

Some themes emerged during the events that had not come out clearly from other forms of engagement. One strong message was the importance of ensuring that we keep focused on what will make a difference to patients – including the importance of choice for patients and, of better information on quality to support commissioners' decisions and of ensuring the delivery of integrated care. The central role of commissioners was a message that was reinforced at both events.

6. Discussion events

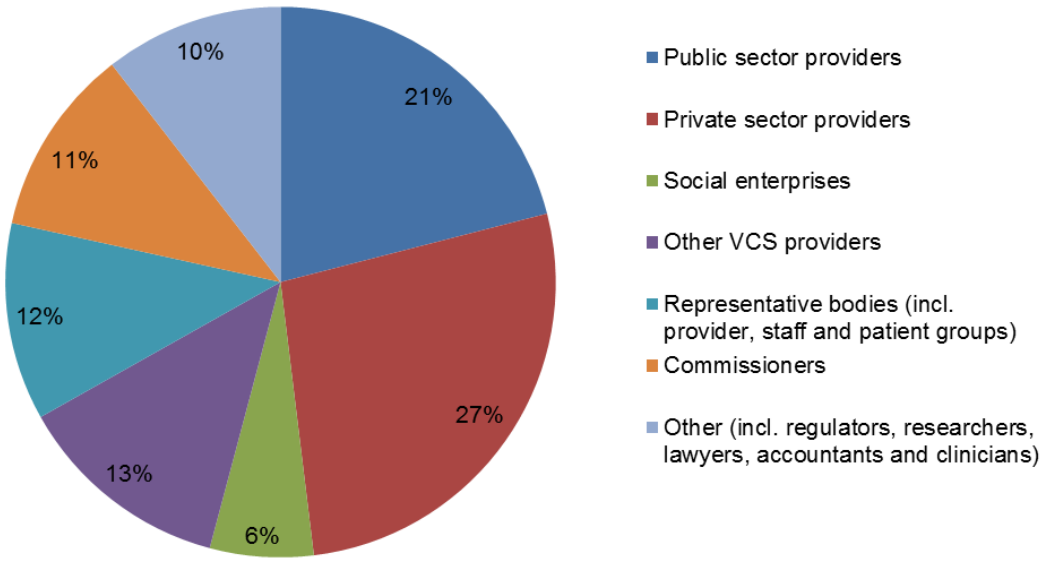
Aside from those described above, we delivered presentations and took part in discussions at 12 events. These included meetings of the provider trade organisations (attended by representatives of the Foundation Trust Network, Association of Chief Executes of Voluntary Organisations, Social Enterprise UK and the NHS Partners Network) the NHS Staff Passport Group (including representatives of the various unions and other staff representative groups) and the Community Health Services Forum. These were particularly important for understanding the ways in which current arrangements impact differently on particular provider groups or areas of care.

Stakeholder engaged with during the Review

The views of stakeholders played a central role in shaping our conclusions and recommendations. Therefore it was important that we gathered as wide a set of views as possible. We had to work hard on occasion to ensure that we achieved this. For example, in the early weeks of the review, we had to be proactive in our attempts to reach public providers (who may initially have seen the review as less relevant to them) and commissioners (many of whom have been busy going through authorisation).

Without counting the extensive engagement we had with partners from across government and other central bodies, we met with representatives of over 180 organisations in total. The willingness of people to give up their time during a period when many have complained of consultation fatigue is testament to the importance of the issues we address in the Review.

Figure 2. Stakeholders engaged with during the course of the Review



Acknowledgements

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2gether NHS Foundation Trust

Association of Chief Executives of Voluntary Organisations (ACEVO)

Addiction Therapy

Angel and Bowden Professional Practical Rehabilitation

Anthony Nolan

Axa PPP Healthcare

Barchester Healthcare

Beacon UK

Beven Brittan LLP

Big Society Capital

Birmingham Community Healthcare NHS Trust

Bristol Community Health

British Chiropractic Association

British Orthopaedic Association

British Society of Hearing Aid Audiologists

BUPA

Business Services Association

Calderstones Partnership NHS Foundation Trust

Carradale Consulting

CBI

Charity Commission

Chartered Society of Physiotherapy

City Health Care Partnership CIC

Coventry & Warwickshire Partnership NHS Trust

David Roberts Physiotherapy

Derbyshire Local Pharmaceutical Committee

Disability Rights UK

Douglas Macmillan Hospice

East Kent Hospitals University NHS Foundation Trust

Employee Ownership Association

English Community Care Association

Expert Patients Programme CIC

Foundation Trust Network

GP Care

Greater Manchester West Mental Health NHS Foundation Trust

Guild of Healthcare Pharmacists

Halton CCG

Harrogate and District NHS Foundation Trust

Healthcare at Home

Healthtrust Europe

Healthwatch England

Heart of England NHS Foundation Trust

Help the Hospices

Hertfordshire and Essex CCG

Hertfordshire Community NHS Trust

Herts Urgent Care

Healthcare Financial Management Association (HFMA)

Horder Healthcare

Improving Care Limited

Independent Mental Health Services Alliance

Independent Pharmacy Federation

Independent Vascular Services

InHealth

Institute of Biomedical Science

Intrahealth

Keep our NHS Public (South West)/38 degrees (Devon)

Lancashire Care Association

Leonard Cheshire Disability

Lloyds Bank Commercial Banking

Macmillan Cancer Relief

Marie Curie

National Association of Primary Care

NHS Cheshire, Warrington & Wirral

NHS Confederation

NHS Direct

NHS Kent and Medway

NHS South CSU

NHS Partners Network

NHS West and South Yorkshire and Bassetlaw CSU (WSYB CSU)

NHS West Cheshire CCG

Norfolk and Norwich University Hospitals NHS Foundation Trust

North East Ambulance Service NHS Foundation Trust

North East Essex CCG

North Manchester CCG

Nottingham City Care

The Nuffield Trust

Office of Fair Trading

One Medicare

One to One Midwives

Optical Confederation

Palliative Care National Council

Pennine Care NHS Foundation Trust

Pharmaceutical Services Negotiating Committee

Pharmacy Voice

Priory Group

RAISE

RBS Health

Regional Voices

Royal College of General Practitioners

Royal College of Radiologists

Royal Surrey County Hospital NHS Foundation Trust

Royal United Hospital Bath NHS Trust

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SEQOL

Serco Integrated Services

Severn Hospice

Sirona Care and Health, St Martin's Hospital

Smile Support

Social Enterprise UK

South West Yorkshire Partnership NHS Foundation Trust

St Gile's Hospice

Stockport NHS Foundation Trust

Sue Ryder

Thames Group UK

The National Council for Palliative Care

The Nuffield Trust

The Practice

The Robert Jones and Agnes Hunt Orthopaedic Hospital FT

The Stroke Association

Tollgate Clinic

University College London Hospital NHS Foundation Trust

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