A fair playing field for the benefit of NHS patients

Supplementary paper

March 2013

Flexibility distortions

Supplementary Paper: Flexibility

Introduction to factors relating to provider flexibility

Flexibility distortions may affect a provider's ability to respond to changing patient needs or the changing requirements of commissioners. This paper examines externally imposed constraints on the flexibility of providers that do not equally constrain all provider types[1].

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. Indeed, the two types of constraints may be mutually reinforcing.

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

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

1. Constraints on inputs

The most common types of potential distortion around inputs mentioned by the people we spoke to were about access to staff and access to facilities. Relatively few respondents to our discussion document (only 3%) suggested this was one of the most important factors to their organisation preventing a fair playing field.

1.1 Access to staff

We heard about many general problems about a lack of flexibility in pay and benefits, and the constraints these impose on, typically public, providers. We cover these types of concerns in the supplementary paper on flexibility under pensions, and pay and other benefits.

This section deals with a narrower point about whether there are specific constraints on the use of clinical staff. However, in discussions with stakeholders we heard that:

> "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)

Specific concerns that we heard related to the use of hospital consultants (and the independent sector has typically used consultants - rather than more junior doctors - for all surgical procedures[2]). Stakeholders have not highlighted specific concerns over access to other clinical staff, and indeed one private provider explicitly noted that this was not a problem that they faced.

The ability of different providers to attract consultants will, in part, be dependent on the model of provision that they have adopted. In particular, the ability to employ consultants may be dependent on the range of opportunities (to offer training, to offer private work, to contribute to clinical research, etc.) that the provider's model of service provision allows for. The endowments of public sector providers mean they are more likely to offer consultants this mix of opportunities. These sit alongside the distortions that VCS providers face (for example a lack of access to the NHS Pension Scheme) which together help explain why it is harder for them to access consultants.

Private providers have told us that in order to access consultants, they typically have to either contract with the public provider that the consultants are employed by (such that some of their time can be released), or secure the services of consultants in their non-contracted hours.

[2] The National Minimum Standards for Independent Healthcare had included a requirement concerning the use of consultant grade doctors on the GMC's Specialist Register. While they are no longer in force, this use of consultants has become embedded in industry standard practising privileges.

In 2009, the Co-operation and Competition Panel (CCP) published a study[3] of the restrictions placed on consultants working for other providers in their non-contracted hours and found that such restrictions did occur and that they were effective at stopping or limiting the ability of consultants to work for other providers.

The study found that patients and taxpayers could only be expected to benefit from restrictions if they related to legitimate patient safety concerns or to the holding of strategic management/advisory roles in more than one organisation. Any other implicit or explicit restrictions on a consultant's ability to work for other providers of NHS-funded services during their non-contracted hours was identified as likely to be a breach of the Principles and Rules for Co-operation and Competition (PRCC)[4].

Findings and conclusions

Since the CCP published its report, complaints and representations to it have been few – and those providers who have approached the CCP to clarify the application of the PRCC did not subsequently bring a formal complaint.

From April 2013, the new Monitor provider licence will be operational for all foundation trusts. And NHS trusts will also be expected to comply with the conditions in that licence, enforced by the means of agreements between Monitor and the NHS Trust Development Authority (NTDA). Provisions in the licence about competition put the current Principles and Rules for Co-operation and Competition (PRCC) on a statutory footing. The competition licence conditions will allow Monitor, where it is in the interests of patients, to take action against anti-competitive behaviour.

The conditions prevent providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition, to the extent that it is against the interests of health care users. It also prohibits the licensee from engaging in other conduct which has the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.

Given that it was not a matter raised by many stakeholders, it may be that there are a limited number of problems about access to consultants in particular areas, including in relation to the price paid. If it is the case that problems persisting after the CCP published its report are localised, rather than widespread, the most efficient way of dealing with this may be for Monitor to consider individual evidenced complaints. Guidance on how Monitor intends to handle complaints and enforce the licence will be available shortly on Monitor's website.

We will remain alert to the extent to which complaints to Monitor in the future may indicate that there are more widespread problems associated with access to

[3] http://www.ccpanel.org.uk/cases/nhs-consultants-non-contracted-hours.html
[4] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_118221

consultants, and will consider accordingly the case for re-examining this issue more broadly.

1.2 Access to facilities

It is clearly the case that for many services, buildings and facilities are required in order to provide them. Some people highlighted the problems of those seeking to expand into, or enter, new areas and services in acquiring buildings and facilities when bidding against an established incumbent:

> "I believe the next most important factor [in provider decisions to expand into a new area] is the availability of buildings from which to offer the service." (Private sector provider)
>
> "The NHS has an advantage in terms of barrier to entry in being the incumbent provider. From a commissioning view, a solution is for greater commissioning control / ownership of capital factors in the delivery of services, i.e. buildings […]" (Public sector 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 or equipment 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." (Social Enterprise)
>
> "There are community hospitals that are empty but because the trusts own them we can't get access." (Private sector provider)

In many public services a physical presence needs to be established in order for a provider to start offering services. So this is a barrier to entry that needs to be overcome for new entrants seeking to compete with incumbent providers. The significance of this in health care will differ between services, depending on – among other things – the availability, cost and complexity of suitable facilities, and the possibility of arrangements to hire or lease buildings and facilities.

While a number of stakeholders commented on access to facilities, a range of different underlying concerns were expressed. As the comments shown above illustrate, for some, concerns relate to constraints on the ability to enhance and develop existing facilities, or to limitations associated with lack of ownership. These comments, in part, reflect the positive link that can apply between ownership and investment – that is, ownership can enhance incentives to invest in facilities as it can provide a more reliable basis for the future benefits of that investment to be realised.

While some providers faced difficulties, other providers noted that, “there is available capacity in many GP and NHS community buildings and some hospital sites”. Even where there is not capacity they are able to access on these sites, providers reassured us that many of the services they offer could be provided at a number of different facilities. They often choose to locate in or next to publically owned facilities because of the benefits of clustering, not because of a lack of alternatives.

Findings and conclusions

Given the relatively limited and somewhat mixed nature of the views that we have received on access to facilities issues, we have not drawn any specific conclusions. We think that further consideration should be given to such issues as relevant in response to individual evidenced complaints, with this providing a basis for more fully considering the extent to which particular arrangements may be operating in ways that are against the interests of patients, and – where they are found to be – considering options for remedying the situation to the benefit of patients.

2. Burdens imposed by external requirements

Just under 10% of respondents to our discussion document listed constraints on the way services must be delivered – in the form of regulations and obligations – as being on the list of the most important issues for their organisation. Matters raised include burdens associated with:

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

They are considered in turn below. Most often, it is public sector providers that feel disadvantaged by these constraints compared to other types of providers.

2.1 The Monitor 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[5]:

- 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.

Findings and conclusions

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.

[5] 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.

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.

The Department of Health has also exempted providers from the licence if they have an annual NHS turnover of £10 million or less.[6] 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[7] 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.

2.2 Freedom of Information

Under the Freedom of Information (FOI) Act, all public authorities are required to provide information requested by the public within 20 days, unless there are good reasons for keeping it confidential. This requirement applies to public providers, but does not directly apply to private sector or VCS providers. Although other providers also need to deal with public requests for information, they are not obliged to make

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

the information available and therefore have more discretion about when and how to respond to such requests.

FOI is a high profile issue. A number of respondents to our discussion paper described FOI requirements as disadvantaging public providers, and the issue was raised in a number of stakeholder interviews. Indeed, some associations argued that the issue was an example of a disadvantage to the public sector that had been given "too little attention" in the past. One aspect of this is the direct cost of complying with FOI requests. Stakeholder responses provided compliance cost estimates of between £50,000 and £250,000 per annum. For example, one interviewee estimated a cost of about £200,000 per annum based on roughly 2 full-time employees (FTEs) working on FOI requests and dealing with about 450 FOI requests per year.

These figures are broadly in line with a submission that the Foundation Trust Network (FTN) provided to the Justice Select Committee in 2012, which identified costs for a foundation trust of between £175,000 and £200,000 per annum[8]. The average number of FOI requests received by foundation trusts in 2008 had been identified by the NHS Confederation as 173 per annum[9], but the 2012 FTN submission indicates that this figure has grown significantly since that time.

Some stakeholders also highlighted the potential for the FOI process to impact on internal decision-making processes in less direct ways:

> "We do find, as I believe most other bodies do, the compliance with FOI regime extremely arduous, and fruitless much of the time." (Public provider)
>
> "FOI requests can for example lead to slower decision making." (Public provider)

These comments point to the effective costs of FOI requirements potentially being significantly higher than the direct costs; for example, that dealing with FOI requests within the required timescales can divert relatively scarce senior management time away from other core activities.

Alongside these costs, the potential benefits to patients of transparency are clear. Increasing transparency can make public services accountable to the people they serve and provides patients with more information from which to make informed decisions. A key finding of the 2013 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was that there is a need to 'ensure openness, transparency and candour throughout the system about matters of concern.'

Indeed the Government has taken steps to ensure providers of all types supply information to commissioners in response to FOI requests and as proposed in 'Everyone Counts – Planning for Patients 2013/14', the NHS Commissioning Board

[8] Foundation Trust Network (2012), "Submission to Justice Select Committee: Freedom of Information post-legislative scrutiny".
[9] NHS Confederation (2009), "Briefing – Freedom of Information in the NHS".

has included, in SC28 of the 2013/14 NHS Standard Contract, a new requirement for all NHS-funded providers to submit data sets to commissioners that comply with industry-wide information standards[10]. The standard contract also allows commissioners and providers to agree upon a data quality improvement plan, with attached financial sanctions for failure to meet milestones. The introduction of these contract conditions provides an example of one way in which common transparency arrangements are being developed across provider types.

Findings and conclusions

Assessing the benefits and practical burdens imposed by transparency obligations is not something that we can fully address within the scope of this review. However, the direction of travel is towards making transparency obligations, where in the interest of patients, apply more consistently across providers of NHS care.

2.3 Reporting requirements

Many of the concerns we heard about the need to provide data related to Freedom of Information and transparency obligations are discussed above. While other reporting requirements were raised in a number of interviews, these comments typically did not identify a fair playing field distortion, but rather commented on how cumbersome reporting requirements are more generally. This was particularly true of more complicated services which are disproportionately or exclusively offered by public sector providers. Thus, for example, one public provider commented in an interview that they did not consider that there were differences in data requirements according to type of provider.

This is consistent with the general picture that was identified in the NHS Confederation's 2009 report, *What's it all for? Removing unnecessary bureaucracy in regulation*. While that report identified that health care providers continue to experience a significant bureaucratic burden, it reported "little difference" between the burdens faced by public and independent health care providers[11].

Those differences that do exist tend to arise because of the Government's need to keep track on the spending of public sector providers. Currently there is only a requirement on public sector providers to submit reference cost data for the purposes of calculating Payments by Results tariffs. The Audit Commission has conducted a survey which suggests that the annual cost to organisations of collecting this data is around £30,000 per year on average[12].

These are likely to have parallels with financial management systems used by private and charitable providers. The Information Centre advised us that other

[10] NHS Commissioning Board (2013), 'NHS Standard Contract 2013/14 – service conditions', February 4th, p. 17.
[11] NHS Confederation and IHAS (2009), 'What's it all for? Removing unnecessary bureaucracy in regulation', p. 18. The NHS Confederation are currently revisiting this work and expect to publish an interim report shortly.
[12] The Audit Commission, Reference Costs – Review of uses by NHS Bodies, 2010. It is worth noting that some private providers have indicated to Monitor they have no objection to submitting reference costing information.

differences are small and include increased requirements on the public sector in the collection of information about patient experience.

Findings and conclusions

In line with the comments above, we did not find this to be a significant area of concern (over and above the FOI issues discussed above). Some people told us that they found specific reporting requirements around performance very burdensome. However, we do not find these are a distortion between different types of provider but are generally related to the service provided.

2.4 Complaints procedures

All providers of NHS services are required by law to make arrangements to effectively deal with complaints (e.g. acknowledging contact within three days, processing efficiently, undertaking proper investigation in a sensitive manner). These legal obligations are incorporated into the NHS standard contract. When complaints have been ineffectively dealt with by other parts of the system, complainants have recourse to the Parliamentary and Health Service Ombudsman.

However, stakeholders observed that complaints by patients about private and charitable providers do not fall under the jurisdiction of the 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[13].

2.5 Procurement rules

Public sector providers are required to secure external services, above a certain value through a competitive process, including advertising procurement tenders through the Official Journal of the European Union (OJEU) when the lifetime value of the contract exceeds 400,000 euros[14]. Contracts subject to these regulations must be advertised via an OJEU notice. This process also sets minimum timescales for the procurement process.

Some public providers (about 6% of respondents to our discussion paper, and a small number of interviewees) told us they found the obligations imposed by public procurement law were a burden, and that private providers were free of this burden.

[13] http://www.dh.gov.uk/health/2013/03/nhs-complaints/
[14] www.ojec.com/thresholds.aspx

> "Our procurement people say the biggest problem is being hidebound by the requirement to go out through the OJEU process and the constraints regarding post tender negotiation which doesn't allow nimble approaches to procurement". (Public sector providers)

Findings and conclusions

While it may be the case the public procurement law does impose some constraints on flexibility on public providers, these may well be in the interests of patients. Private and VCS providers will also use procurement processes, and will typically have internal process requirements concerning how procurement should be undertaken, with these requirements providing a means of ensuring appropriate consideration of quality and value for money. In a similar way, one objective of public procurement law is to ensure the procurement exercises allow for open competition, where the value of a contract exceeds a defined level, and so ensure a more open, competitive market for the provision of services paid for by the taxpayer.

2.6 Emergency planning rules

Legislative provisions related to emergency planning and incident management apply to some public providers, but do not apply to other providers:

- the Civil Contingencies Act 2004 imposes a duty to provide services in the event of local or national emergencies; and
- the NHS Emergency Planning Guidance 2005 (updated) sets out some specific ongoing requirements that apply to public sector organisations.

However, the NHS Standard Contract contains emergency planning and incident management requirements that apply to all providers of NHS-funded services under that contract. These provisions are set out in Service Condition 30 of the NHS Standard Contract[15], and require the provider to:

- contribute to and cooperate in the development of any relevant Major Incident Plan;
- assist in the development of, and participate in, joint planning and training exercises connected with Major Incident Plans;
- maintain an up-to-date emergency response plan;
- if a major incident occurs, comply with Major Incident Plans and implement emergency response plans; and
- provide further assistance as required by the Commissioner.

Findings and conclusions

Given the requirements that are set out in the NHS Standard Contract that will apply to all providers, we do not find that the existence of similar legislative requirements

[15] www.commissioningboard.nhs.uk/files/2013/02/contract-service.pdf

that apply only to public sector providers gives rise to fair playing field issues. We note that this was not highlighted as a significant issue by stakeholders.

3. Barriers to changing services

Distortions from the constraints public sector providers face when they contemplate changing or stopping services were mentioned in the list of most important issues by 8% of respondents to our discussion document, and frequently came up in interviews with providers.

There were a complex, and intertwined, range of potential distortions mentioned that included:

- service obligations;
- 'cherry picking' and related cross-subsidy concerns;
- implications of scale and scope economies;
- cultural and political constraints; and
- service reconfiguration/redesign process requirements.

We describe below the key issues that were raised, and some of the policy initiatives that are already underway that may lessen the impact of some of these factors.

3.1 Service obligations

Where some providers face obligations to continue to provide services that do not apply to other providers, there is the potential for those obligations to give rise to fair playing field distortions. This issue was raised by a number of stakeholders, for example:

> "Providers have different levels of flexibility over services they offer. For example, NHS foundation trusts are tied into their terms of Authorisation to provide certain types of service, while other providers may choose to focus on delivering the more profitable procedures." (Public sector provider)

This raises the potential for some providers to be obliged to continue to provide a service that, were it not constrained by this obligation, it would choose to no longer provide. Service obligations do not appear to have been a historic problem as Monitor has never received a request from a foundation trust for variation of its original terms of Authorisation.

Still, in future a key issue is the extent to which the price paid for the service reflects the costs reasonably associated with its provision. Where it does not, the implication is that some kind of cross-subsidy may be needed to sustain the provision of the service. As discussed below, a number of stakeholders explicitly highlighted concerns that relate to cross-subsidies.

The Act and Monitor's provider licence introduce a new continuity of service regime, and foundation trusts will no longer face mandatory service provision requirements in their terms of Authorisation. The new continuity of service regime aims to identify those services which, for the benefits of patients, must have controls on whether a provider can cease providing them, and those which need no special controls. In

particular, under the new continuity of service regime, services identified by commissioners as Commissioner Requested Services (CRS) will be subject to controls on providers withdrawing them.

Importantly, these licence conditions do not depend on the type of provider; they will apply equally to all types of provider supplying Commissioner Requested Services. The development of these arrangements should alleviate some of the concerns raised by stakeholders in relation to service obligations. However, in practice, transitional arrangements to protect patients mean that it may take several years before the controls on public providers are lessened. As was set out in our licence statement, we will keep the operation of the Commissioner Requested Services and Continuity of Services regimes under review and intend to conduct a short review, gathering stakeholder feedback, in April 2014.

3.2 Cherry picking and related cross-subsidy concerns

A provider may be obliged to continue to provide a service where the funding that it receives for that service is below its costs of provision. This type of concern has frequently been presented in the context of Universal Service Obligations in other sectors. The key issue is the extent to which the price paid for the service reflects the costs reasonably associated with its provision. Where it doesn't, the implication is that some kind of cross-subsidy may be needed to sustain the provision of the service. That is, the sustained provision of one service may be dependent, to some extent, on earnings from the provision of other services where the price paid for those other services are above relevant costs. This can result in the provision of those other services being attractive to entrants, and the potential impact of this was raised by a number of respondents.

In particular, some public providers said that private providers have the opportunity not only to 'cherry pick' patients (discussed in the costs chapter and costs supplementary paper), but to 'cherry pick' services, and that the need to financially support some services can result in significant financial tensions:

> "There is a fragile status quo, effectively there is currently cross-subsidy of loss-making services within acute trusts. This means that there are tipping points so that cherry picking of services will create situations where certain services will no longer be viable. These pressures are already being felt through the implementation of Any Qualified Provider (AQP), Choose and Book and the movement of services into the community." (Public sector provider)
>
> "It has become apparent through the review that the lack of cost-reflective pricing causes a range of issues but from a FPF point of view, the key issue is around cherry picking (for services and for less commonly for less complex patients)." (Representative body)

This issue highlights the potential for limitations in the pricing and reimbursement arrangements to impact on the constraints that providers can face. Our ongoing

pricing work aims to lessen the significance of such issues both by improving the cost information on which prices are based, and through developing pricing arrangements that allow for relevant costs to be more effectively reflected. Over time, these developments would be expected to lessen the extent of these tensions.

3.3 Implications of scale and scope economies

Some foundation trusts said that distortions arose from the lack of control they had because they were obliged to provide emergency care functions:

> "The open door provided by A&E departments means we lack the control over access and service provision that is normal in other organisations." (Public sector provider)
>
> "Probably the most significant distortion to a fair playing field is the historical configuration of clinical services including the requirement for most NHS providers […] to provide emergency care, frequently running at a loss. This is a barrier to exit for incumbent providers which is just as significant as the barriers to entry for new providers." (Public sector provider)

While the issues raised here can also be understood as related to current limitations in the pricing arrangements, they highlight some of the difficulties that can arise in relation to such pricing. In particular, they highlight the extent to which there can be economic interactions between the provision of different services that can impact on how services may be most appropriately provided and priced. Put differently, the development of more effective pricing and reimbursement arrangements will be complicated by a range of economy of scale and scope considerations, and these considerations (together with the prevailing configuration of services) will affect assessments of the desirability of changing and stopping the provision of particular services. In line with the comments above, we are seeking to better identify and take account of such factors in our ongoing pricing work.

3.4 Cultural and political constraints

Another theme raised by some stakeholders was that, even if one left aside obligations that foundation trusts may face to provide a service (and how those rules may change in the future), there are a range of cultural and political factors that can contribute to why a foundation trust may not contemplate reconfiguring the provision of its services:

> "The other key issue is that of mandatory services […] which will need to continue to be provided. […] Even if the concept of protected 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)
>
> "Re-configurations and/or service delivery changes that make patient quality and economic sense are often constrained by political considerations restricting an

acute trust's ability to optimise its organisation. This is a major issue which adversely affects an acute trust's ability to compete to provide services, to respond to competitive pressures and to enter new areas." (Provider)

We consider issues concerning the impact that the policy environment can have on provider decision making, and the particular impacts that it can have on public providers, later in this paper.

3.5 Service reconfiguration/redesign process requirements

Some public providers highlighted the potential for reconfiguration processes to give rise to fair playing field distortions. One provider described the challenges 'where reconfiguration decisions can be affected by local and national politics'. They argued that the consequence was that 'service changes are often held up in lengthy review processes. This can place NHS providers at a competitive disadvantage in terms of achieving service sustainability and reconfiguring to embrace innovative new practices.'

Cultural and political factors were highlighted above, and the impact of the policy environment is considered further later in this paper. However, another particular issue that was mentioned in this context was the specific process requirements that apply. Section 242[16] of the NHS Act 2006, as amended by the Local Government and Public Involvement in Health Act 2007, states that:

Section 242 of the NHS Act 2006

"Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in—

(a) the planning of the provision of those services,

(b) the development and consideration of proposals for changes in the way those services are provided, and

(c) decisions to be made by that body affecting the operation of those services."[17]

Relevant English bodies include NHS trusts and foundation trusts, but not other types of provider. While this gives rise to a difference in legal obligations between public and non-public providers, in practice it does not give rise to material impacts. Importantly, commissioners are also relevant English bodies under Section 242 of the NHS Act 2006, and thus whenever a significant change is being considered that may trigger these requirements for a public provider, they would also effectively be triggered for a commissioner. Moreover, Department of Health (DH) guidance

[16] http://www.legislation.gov.uk/ukpga/2006/41/part/12/chapter/2
[17] http://www.legislation.gov.uk/ukpga/2007/28/section/233/prospective

highlights that while providers may bring forward proposals for reconfiguration, it will typically be for commissioners to lead the process[18].

Evidence on referrals to the Independent Reconfiguration Panel (IRP) is consistent with this. Reconfiguration proposals can be referred to the IRP by local Health Overview and Scrutiny Committees, and IRP will report to the Secretary of State. In 2011-12, the IRP assessed 14 cases and conducted a full review of 3 proposals for change[19]. While some public providers were involved with these reviews, in all cases it was the proposals of commissioners which were referred to the IRP by the local scrutiny committees.

While public providers may be more likely to be involved in reconfiguration processes that are captured by these provisions (given the nature of the services that they offer).

Further guidance on reconfiguration processes is due to be provided by the Department of Health in March 2013. In particular, Sir Ian Carruthers is undertaking a review of the operational framework through which the NHS and its partners plans and develops major front line service changes, and which takes account of the structural changes introduced by the Act. The review will produce updated guidance.

These developments to the guidance will be focused on updating to take account of legislative and related changes. More generally, if the established process unduly hinders reconfiguration in the sector, then this will limit the flexibility of existing public providers to respond to new opportunities to improve services to patients. At the same time, limitations on the reconfiguration of existing facilities may hinder the development of opportunities for other providers.

Work for the King's Fund has argued that there are significant difficulties with reconfiguration processes that hinders progress:

> "The current reconfiguration process is lengthy, wasteful and carries significant risks to the delivery of safe services […] A major stumbling block in many hospital reconfigurations is public concern and political opposition."
>
> "The public and local politicians find it hard to accept change to hospital services, often because the case for change is not well articulated […] This resistance to change means that the current process can be protracted and expensive. Its drawn-out nature can leave quality issues unresolved and threaten the quality of patient care. For example, the reconfiguration in South East London took more than six years, and services at Queen Mary's Sidcup had closed on 'emergency' grounds before they were given final official support for closure."[20]

[18] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_118085.pdf
[19] Review analysis of IRP website: http://www.irpanel.org.uk/view.asp?id=58
[20] King's Fund (2011), "Reconfiguring hospital services".

3.6 Findings and conclusions

Barriers to reconfiguration for existing providers are clearly strongly linked to the opportunities available to those seeking to expand into, or enter, new areas and services. To the extent that rules, culture, cross subsidies and economies of scale and scope between services restrict the potential to reconfigure, they are also likely, probably to a lesser extent, to restrict opportunities to provide new services[21].

We will give further consideration to the barriers to reconfiguration issues raised in this section as part of our planned review of the operation of the licence, Continuity of Service regime and the designation of Commissioner Requested Services planned for April 2014.

[21] Monitor (2012), Economies of Scale and Scope www.monitor-nhsft.gov.uk/economiesofscaleandscope

4. The policy environment and central control

The policy environment that providers operate in may impact on the decisions of different types of provider in different ways. 5% of respondents to our discussion document said that these types of distortion were important to their organisations.

It is inevitable that politicians will have different views about the most appropriate and most effective way of delivering public services. Thus, a degree of general policy uncertainty is to be expected and affects all providers. This section tackles two more specific issues:

- constraints which restrict the flexibility of public providers and which stem from the particular scope that central Government has to influence their governance and financing arrangements; and
- the impact that policy uncertainty may have on different types of provider – these may have the greatest impact on entrants to new services or areas.

4.1 The influence of the centre over public providers

The Government has significantly greater scope to influence NHS trusts than foundation trusts as set out below.

NHS trusts

When the Strategic Health Authorities (SHAs) are abolished in April 2013, NHS trusts will be overseen by the NTDA. The NTDA's role will encompass functions previously undertaken by the Department of Health, SHAs and the Appointments Commission, and will include responsibility for:

- performance management of NHS trusts;
- management of the transition to foundation trust status;
- assurance of clinical quality, governance and risk in NHS trusts; and
- appointments to NHS trusts – for example, of chairs and non-executive members and trustees for NHS charities where the Secretary of State has a power to appoint[22].

As part of its performance management role, NTDA will be responsible for monitoring NHS trusts' performance and working with them on issues such as waiting times and health care-acquired infection rates[23]. This will include overseeing service quality, governance and financial performance and intervening where necessary.

These arrangements give the NTDA considerable influence over NHS trusts, constraining their individual flexibility. As an example of the potential for the NTDA to intervene in the operations of NHS trusts, it outlined in recent guidance that it

[22] http://www.ntda.nhs.uk/about/
[23] Department of Health (2012), 'Building the NHS Trust Development Authority', January 5th.

expects every NHS trust to identify five key areas of delivery where there is a significant variation from the top performers in the NHS and to set out an improvement plan to bridge that gap in 2013/14[24]. These plans will have to be agreed and signed off by the NTDA.

The NTDA is itself subject to direction by the Secretary of State and exercises its authority by delegation. This gives the Government greater scope to influence the NTDA, and in turn NHS trusts, than foundation trusts. Given that NHS trusts have not been authorised as foundation trusts, this may be appropriate.

Foundation trusts

NHS foundation trusts were created specifically with the intention of devolving decision making from central Government to local organisations and communities. In particular, foundation trusts should:

- not be directed by Government and should have greater freedom to decide, with their governors and members, their own strategy and the way services are run;
- be 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;
- commissioners through contracts;
- Parliament (each foundation trust must lay its annual report and accounts before Parliament);
- the Care Quality Commission - through the legal requirement to register and meet the associated standards for the quality of care provided; and
- Monitor - for compliance with their licence from April 2013 onwards.

Foundation trusts, however, told us that they do not always feel free of direction from Government, and do feel constrained and influenced by political interventions in their affairs:

> "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)
>
> "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

[24] NHS Trust Development Authority (2012), 'Toward High Quality, Sustainable Services – Planning guidance for NHS Trust Boards for 2013/14', December 21st, p. 6.

of intense political debate […] This can place NHS providers at a competitive disadvantage." (Representative body)

To some extent it is clearly to be expected that foundation trusts would continue to feel constrained by the Government, as the Government does continue to have a significant role in their governance and financing. In particular:

- foundation trusts have to appoint an accounting officer, usually the Chief Executive of the organisation[25]. The accounting officer is directly accountable to Parliament via the Public Accounts Committee, subject to rules determined by HM Treasury; and
- foundation trusts raise most of their funding from the Department of Health, or with its support.

In practice, though, these government roles can mean that there are still significant opportunities for intervention into the decisions of foundation trusts, in ways that may constrain their flexibility, directly or indirectly.

Examples of influence over NHS and foundation trusts

An example of the complexities and constraints that this can generate for investment decisions is provided in the box below.

Example 1: planned investment in a new hospital

In March 2010, the then Health Secretary approved a new major development to transform services principally for residents in two adjoining and large towns. The development was intended to replace older hospitals on sites in the two towns. When the Coalition Government came into power in May 2010, HM Treasury announced the cancellation of the project following its review of all public sector projects in the pipeline at that time. In January of this year, the hospitals agreed to proceed with the development, subject to a new procurement process, the use of pension fund financing and, potentially, without any deed of safeguard from the Government. However, full implementation of the development remains subject to clearance of a number of hurdles, including decisions from HM Treasury, the Department of Health, Monitor and potentially others. The uncertainty which results from this is likely to hinder the progress of the hospital investment.

Stakeholders from foundation trusts and NHS trusts told us about a number of different ways in which interventions can arise, through policy initiatives, interventions in investment decisions, data collection requests, and targets that are requested of NHS trusts and foundation trusts by central Government.

[25] http://www.hm-treasury.gov.uk/psr_governance_accountingofficers.htm.

Central policy initiatives are frequently implemented and communicated through "Dear Colleague" letters sent from the Department of Health to providers. In the second half (July – December) of 2011 there were 72 "Dear Colleague" letters published on the Department of Health's website, an average of 12 per month, and 50% of these were addressed only to public providers. An example of these letters is set out below:

Example 2: Review of Critical Infrastructure Risk

On 13 December 2012, NHS Chief Executives, Directors of Finance and NHS Estates & Facilities Directors were invited to participate in the Review of Critical Infrastructure Risk[26]. This review was launched by DH following reports of significant investment needs in backlog maintenance on facilities. For this purpose, NHS trusts were asked to undertake a first series of actions:

- "review the robustness of their assessments of High and Significant risk backlog maintenance;
- consider any identified risks in the light of the public sector Equality duty and potential impact on people sharing protected characteristics; and
- ensure that their reported backlog maintenance meets the risk definitions in appropriate guidance."

The letter also announced further actions to be decided in the first quarter of 2013 following the analysis of trusts' findings. Potential actions were defined as "changes to policy, guidance and support that is needed, both in the short and long term."

Another example of a central initiative raised by stakeholders was the requirement to meet national targets related to access. There are a wide range of targets which public sector providers are measured against, and these have evolved over time. One public provider commented on the impact of these central targets as follows:

"The national target-driven approach places an operational, administrative and cost burden on acute trusts to which alternative providers may not be fully exposed. These factors also restrict the ability to make commercially-focused decisions." (Public sector provider)

However, it is notable that quality requirements that apply to all providers (irrespective of their type) are now defined under Schedule 4 of the NHS Standard Contract. These cover the same areas as the access targets, such as referral to treatment times and diagnostic test waiting times. This highlights a positive

[26] DH (2012), Gateway Reference 18469.

development in terms of application of common requirements to different types of provider.

Another example of a central initiative raised was the Department of Health's "Deep Clean Programme" in 2007-08.

Example 3: deep cleaning

In response to an increase in rates of MRSA and other hospital-acquired infections, in Autumn 2007 the Prime Minister and Secretary of State for Health announced that all hospitals would require a 'deep clean' within the next year. In November 2007, the Department of Health wrote to all NHS chief executives providing more details of the programme, including monitoring requirements:

"Matrons and Clinical Directors are required to report quarterly to Trust Boards on cleanliness and infection control. These reports will focus on compliance with statutory obligations.

The Code of Practice for the Prevention and Control of Healthcare Associated Infections will be amended to reflect this new requirement. This will mean that the Healthcare Commission (and, in due course, the new regulator who will be able to impose fines, halt new admissions or cancel a provider's registration entirely) can consider these issues when checking compliance with the standards."[27]

The letter also set out the Department's expectations for how the programme would be staffed and organised:

"Trust Directors of Nursing will need to work with Directors of Estates and Facilities to:

1. Instigate any necessary changes to ensure that all Matrons have personal responsibility and accountability for delivering a safe and clean care environment.

2. Make clear that the nurse in charge of any patient area is directly responsible for ensuring that cleanliness standards are maintained throughout that shift.

3. Involve Directors of Nursing, Matrons and Infection Control Nurses in all aspects of cleaning services, from contract negotiation and service planning to delivery at ward level.

4. Require cleaning providers (if they have not already done so) to set out how nurses can request additional cleaning, both urgently (e.g. spills or discharge cleaning) and routinely (e.g. where standards are persistently below expectations)."[28]

Additional funding to support the initiative was identified at SHA level. Providers

[27] DH Gateway Ref: 8977.
[28] DH Gateway Ref: 8977.

were required to submit plans setting out how and when deep cleaning would be undertaken, to gain access to these funds. Acute, district general and community hospitals received funding. By May 2008, 328 participating trusts had completed their deep clean.

These examples, which may well be desirable policy initiatives in their own right but which highlight the role of Government and the centre are consistent with some other broader assessments that have been made. For example, Bill Moyes, former Executive Chairman of Monitor, has commented that:

"Even with their existing freedoms…[foundation trusts] still feel that the heavy hand of the Secretary of State is coming in their direction and spend too much time worrying about what the Department of Health and ministers want."[29]

A 2011 King's Fund report commenting on Bill Moyes statement noted that:

The government is attempting to tackle that, distancing ministers from day-to-day involvement in the running of the service through the creation of a commissioning board. But the early signs that this will make any substantive difference are not encouraging. The coalition government halted all hospital reconfigurations into which much time, effort, consultation and leadership had been devoted."[30]

These types of constraints can lead to providers trying to meet multiple potentially conflicting objectives. The King's Fund Commission on Leadership and Management in the NHS argued strongly that NHS leaders face a huge number of competing demands and difficult priorities to manage. Recent qualitative research has suggested that foundation trust governance structures remain somewhat unclear[31].

Findings and conclusions

All public providers face significant constraints on their flexibility, and those constraints can come through a range of formal and informal routes. The constraints on NHS trusts are particularly significant given that they can be subject to directions from the Secretary of State. While foundation trusts have a greater degree of autonomy, they can still face significant constraints, often perceived rather than actual, that may impact on their incentive and ability to identify and take opportunities to improve patient care.

4.2 Policy uncertainty

Both the participation chapter and supplementary paper discuss the problems uncertain commissioning intentions cause prospective entrants. This section

[29] Quoted in Timmins (2010), "Fear over quality of care if NHS centralises", Financial Times (12/01/2010).
[30] King's Fund (2011), "The future of leadership and management in the NHS."
[31] Allen et al (2012a, 2012b) and Wright et al (2012).

considers uncertainty outside and beyond commissioning intentions. As in participation, uncertainty is liable to have an impact on the ability and willingness of providers to enter new areas and services and make investments.

A long-term commitment to a stable policy environment would reduce risks to investments by all types of provider in new and existing services, and in people and skills. This is particularly the case where investment decisions may be large scale, and where the policy environment is unpredictable.

People from both public and private providers said that an uncertain policy environment hinders their organisations from making investment decisions:

> "Policy instability is a real issue. It makes it very difficult for them to go ahead with longer-term investments in the sector." (Private sector provider)
>
> "The absence of longer contracts and stable prices makes it difficult to plan for the long term." (Public sector provider)
>
> "[…] there are barriers to entry for new entrants in terms of the initial investment required." (Public sector provider)
>
> "[…] the roles of the NHS Commissioning Board (NHS CB) and of Clinical Commissioning Groups (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)

Findings and conclusions

The negative impacts that policy uncertainty can have for investment and innovation – and the potential benefits of policy stability – are widely recognised. For example, "policy uncertainty" was the first area that the Julius Review[32] of the Public Services Industry highlighted as preventing the realisation of value. It was noted, including by reference to stakeholder views and differential experience across sectors, that long-term commitment from the Government is important for several reasons:

- having a programme of work allows both commissioners and suppliers to learn from experience as the process progresses;
- the risks to organisations entering new areas are reduced as they are not linking their entire investment to a single contract. This is particularly important when bid costs are high; and
- a programme of work encourages organisations to make a longer-term commitment in terms of investing in the necessary people and skills. Where

[32] Julius (2008), "Public Services Industry Review" http://www.bis.gov.uk/analysis/economics/public-services-industry-review

commitment is less clear, a higher risk premium will be included in the price offered.

Policy uncertainty can particularly matter when, in order to enter or expand, providers need to make irrecoverable investments, such as with the purchase and development of buildings and equipment. Research for the World Health Organisation has suggested that uncertainty is particularly problematic in health care:

> "A major challenge in designing hospitals – or indeed any large-scale investment project – to be sustainable in the long term is the long time periods involved in planning, financing, construction and operation […] Health care is much more complex [than other public sector infrastructure investments], characterized by rapid change, high recurrent costs, unpredictable horizons and the need for continuing reinvestment."[33]

In practice, strategic decisions can often more generally have a significant 'investment' component, even where capital expenditure (as typically understood) is limited. For example, entry and expansion decisions typically involve significant investments in the development of relevant capabilities, relationships, branding etc., and often such investments will represent a form of 'sunk' commitment once undertaken. Expectations in relation to future conditions, and thus policy uncertainty, can be a key feature in the assessments that underpin such decisions.

Previous research by Civitas makes a similar point in relation to the importance of policy stability:

> "There must be sustained commitment on behalf of the Government to the market and to principles and parameters that support it. This, above all, means consistency in policy (the continued lack of which is discouraging long-term investment)."[34]

This consistency is most likely to be achieved in the NHS when the Department of Health, the Commissioning Board and regulatory bodies are clear about their respective remits, transparent about their long-term objectives and openly work towards them over time. Stakeholders have expressed some scepticism, noting that "the same people are doing the same jobs with different labels." Nevertheless, the Act, by establishing autonomous bodies such as the NHS Commissioning Board and constraining the ability of Secretary of State to direct the health service, does help to address poicy uncertainty. At the same time, we recognise that different governments will inevitably have different views about the appropriate way to deliver public services. While these create policy uncertainty, it is an essential part of the democratic process.

[33] Rechel et al (2009), "Capital investment for health: Case studies from Europe.
[34] Civitas (2010), "Refusing Treatment".