

A fair playing field for the benefit of NHS patients

Supplementary Paper
March 2013

Participation Distortions



Fair Playing Field Review:

Supplementary Paper - Participation Distortions

1. Introduction

This section concerns providers' ability to participate in the delivery of health care to patients.

The ability for appropriate providers to have a fair opportunity to deliver clinical services was the single greatest area of concern raised by stakeholders during the review. These opportunities are created by commissioners, who have a duty to secure best value for patients.

The key potential fair playing field issues that can arise in relation to commissioning and procurement relate to incumbency advantages - existing providers can have significant advantages in terms of the provision of services going forward. If opportunities do not arise, or are not designed in a fair and appropriate way, then the most likely outcome is for the status quo to prevail, including where this may not be in the best interests of patients. Undue limitations on the opportunities that alternative providers have to offer services may hinder the potential for improvements in the quality, efficiency and effectiveness of patient care to be realised, and thus harm both patients and taxpayers.

Incumbent providers will often be public sector providers, although that will not always be the case. For example, some areas of mental health services are delivered primarily by the private sector.¹

Alternative providers will in some cases be private or VCS providers. They could, for example, be:

- private sector midwives delivering babies in the community;
- charities delivering hospice care or joint replacements; or
- social enterprise delivering diabetes services in the community.

In practice, though, bidding history for NHS contracts suggests that alternative providers are often likely to be other public providers who may be able to provide services in a different way. For example, a public sector provider of community services may be able to offer some services that provide an alternative to the provision of care in a hospital context. This factor, therefore, has relevance more generally to the potential for commissioning behaviour to inhibit some of the ways in which the delivery of services could evolve to the benefit of patients.

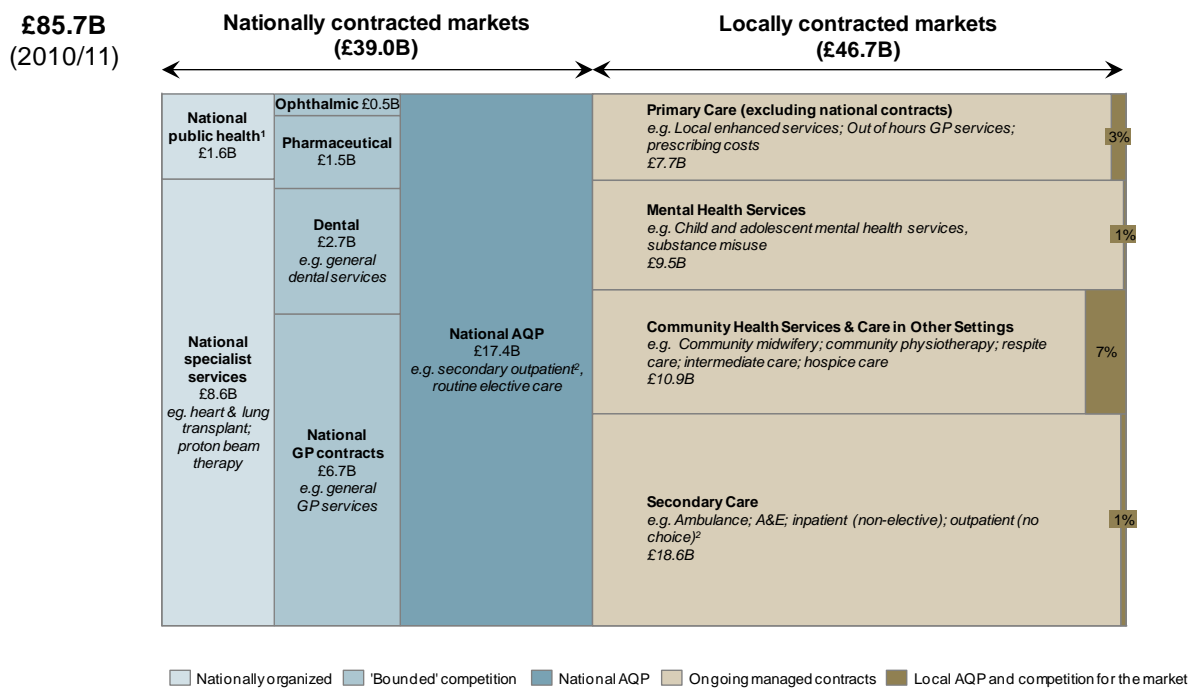
¹ NHS Confederation (2012): Review of the Provider Market for Mental Health Services: Report commissioned by the Department of Health

Given the extent to which commissioning and procurement were raised by stakeholders in response to our call for evidence, we considered related issues in some detail as part of the Review. The following summarises the scope of commissioning activities, before highlighting those areas which – in light of stakeholder comments – we focused on in the review.

1.1 An overview of how different services are commissioned

The annual government spend on NHS-funded clinical services in England is ~£86bn. This funding flows through various channels to buy a wide range of services from different providers – including, for example, from GPs providing primary care, Mental Health Trusts providing early intervention services, and highly specialised national centres carrying out complex procedures such as heart and lung transplants. A breakdown of these services, in terms of how they are contracted for and the level of associated funding, is provided below.

Figure 1: Overview of nationally and locally contracted markets in the NHS (from 1st April 2013)²



² Source: Department of Health (DH) programme budget 2010/11; DH 2012 Baseline spending estimates for the new NHS and Public Health commissioning architecture; Monitor Fair Playing Field Research 2012. (1) Chart does not include Local Authority element of public health spend. (2) Cancer, maternity and mental health outpatient services are excluded from national choice framework. See note at the end of this chapter for a full breakdown of what is included under each of these categories.

The playing field can be described in a number of ways: from thousands of individual contracts to Health Resource Group (HRG) codes to very high-level divisions between primary, community, acute and specialist care. The illustration of the playing field presented here divides it into 11 categories based on spending data. It draws on existing spending categories set out in two sources of spending data:

- Programme budgeting data for 2010/11.
- “Baseline spending estimates for the new NHS and Public Health commissioning architecture” published by the Department of Health in February 2012 but based on the 2010/11 data.

The latter data set maps the programme budgeting information into the new organisational structure of the NHS. This allows us to understand who will be spending the money under the new institutional structures.

The review and related work undertaken by Monitor and the NHS Commissioning Board (NHS CB) has been used to provide two further dimensions to our illustration of the playing field.

First, we have divided the categories into national versus locally contracted services. This is based on who is the counterparty to the contracts following the reforms. For example, national GP contracts, which will be agreed with the NHS CB, are placed in the “nationally contracted services” category.

Secondly, we have shaded the boxes to indicate the role of choice in each of the areas of the playing field. The figures at the right-hand side of the diagram reflect information from a survey of all commissioners (of which 50% responded) conducted as part of work being undertaken by the NHSCB and Monitor looking at the use of choice in locally commissioned services and by a review of Supply2Health tender notices that sought to understand the value of contracts being tendered locally.

1.1.2 Key commissioning issues considered in the review

It is for commissioners to determine the best way to secure services for their local population, subject to a framework of rules. Their options include extending and varying existing contracts, competitive tendering or widening choice of qualified provider.

In order to consider whether the opportunities for non-incumbent providers to offer services may be unduly limited, we considered the views of providers and commissioner (as well as other available evidence) concerning the processes through which commissioners determine their procurement strategies.

There are many descriptions of the activities involved in commissioning. We have chosen to look at the concerns raised by stakeholders under three categories of:

- **Strategic planning and the development of a procurement strategy:**
 - Strategic planning: 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
 - Procurement strategy: the determination of an approach to procurement given the outcomes of strategic planning. This includes the decision over whether to extend or vary the contracts of existing providers or whether to introduce additional providers, either instead of or alongside existing providers. It also includes the decision over how to 'bundle' the services being purchased.
- **Procurement processes:**

How planned procurement processes are implemented.
- **Whether patient choice of provider is supported:**
 - Where participation of providers depends on the choices patients make, whether NHS patients are able to make good choices.
 - We find that in each of these three areas there are improvements that could be made to ensure that patients are able to access the provision most suited to their needs.

A particular issue that was raised by stakeholder during the review was the commissioning and provision of GP services. This was a subject that cut across each of the three areas described above. Given this, some specific consideration to the potential for fair playing field issues to arise in relation to GP services is provided in a fourth section on:

- **General Practice and associated services.**
 - 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
 - concerns about a lack of choice of GP practices for patients

Note on programme budgeting data used to inform Figure 1 on page 2.

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- Programme budgeting data for 2010/11.
- “Baseline spending estimates for the new NHS and Public Health commissioning architecture” published by the Department of Health in February 2012 but based on the 2010/11 data.

We have taken the values directly from these sources as follows.

1. National Public Health (£1.6bn): this is spending identified within the category “public health spend commissioned through NHS CB”
2. National Specialist Services (£8.6bn): this includes spending identified within category “Specialised Services – NHS CB direct commissioning”
3. National GP Contracts: this includes spending identified within the category “GP services excluding local enhanced services and out of hours services”
4. Dental (£2.7bn): spending in the category “General Dental Services - contractor and salaried led (net of patient charges)” plus “Secondary dental care”
5. Pharmaceutical (£1.5bn): spending in the category “Pharmaceutical Services (net of patient charges)”
6. Ophthalmic (£0.5bn): spending on “General Ophthalmic Services”
7. National AQP (£17.4bn): spending on “Inpatient elective care” plus “Outpatient” minus “Outpatient – Mental Health; Cancer; Maternity”, which are not part of the National Choice Framework
8. Primary Care, excluding national contracts (£7.7bn): spending on “Out of hours primary care” plus “Services currently commissioned through local enhanced services (excluding public health)” plus “Prescribing costs” minus figure identified within primary care element of Mental Health programme budget category
9. Mental Health services (£9.5bn): spending identified within “Mental Health disorders”
10. Community Health Services and care in other settings (£10.9bn): spending on “Community Care” plus “Health and Social Care in Other Settings” minus spending identified within categories “community care” and “health and care in other settings” element of “Mental Health programme budget category”

Supplementary Paper - Participation

11. Secondary care (18.6bn): spending in “Ambulance” plus “A&E” plus “Inpatient non-elective” plus “other secondary care” plus “outpatient – Mental Health, Cancer, Maternity”

2. Strategic Planning and the development of a procurement strategy

Strategic Planning involves three key steps:

- Assessing local need.
- Assessing current provision.
- Identifying potential alternatives (market engagement).

These steps are designed to feed into the development of a procurement strategy that best reflects local demand and available supply.

The outcomes of these three steps will all directly inform the development of a commissioning plan. If Strategic Planning is not done effectively then the commissioning plan will not reflect an adequate understanding of the demand or supply side of the local healthcare market, and commissioners are less likely to be able to make the best decisions around future provision.

Strategic planning has a critical role in terms of fair playing field issues as the role that can potentially be played by alternative providers will be heavily affected by it. If insufficient attention is given to the potential role of alternative providers in the strategic planning process, then this will tend to reinforce the status quo, as the default position for most services will be for them to stay with the incumbent. Thus, the role that alternative public and non-public providers could play in seeking to improve the quality, efficiency and effectiveness of the provision of patient care may be unduly diminished.

2.1 Evidence on the introduction of new providers

An initial indication of extent to which commissioner strategic planning processes might unduly limit the opportunities of alternative providers can be provided by considering data on the extent to which 'local' services have been subject to competitive tender or local AQP arrangements. This highlights those occasions where providers other than the incumbent have been given specific opportunities to offer their services.

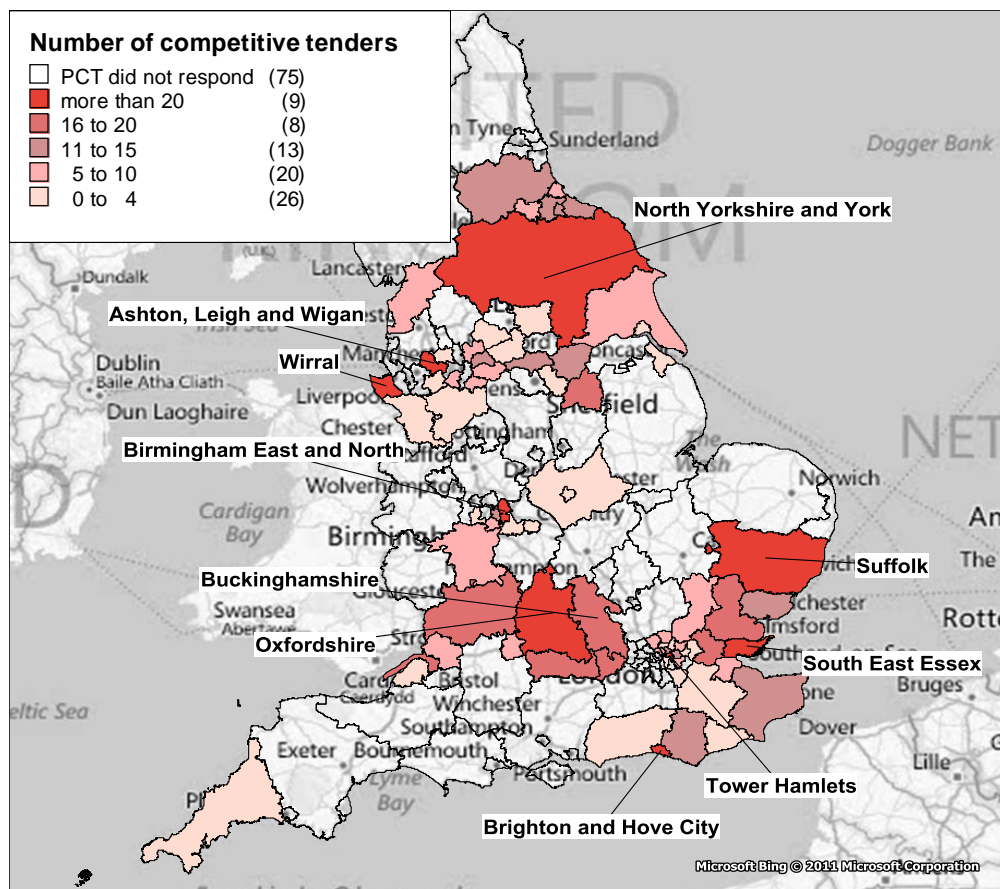
It is for commissioners to determine the best way to secure services for their local population, subject to a framework of rules. Their options include extending and varying existing contracts, tendering or widening choice of qualified provider. Recent research undertaken by the NHS Commissioning Board and Monitor on choice and competition in the NHS showed that less than 3% of the £46.78 billion budget that local commissioners used to provide clinical services involved the use of a competitive tender or local AQP. In practice, the extent to which competitive tenders and local AQP provisions were used differed by type of care:

- 1% of secondary care;
- 1% of mental health;
- 3% of primary care;

- 7% of community care.

There were also some significant differences by geographic area, with, for example, 8% of services being provided using a competitive tender or local AQP in the East of England, while the equivalent figure for London was only 0.7%. This looks to be a significant difference. While some geographical variation would be expected, given, for example, differences in local requirements, the extent of this difference is striking.

Figure 2: Number of competitive tenders undertaken by primary care trusts (PCTs) between April 2008 and September 2012 (survey respondents only)³



Only in some cases will the choice and competition be the most appropriate tool for improving services. Nevertheless, the very low level of the overall percentage of areas for which alternative providers have had the opportunity to offer services indicates – on the face of it – that strategic planning approaches may be unduly limiting the opportunities of providers other than the incumbent, and potentially to a significant degree. This was clearly the view of many stakeholders, and we were told by some that there were often

³ Source: NHS Commissioning Board/Monitor survey of all PCTs, results based on 76 PCT responses (50% of all PCTs) covering 700 competitive tenders. The top 10 PCTs (in terms of volume of competitive tenders undertaken) are labelled.

situations when alternative providers have been willing and able to offer higher quality services than the incumbent, but where commissioners had been unwilling to provide for a competitive process.

“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)

In order to examine this further, we considered evidence on each of the different stages of the strategic planning process: assessing current provision; identifying potential alternatives; and improving efficiency in the provision of services.

2.2 Assessing current provision

A key part of the strategic planning process is assessing current provision in order to understand the current 'baseline'. This enables the identification of current areas of poor performance, and – more generally – of where quality improvements may be possible.

Recent analysis undertaken for the Atlas of Variation⁴ highlights unexplained variations in the quality of care across England, helping commissioners identify where to focus attention to improve care. The study makes clear that there are variations in the relative quality of care provided from region to region. Where lower quality care does exist, it raises the question of what commissioners are doing to address it. Although introducing new providers will not be the solution in every situation, it is relevant to ask whether commissioners have considered using this as a tool to improve the quality of care their populations.

The review heard from several commissioners that, in practice, they are only able to assess a relatively small proportion of the total number of contracts they hold with providers of clinical services. As one remarked:

“Contracts are managed at different levels depending on their complexity. We have over 350 contracts of varying complexity and the level of management applied and needed by these contracts varies dependent on their complexity, value and length. 40 or 50 of these are managed in great deal with the remainder having varying levels of input.” (Commissioner)

In a workshop, another commissioner noted that the recent CCG authorisation process had required them to catalogue all the contracts they currently held, bringing to light some that they had not known existed. Two providers described instances of their contracts running out without commissioners noticing.

If commissioners are only actively assessing a relatively small proportion of their services, then the potential for opportunities to be created for alternative providers is inevitably likely to be somewhat limited. One commissioner confirmed that if a new entrant came to them

4 <http://www.rightcare.nhs.uk/index.php/nhs-atlas/>

and was able to offer higher quality services they would probably turn them away "unless it happens to be in one of the 3 or 4 services we are reviewing that year"⁵.

Concerns were also raised by several stakeholders that commissioners are, in some instances, including a greater number of key performance indicators (KPIs) in the contracts of private sector providers and that their decision of when to use service reviews may not always be made in an even-handed manner. While evidence for this is largely anecdotal, commissioners we spoke to confirmed their understanding that this does take place. They suggested that it may be motivated by a greater degree of risk aversion in relation to private sector providers due to the perceived additional reputational risks for commissioners associated with underperformance by a private sector provider.

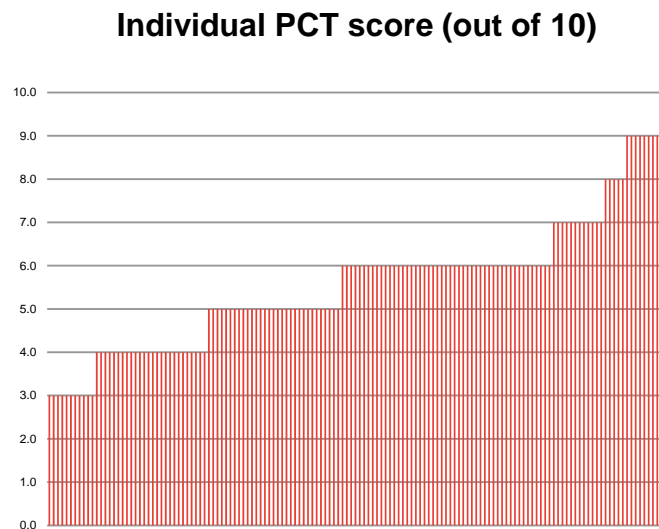
However, the greater number of KPIs may in part be understood as a result of commissioners moving toward a more contractualised set of arrangements with new providers than they have previously maintained with public providers. The opportunity to reflect on the appropriate indicators to manage providers' performance may be an additional benefit that arises through a rigorous strategic planning process.

2.3 Market development

The importance of commissioners engaging in market development activities has been recognised for some years, and several previous policy initiatives have been launched in order to develop skills in this area. The World Class Commissioning (WCC) exercise sought to understand the level of capability in commissioners across eleven different areas. The last WCC exercise was conducted in 2010 and tested PCT competencies across 11 areas, comprising a total of 33 sub-competencies. The area relating to commissioners' ability to "stimulate the local market" received some of the lowest scores, with the vast majority of commissioners scoring 6 or lower out of 10 - i.e. they had at most only 'baseline' competency (see figure below)⁶.

⁶ Note, this is based on the combined score of 3 sub-categories that make up 'stimulate the market'. Each is scored out of 4, with 2 representing 'baseline performance', 3 representing 'national best practice' and 4 representing 'world class commissioning'.

Figure 3. World Class Commissioning Scores for ability to “stimulate the market”⁷



Scoring of performance in this area was based on having certain skills, processes in place and knowledge, all of which lead to outputs. These are summarised in the table below:

World Class Commissioning – Ability to Stimulate the Market

Scoring of performance in this area was based on having certain skills, processes, knowledge and outputs.

Skills expected:

- Establishing and developing formal and informal relationships with existing and potential providers.
- Patient, public and staff engagement skills.
- Signalling to current and potential providers their future priorities, needs and aspirations.
- Provision analysis and monitoring skills, risk assessment, market segmentation, simulation tools.
- Project management skills.
- Negotiation skills.
- Presentation and influencing skills.

⁷ Source: HSJ presentation of scores from WCC exercise – see <http://www.hsj.co.uk/maps/world-class-commissioning-scores>.

Process and knowledge expected:

- Maps and understands strengths and weaknesses of current service configuration.
- Deep understanding of methods to find out what matters to patients, the public and staff and is able to respond when defining service specifications.
- Models the impact of commissioning decisions on current service configuration.
- Promotes services that encourage early intervention.
- Has clear understanding and knowledge of the abilities and role of the third sector.
- Translates strategy into short, medium and longer term investment requirements.
- Is aware of market trends.
- Creates incentives where necessary for market entry.
- Stimulates provider development matched to the requirements of the user.
- Specifies realistic time schedules.
- Develops relationships with potential providers.
- Communicates with the market as an investor.

Outputs expected

- Rigorous, clearly defined commissioning strategy.
- Summary and analysis of patient, public and staff data, surveys, focus groups, complaints and concerns.
- Analysis of provider networks.
- Summary and analysis of provider data.
- Demonstrable methods to reward providers for consistent high performance.
- Process for quality assurance.
- Reports to Board on provider development and management issues

The box above describes the types of skills that were examined as part of understanding competence in this area. We are not aware of any analysis breaking down the overall score into this category into its component parts. However, some involved in the process suggested that scores were low across many of the areas, particularly:

- the depth of relationships and understanding of alternative providers;
- stimulating provider development; and
- communicating with the market as an investor.

These and other factors led to commissioning strategies that did not have the depth that was expected from the evaluators.

The King's Fund reached a similar conclusion in a 2010 study, commenting that:

“The interviews and focus groups conducted as part of our research included questions on the developmental needs of PCTs [...] 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.”⁸

These findings are consistent with a range of more general observations made in other examinations of commissioning capabilities:

- Checkland et al, assessing commissioning in the English NHS, stated that explanations for a perceived "failure" in commissioning amongst politicians and policy commentators focus on the capability of staff engaged in commissioning.⁹
- The House of Commons Health Committee highlighted that the: "World Class Commissioning assurance process confirmed that the quality of commissioning by PCTs was largely poor to mediocre. There was a sizeable gap between what was being delivered and the standards expected."¹⁰
- The Health Committee also noted that: "The Department itself acknowledged that in the past, commissioning had often been seen within the NHS as a less attractive career option and of lower status than managing acute NHS trusts, and consequently the calibre of leadership was often weaker, particularly at middle management level."¹¹
- Chris Ham, writing in the *Journal of Health Services Research and Policy*, noted that: "A recurring theme in the reflections of US observers of the UK NHS is the need for commissioning organisations to be large and strong, and to have sufficient resources to hire staff with the requisite skills. In practice, this means

8 The King's Fund. 2010. Building High-Quality Commissioning.

9 Checkland et al (2012), *Commissioning in the English National Health Service: What's the problem?* Journal of Social Policy.

10 HOC Health Committee. 2010 Fourth Report of Session 2009-10, Volume 1.

11 HOC Health Committee. 2010 Fourth Report of Session 2009-10, Volume 1.

investing resources in hiring experts with relevant skills on a scale much bigger than hitherto contemplated."¹²

The ability to 'stimulate the market' is an important skill in relation to the focus of this review. It can provide for a more credible signal of opportunities for alternative providers to participate, and provide a firmer basis upon which potential providers can better understand likely commissioner requirements. Several stakeholders expressed the view that commissioners lacked capabilities in this area.

For example, one stakeholder commented that commissioners sometimes confused the distinction between market development (where they are encouraged to have open dialogues with any providers) and engagement during a specific tender process (where there are strict rules about disclosure and conflict of interest). As a result, they would default to 'playing it safe' and not engage with providers for fear of breaching procurement rules. Stakeholders made a range of more general comments on commissioner capabilities that are considered further below.

2.4 Designing a procurement strategy

In light of their assessment of current provision, and the identified potential for alternative sources of provision through market engagement, commissioners need to design a procurement strategy.

2.4.1 Factors that may constrain commissioners' consideration of alternative providers

The review identified a number of factors associated with the designing of commissioners' procurement strategy that can be expected to undermine the extent to which commissioners provide opportunities for alternative providers to offer services. In particular:

- the stability and predictability of the environment within which commissioners develop their procurement strategy;
- limitations on the capacity and capabilities of commissioners when developing that strategy;
- the risk/reward balance that commissioners may consider they face when assessing alternative approaches.

These issues are considered in turn below.

¹² Chris Ham. 2008. World Class Commissioning: A Health Policy Chimera? Journal of Health Services Research and Policy. Vol 13. No 2. April 2008.

2.4.1.1 The stability and predictability of the commissioning environment

Commissioners (including at 2 workshops and in a number of interviews) identified a number of factors, related to the stability and predictability of the environment within which they operate, which were considered to make it difficult to think and act strategically. These were:

- frequent wholesale restructuring of the commissioning system;
- uncertain income levels given annual budget settlements; uncertain outgoings given annual fluctuations to the national tariff; and
- shifting priorities in the operating framework each year, and from other annual targets.

One commissioner described the impact of these factors as follows:

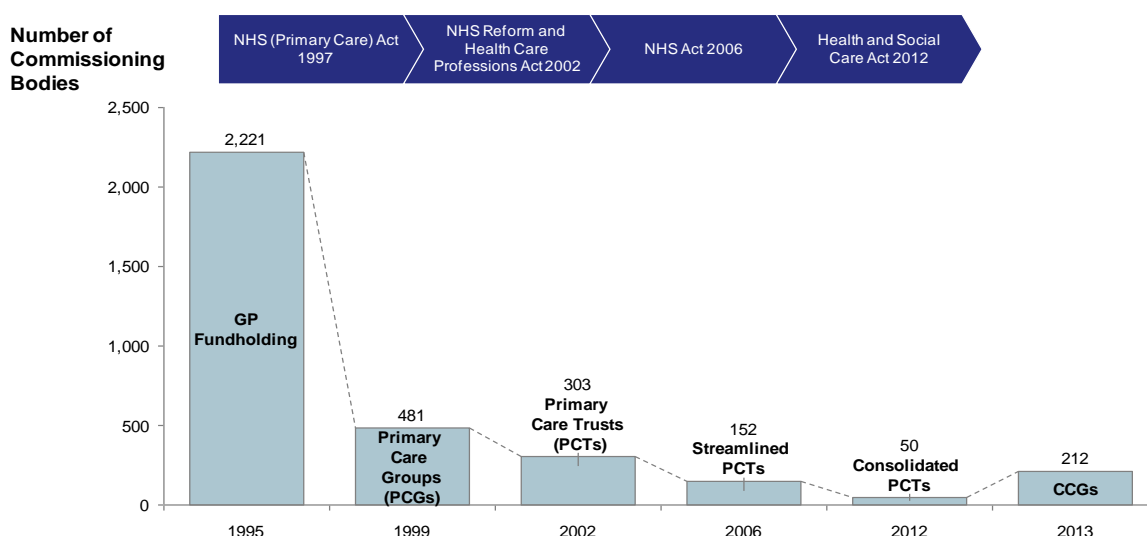
“Most of the time we’re treading water – at best.”

That is, these factors can result in putting a lot of focus on managing short-term budgets, especially in relation to their local acute services, and as a result finding it difficult to think strategically about the long-term design of their procurement strategy in relation to services more broadly. These factors are discussed below.

Frequent restructuring of the commissioning system

Commissioning in its present form has its origins in the purchaser-provider split, which dates back to 1991¹³. There have been several organisational changes since then, and the NHS is currently transitioning to the next commissioning model, to start in April 2013. This journey can be seen in Figure 4 below.

Figure 4: Restructuring of the commissioning system



13 Following the NHS and Community Care Act 1990.

We heard from several commissioners during the course of the review of the impact that wholesale changes to the commissioning landscape had on their ability to carry out 'business as usual' activities.

Uncertain income and outgoings

Commissioners can face significant uncertainties over their future income and outgoings that can be difficult to predict. There is uncertainty over how much funding they will receive in their annual budget settlement. They also face difficulties predicting their costs given the extent to which national tariff prices can fluctuate year on year, and movements in the level of efficiency targets that are set for foundation trusts (FTs). The extent of tariff movements in recent years was highlighted in a recent report commissioned by Monitor¹⁴.

Shifting priorities

Commissioners told us that priorities, including targets, set in the operating framework can get in the way of them deciding locally where to prioritise their resources and attention.

2.4.1.2 Limitations on the capacity and capabilities of commissioners

Over the course of this review, 55% of stakeholders – including commissioners themselves – highlighted low capabilities and skills as a major issue in commissioning. A number of providers commented in general terms on capability concerns.

“The commercial capability within the NHS is pretty dire [...] I have been continually appalled that a multi-billion pound business [...] has such a poor level of commercial expertise.” (Commissioner)

“Our experience of commissioners suggests that sometimes they lack capability, or a full understanding of their objectives and certainly are very stretched in terms of resource.” (Public sector provider)

Capacity limitations were also highlighted by a number of commissioners as a major issue:

“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)

One message from engagement with commissioners was that they have fixed resources and multiple priorities, and that their capacity to undertake competitive procurement is limited. The process involved in competitive tendering can be expected to be more resource intensive than the process of rolling over existing contracts. In stakeholder discussions, the consensus was that the lack of commissioner capacity does represent a major barrier to competitive procurement.

14 An evaluation of the reimbursement system for NHS-funded care, PWC (2012).

This view that capacity constraints have an impact on commissioners' ability to conduct additional tender exercises has also been commented on in previous reports. In 2011 the Nuffield Trust reported that:

"The process of specifying, tendering and contracting for new forms of integrated care was prohibitively costly in some of the cases examined [...] It will become increasingly difficult to fund and undertake such radical pathway redesign and contracting once 45% management costs have been removed from NHS commissioning by 2015, and in a context where resources for anything other than frontline services are subject to major scrutiny as efficiency savings are sought."¹⁵

An earlier report by Chris Ham also commented on this issue, comparing it to levels of capacity in equivalent roles in other health care systems:

"Managed care organizations in the US have levels of administrative support 30 times higher per capita than primary care organizations in England (based on 1999 data). These observations are reinforced by evidence from earlier UK experience of commissioning indicating that total purchasing pilots with higher levels of management expenditure achieved the best outcomes."¹⁶

In a recent survey, 71% cited "lack of CCG / commissioning capacity and capability" as a key impediment to their effectiveness in the coming year¹⁷. With only a finite level of resources available, commissioners need to make efficiency gains or better target existing resources to increase the number of services put through a more complex process.

The case study below illustrates the benefits that can be achieved through building effective capacity in relation to procurement.

Case Study – East of England capacity and capability building

East of England Strategic Health Authority invested significantly in capacity and capability building in procurement. They established a Strategic Projects Team (SPT) with clear remits to support procurement – the only example of its kind nationally.

Over 50% of the SPT staff had relevant commercial experience from non-public sector backgrounds¹⁸. The region now has the highest level of competitive procurement nationally, with 4.3% of local NHS spend competed, compared to a national average of 1.5%¹⁹.

Over four years the SPT provided bespoke support around complex transactions. They

15 Nuffield Trust 2011. Commissioning Integrated Care in a Liberated NHS.

16 Chris Ham. 2008. World Class Commissioning: A Health Policy Chimera? Journal of Health Services Research and Policy. Vol 13. No 2. April 2008.

17 HSJ CCG Barometer Survey, November 2012.

18 SPT website: <http://www.strategicprojectseoe.co.uk/>

19 NHS CB / Monitor, Choice and Competition team

managed a total contract value of £3.7bn.

The SPT have delivered projected savings to the NHS of £400m and created £100m additional external investment to the NHS. The team won the Procurement Leaders Award (2012) for their work at Hinchingsbrooke, seeing off competition from the State of Arizona and Singapore Health Services. They have also been highlighted by the Department of Health (DH) as a gold standard for others to follow.

Source: Your Strategic Projects Team, NHS East of England (2011)

2.4.1.3 The balance of risk and reward

A number of factors were found to have a potential impact on the way in which commissioners assess the risks and rewards associated with providing opportunities for providers other than an incumbent to offer services:

- fear of destabilising a local provider or the local health economy;
- concern that allowing for other providers may undermine the provision of integrated care;
- a lack of understanding of the potential benefits that alternative providers could bring;
- pressure (either internally or from other parties) to maintain the status quo; and
- the risks of challenge.

We discuss each of these in turn, below.

Destabilisation

Even when commissioners have the capacity to conduct effective strategic planning, they frequently come up against the challenge that changing the structure of clinical provision in their area presents them with new risks that need to be managed. For example, the desire to move a profitable service away from an acute trust because you want it delivered in a community setting could potentially have a detrimental impact to that trust's overall financial health.

The threat of destabilising an incumbent provider, or even an entire health economy, was cited by some stakeholders as a reason why changing patterns of provision could bring significant risks. This issue has also been commented on in other investigations of the topic. For example, a Civitas report noted that:

“...a defining feature of markets is that organisations can fail. However, a few interviewees referred to a significant contradiction between this and the reluctance of any government to countenance hospitals closing or being taken over, often for fear of harming the NHS ‘brand’. In the words of one PCT executive: ‘We can’t afford, politically, to shut down a hospital, however bad it is.’ Another reported (for the same reason): ‘We can’t put competition against a failing district general hospital.’”²⁰

This can have a direct impact on the ability of patients and taxpayers to secure higher-quality services:

“A private provider bid for a service that was being commissioned in the community instead of the acute. The tender was pulled late in the process when the PCT realised that the acute would have over £50m gap in its financials. The private bid was £20m lower than the incumbent's.” (Private sector provider)

In terms of the potential for destabilisation, commissioners can face an asymmetry of information relative to incumbents. They may rely on incumbents to provide the data they need to make effective decisions on how to manage the risks involved.

The review heard evidence from commissioners of incumbents using this asymmetry to their advantage. One commissioner described a situation where they decided that it was appropriate to put a service out to local AQP. The local acute trust was the only incumbent currently delivering this service, and raised very strong objections – citing the fact that competition for this service could leave them financially unviable. The commissioner described that the trust did “everything in their power to stop us from going to AQP”, but the PCT maintained its position and pressed ahead with the plans. When the service was put out to tender on an AQP framework, however, the trust did not bid for it. When asked why this was by the commissioner, given the fact they had fought so hard to keep it, the trust authorities admitted that it wasn't an important service for them.

The following example demonstrates the improvements commissioners can introduce to patient care by being prepared to challenge the status quo.

Case Study: Fertility Treatment

A PCT wanted to combine two Fertility Services contracts under a single provider, replacing two previous contracts that had been awarded to private and NHS providers.

The PCT conducted a market assessment and judged that a competitive tender process was appropriate. The tender process received four bidders from both public- and private-sector providers. A public-sector provider was ultimately chosen to deliver the service.

The procurement resulted in improved quality of service, reduced waiting lists, better

²⁰ Civitas. 2010. Refusing Treatment..

capacity, and cost savings.

A representative from the PCT told the Review: “It is important to organise your team effectively and early. Lack of clear roles and responsibilities can lead to delays and loss of focus on the potential benefits and opportunities. The PCT must know the marketplace and the factors which influence quality and the cost to serve”.

Integrated care

It is also clear from our stakeholder engagement that many commissioners consider the introduction of the possibility of multiple, alternative providers as having the potential to undermine the delivery of integrated care.

In terms of integrated care, Monitor recently published an independent report into this area highlighting integrated care as "not about structures, organisations or pathways – it is about better outcomes for service users."²¹ 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.”

Speculative benefits

Many commissioners we spoke to commented on the fact that the benefits of introducing new entrants to a market were not clear to them. For example, a lack of good, comparable information can make it difficult to make confident assessments based on quality.

A number of charities complained that commissioners do not take adequate account of the contribution they make over and above the delivery of narrow service specifications. It was pointed out to us that recent changes introduced by the Social Value Act 2012 require commissioners to do so.

Pressure to maintain the status quo

Cultural pressures can compound the likelihood that commissioners will maintain contracts with incumbents. This can manifest itself in several ways. Qualitative evidence from commissioners and providers suggests that the personal and professional links that commissioners have with local providers can be important, despite the purchaser-provider split, as can related political pressures. These links can make commissioners wary of doing things that would upset the status quo. This barrier was cited by a wide range of stakeholders, and it is clearly an emotive issue:

21 Monitor, Barriers to Integrated Care (2012).

“There is a cartel nature of NHS providers ... they can stop things happening that they don't like. They are very powerful lobbyists with significant influence – they have both public acceptability and large numbers working for them – it's hard to stop commissioners caving in to that.” (Commissioner)

“Sometimes it is politically unacceptable for a non-NHS organisation to be the lead contractor.” (Private sector provider)

This barrier has also been commented on elsewhere: a joint Nuffield Trust and King's Fund report highlighted a "power differential" between PCTs and trusts, with PCTs appearing to be fundamentally weaker organisations when compared with the powerful position occupied by health care providers and, in particular, hospitals²².

- Incumbent providers (especially larger ones, in established positions) may seek to exert influence over commissioners for their own benefit.
- Certain communities and groups, such as local populations, might exert pressure to preserve existing institutions and models of care.
- Where incumbent providers are public sector organisations, commissioners can feel conflicted in acting in a way that they might perceive to be against the interests of people they have organisational links to.

In a recent survey of CCGs conducted by the HSJ²³, 81% of respondents agreed that they expected that the effectiveness of CCG commissioners would be hindered by “resistance from existing providers and their clinicians” and “political opposition to service changes” in the forthcoming year²⁴. This is illustrated by the case study below.

22 Nuffield Trust and The King's Fund (2010) *Where next for commissioning in the English NHS?*

23 HSJ CCG Barometer Survey, November 2012.

24 HSJ CCG Barometer Survey, November 2012.

Case study: Community-based minor surgery

A new approach to minor orthopaedic surgery was pioneered with the support of an NHS teaching hospital and PCT in the early-mid 2000s. This approach saw the surgery delivered within GP practices, rather than within the local hospital. It showed clear benefits to patients, in terms of higher quality outcomes, and was delivered at lower cost to the PCT.

A GP sought to duplicate this approach in another part of the country, and approached the local PCT and acute hospital to discuss the alternative, community-based pathway.

The GP reported that despite clear evidence of the potential benefits, it still required him to invest considerable time and resources in negotiating with his local PCT to get this service into operation. He felt this was at least in part due to "strong lobbying against the idea by the acute hospital" who felt that it could result in destabilising them.

The service was eventually tendered, but only after 3 years of concerted efforts by the GP to set it up.

The approach now delivers 80% of local services, with benefits both to patients and taxpayers:

- Hospital surgery costs £1,360 per treatment; community delivery costs £570 per treatment.
- Patients in hospital receive six-week sick notes; community patients are fit to return to work much more quickly (usually within two weeks).
- Hospital surgery can take many hours on site; community surgery takes ~30 minutes.
- Hospital patients have waiting times of many weeks; community patients have no more than ten days' waiting time.

The risks of challenge

The risks in this area are compounded by the fact that commissioners may attract a significant amount of public scrutiny for any decision that threatens to change the status quo. 30% of stakeholders, including commissioners themselves, expanded on this topic, citing it as a significant barrier.

“Commissioners don’t want to go out to tender because they’re scared of challenge and criticism.” (Private sector provider)

The net impact on the balance of risk and reward

The main finding in this area is that current arrangements frequently support the preservation of the status quo, even when a change could result in higher-quality services. Stakeholders told us that commissioners tend to be quite risk-averse, and see relatively little “upside” in choosing to put services out to tender or experimenting with new providers.

“The NHS in general is often excessively risk averse. Inappropriately so.” (Clinician)

“[Commissioning] has a problem of demand and not supply [...]The problem is that none of the commissioners see any upside in developing these capabilities. No one will thank them for running a more professional process, but many people could attack them.” (Think tank)

2.4.2 Bundling

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 so, they need to offer a range of activities or services beyond their capability.

15% of respondents to the discussion paper ranked this as one of the most important issues for the Review to address.

Bundling encompasses several different issues: national and local tariffs may bundle together particular activities into a single price; block contracts may bundle together several services into a single contract. We discuss bundling related to activity and pricing under our discussion of “case mix” in the cost section. Here we discuss block contracts and the bundling of services.

Providers can be prevented from getting on the playing field if, in order to so, they need to offer a range of activities or services beyond their capability and/or appetite. This can happen when (say) a provider is only able to supply one service, but a commissioner will only purchase that service from it if it also agrees to supply another service.

Bundling is in patients’ interests when, for example, it is necessary to reduce transaction costs, deliver economies of scale and scope, and enable integrated care. However, bundling could distort the playing field and be against patients’ interests when it is not a result of a reasoned decision about who is best placed to supply different services, but rather a consequence of:

- restrictions or deficiencies in the reimbursement system – for example, a single Payment by Results (PbR) tariff for multiple activities and services that could be efficiently supplied separately; and/or

- limitations in commissioning – for example, a lack of knowledge about who could supply the services; and/or
- the behaviour of incumbent providers – for example, a provider may be unwilling to supply one service where it has market power unless the commissioner agrees to buy another service from it.

Stakeholders were concerned that bundling could distort the playing field.

“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)

Unfortunately, there is no comprehensive source of information that either (a) describes the activities or services that commissioners will only buy in combination (for any of reasons set out above) or (b) lists those services or activities that could be efficiently supplied separately. As a consequence, it is very difficult to gauge the extent of bundling that happens or identify when it is most likely to distort the playing field.

Stakeholders pointed to the use of block contracts as an indicator of bundling. That is, although the use of 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 use of block contracts often coincided with such a situation.

The evidence on spending shows that block contracts are frequently used in relation to community and mental health services. Figure 4 below shows that 65% of mental health payments and 90% of community payments were made under block contract arrangements in 2010-11. These arrangements therefore account for approximately £15 billion of spending²⁵.

Figure 4. The use of block contracts in the NHS

	Acute	Mental health	Community	Total
PbR	65%	0%	0%	£28 billion
Block contracts	35%	65%	90%	£36 billion
Local tariffs		35%	10%	
Total	£44 billion	£12 billion	£8 billion	£64 billion

We therefore looked at the block contracts used in community services in more detail. Our research shows that they did indeed cover a large number of quite different services. We asked four community trusts for information about the number and type of services they

²⁵ Sources same as for Figure 1 above.

supply; we found that they each provided between 47 and 67 different services across the range of case management, clinic-based care, bed-based care and walk-in care. A single community trust could provide anything from advice to the community about whether and where they should seek treatment (case management), to blood sampling (clinic-based care), to nursing for the elderly (bed-based care), to sexual health advice (walk-in care).

The fact that these wide-ranging services are purchased together does not necessarily distort the playing field. But some stakeholders (including commissioners) suggested that this was often not the result of a reasoned decision about who is best placed to supply different services, but rather a consequence of:

- restrictions or deficiencies in the reimbursement system – specifically, a lack of separate tariffs for services covered by the block contracts (we note that this is set to change for mental health services); and
- limitations in commissioning – including a lack of capability and capacity to undertake separate procurement exercises for each service.

The information available has not allowed us to conclude definitively whether bundling is distorting the playing field and is against patients' interests.

However, the evidence we have gathered further reinforces the need for ongoing 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. Procurement processes

There are a number of ways in which commissioners can, intentionally or otherwise, make decisions during tendering processes that can weaken the ability of some sufficiently qualified providers to compete relative to others. Where this results in higher-quality and/or more efficient and effective providers missing out on the opportunity to participate, patients and taxpayers both suffer.

3.1 How might procurement processes have a fair playing field impact?

Commissioners design and run procurement processes in order to select appropriate providers to deliver required services. This can result in them procuring multiple providers *in* a market (such as local AQP services), or procuring a single provider *for* a market (such as the provision of local acute services through a single trust).

Large elements of the procurement process are nationally mandated, providing procurement teams with clear guidance on what to do. However, commissioners have discretion over the design and execution of certain elements of the process, allowing them flexibility to tailor it to local needs. This factor focuses on the way in which commissioners use this flexibility, and the impact this can have on different providers' ability to participate effectively in the procurement process.

In particular, the specific way in which tenders operate can potentially generate undue advantages and disadvantages for particular types of potential provider. This can make particular types of provider less likely to be successful, and may make them less likely to participate in the first place. This may be particularly so when smaller providers are being considered, given the resources that may be required in order to fully engage with the tendering exercise.

3.2 Evidence on potential fair playing field impacts

We have received a significant amount of feedback from all provider types that tendering processes deliberately or inadvertently favour incumbents - through interviews, responses to our call for evidence and to our discussion document, and at engagement events. In particular, the potential for tendering processes to cause unfair distortions was regarded as an issue by 68% of the stakeholders consulted during the review. This is supported by evidence gathered by the Future Forum and referenced in 'Securing Better Value for NHS Patients' (DH 2012).

We have considered evidence on a number of particular ways in which some types of provider could potentially be disadvantaged in tendering processes. In particular:

- the administrative burden of the tender process;
- the length of the tender process;
- delays in tendering processes;

- the definition of service requirements;
- working capital and reserves requirements,
- contract length.

The following also considers more general concerns about bias and conflicts of interest in tendering processes, and evidence on participation in tenders.

3.2.1 The administrative burden of the tender process

One issue that was highlighted by commissioners and providers was the potential for disproportionately burdensome tender processes to be used. For example, stakeholders commented that:

“[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 running of an acute hospital.” (Commissioner)

Related issues on the use of disproportionately costly tendering approaches have also been commented on elsewhere:

Civitas reported that: “We found certain PCTs to be using contracts of over 160 pages for community services worth little more than £70,000 per annum i.e. below the threshold for tender.”²⁶

Unduly high administrative costs have the potential to deter participation, in particular by smaller providers.

3.2.2 The length of tender processes

A number of participants in workshops and stakeholder forums held by the review remarked that short timelines clearly favoured incumbents and made it difficult or impossible to bid as a new entrant. One recent example of this was a recent invitation to tender (ITT) seen by the Review team for local AQP services. The tender was put out just before the Christmas holidays with less than a month's turnaround time, and a requirement for providers to already have links to an incumbent's IT system. Some local, alternative providers felt that the process was designed in a way that deliberately excluded non-incumbents from entering the market.

However, unduly long tender processes can also be problematic as they can imply significant resource demands on those who participate. One stakeholder gave the example of procurement for a Recovery at Home service which had a detailed tender process that took a total of 22 months. An equivalent area had procured a very similar service at the same time: using a simple specification and having already informally tested / engaged the market, the tender process took “approximately 20 days.”²⁷ We were told

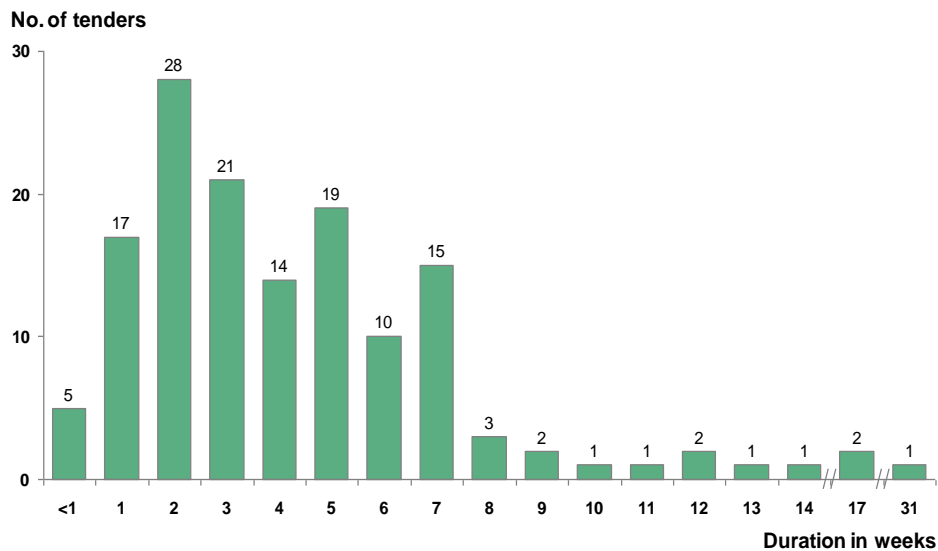
26 Civitas. 2010. Refusing Treatment.

that smaller potential providers were often unable to bear the costs of investing at risk over such a long period and that this unfairly excluding them from a process that could have taken far less time to conduct.

Similar issues have also been identified in other studies. For example, Alterline research reported that: “Some interviewees expressed frustration at the length of time it takes to procure services and the additional costs this incurs. Buying cycles are often extremely lengthy with many taking well over 12 months from the initial concept through to contract negotiations. Lengthy procurement partly stems from a misunderstanding of what is required legally and a feeling that more haste less speed is better for all.”²⁸

Analysis of an online tender portal reveals variation in tender timescales for similar services, as can be seen in the following chart.

Figure 5. Duration of UK brain injury, stroke services and Huntington disease services tenders (2008 – 2012)²⁹



It is not possible to say from this data whether the tenders were executed appropriately or not, but it is clear that there can be a relatively wide variation in timescales for similar services (from less than a week through to over half a year). This was commented on by a stakeholder during the review, who saw the variation in tender execution from region to region as a major barrier to them achieving economies of scale nationally, as every time they wanted to bid to run the same service in a different location they have to reinvent their approach.

²⁸ Alterline Research 2012. Strategic Outsourcing in the NHS: Beyond ideology and money?

²⁹ Tenders Direct, December 2012.

3.2.3 Delays in tendering processes

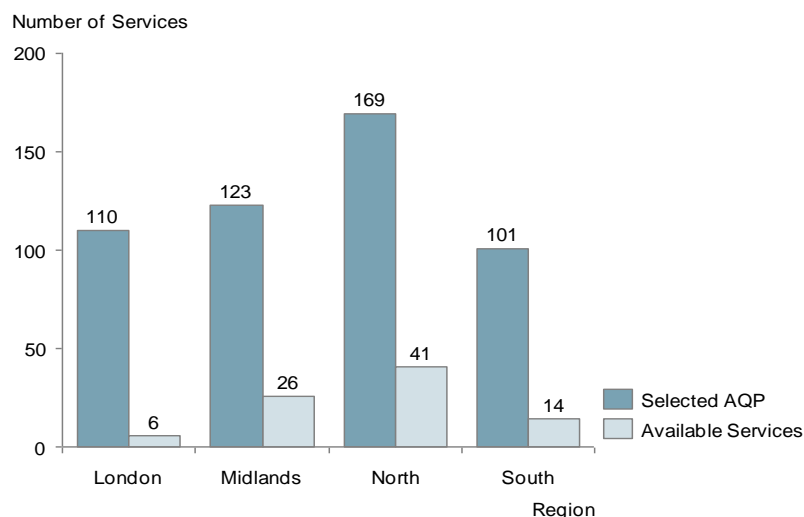
One area where there has been a delay in opportunities to provide additional services has been local AQP. Following an engagement with patients, health care professionals and providers, the NHS Mandate provided that PCTs should have identified three or more community services for local AQP implementation by 31 October 2011, and have implemented AQP by September 2012.

AQP roll-out started with selected community and mental health services from April 2012. The DH identified eight services, from which commissioners were expected to select three or more for their local areas in which to implement AQP for 2012/13.

It was expected that, following an engagement with patients, health care professionals and providers, PCTs would have identified three or more services for AQP implementation by 31 October 2011, and have implemented AQP by September 2012.

However, by the end of December 2012 only 87 services were fully available to providers, and only 13 PCTs were delivering the full 3 AQP services³⁰.

Figure 6. Available AQP Services by PCT³¹



The delay to the tendering of local AQP services will have a direct effect on those new entrants looking to enter these markets by raising the cost of bidding and postponing potential income from the delivery of services. This is particularly likely to be felt by smaller potential providers, who are more dependent on individual contracts.

30 Source:

<https://www.supply2health.nhs.uk/AQPResourceCentre/AQPMap/Pages/servicesmapdataall.aspx?Status=s>
– accessed on 21 December 2012

31 Source:

<https://www.supply2health.nhs.uk/AQPResourceCentre/AQPMap/Pages/servicesmapdataall.aspx?Status=s>
– accessed on 21 December 2012

3.2.4 Specification of service requirements

Some stakeholders raised particular concerns over the reliance that commissioners can place on incumbent providers to help them scope service requirements.

“[Incumbents] are often involved in scoping of service tenders, whereas we are often not engaged until late in the process.” (VCS provider)

“It is often clear to us that the incumbent has scoped significant parts of the spec prior to involvement of any other organisation.” (Private sector provider)

Where this occurs, the incumbent will be advantaged both in terms of their understanding of the requirements, and their ability to provide the relevant responses.

“There needs to be equal access to datasets used by commissioners. The providers for services cannot put in an accurate bid for services if they do not understand the requirements and challenges.” (Private sector provider)

Another pointed to ways in which service specifications can favour particular types of provider:

“Tenders are put forward as suitable for social care providers which are potentially skewed in favour of clinically based providers – includes forms of contracts which a non-clinical provider could not meet (e.g. in terms of registration with professional bodies), wording and language in contracts which is not understandable outside specialist clinical environments.” (VCS Provider)

3.2.5 Working capital and reserves requirements

Particular concerns were raised by a number of stakeholders (and in particular some VCS providers) over the requirements on working capital and/or reserves specified in contracts. For example, a social enterprise considered that:

“Immature commissioning capabilities often result in very risk-averse commissioning behaviour and an over-reliance on the procurement process, rather than intelligent commissioning, to protect against risk.”

This was said to result in:

“An over-reliance on financial stipulations within contracts – which are disproportionate to the size of the contracts and penalise under-capitalised social enterprises.” (Social enterprise)

It was noted that limited trading history, reserves and asset base was common for social enterprises, and could be particular issues for social enterprises that had been ‘spun out’ of the NHS (having previously been PCT ‘provider arms’). Similar stakeholder comments were made by other VCS providers and some private providers:

“[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)

‘Access to the working capital necessary to sustain PbR contracts [...] has been reported widely by our members as a key barrier to bidding for contracts.’ (VCS Provider)

“Commissioner for health prevention services sought a bond – as a social enterprise, we cannot get these. (Social enterprise)

“Often the minimum turnover / years of trading requirements rule out small new entrants.” (Private sector provider)

The above comments highlight the extent to which financial requirements related to, for example, working capital and/or reserves have given rise to stakeholder concerns, although it is notable that one VCS provider noted that they did not have such concerns with the commissioners that they dealt with:

“Locally commissioners are relatively good around ensuring things like financial guarantees / accounts etc. do not discriminate.” (VCS Provider)

We consider that these issues should be examined further. There can be good underlying reasons for seeking to introduce financial safeguards in relation to contracting processes, and thus the key questions will concern the extent to which the use of such safeguards is reasonable and proportionate given the relevant circumstances, and the extent to which differences in treatment between providers reflect differences in the financial risk that contracting with those providers may pose, in a reasonable and proportionate manner. Given the extent of stakeholder concerns on these issues we recommend that a more detailed assessment of the use of such financial safeguards is undertaken.

3.2.6 Contract length

Currently, commissioners’ ability to determine appropriate lengths of contracts is limited. In particular, when extending the contract of incumbent providers (without a competitive process) commissioners may currently only do so by one year. Commissioners will be given greater flexibility under future arrangements and our research suggests this is an important development.

Concerns over contract length were raised by many stakeholders, including both commissioners and providers.

12% respondents to the discussion paper cited this issue. Two thirds of these were VCS providers. Contract length was raised as an issue in 9 stakeholder interviews.

Help the Hospices said that c.70% of their members’ contracts are for one year durations.

“NHS contract durations can be ridiculously short.” (VCS provider)

“Contracts are too short. Non-incumbents need a minimum period to make the capital investment pay off.” (Private sector provider)

On the other hand, an association acknowledged that ‘smaller providers may find it hard to compete for contract tenders that are bundled or short in length’, but noted that ‘short contracts can sometimes be useful for small providers to demonstrate their ability to deliver a service, which could help them to compete for a tender in the future.’

One VCS provider argued that contracts should be longer (c.10 years) but with break clauses and certain performance clauses.

3.2.7 Cultural bias and conflicts of interests

This potential for biases and conflicts of interest to play a role in the commissioning was mentioned by ~70% of stakeholders. Some examples of the comments we heard include:

One of the main reasons highlighted for this potential bias is that commissioners can see themselves as part of the same overall institution as public sector providers, and may have worked as colleagues with staff in provider organisations over many years.

“As an NHS manager you will have worked with almost all the commissioners, finance directors and chief executives [...] would call them by their first names [...] but wouldn’t even know the names of the private sector equivalents.” (Commissioner)

“NHS organisations have disproportionate access (formal and informal) to the people making the procurement decisions.” (Private sector provider)

This issue has been commented on elsewhere. For example, Civitas reported that “there is a deep cultural reverence for the NHS as something more than a health system. The emotive notion of the NHS family encourages a counterproductive ‘us versus them’ attitude with regard to the private and voluntary sectors and has been used in the words of one official ‘by most people in most places to try to block the market’.”³²

There have been cases of tender assessments being called into question on grounds of conflicts of interest. For example, the CCP investigated a complaint against NHS Peterborough regarding the reconfiguration of local primary care services:

“Under the terms of the Procurement Guide, we also assessed whether NHS Peterborough’s management of potential conflicts of interest in its commissioning process had been appropriate. We found that the involvement by NHS Peterborough of two clinicians in lead, influential roles, in a service reconfiguration consultation process was not appropriate in circumstances where those clinicians were associated with providers that would be directly affected, and might gain, from the process itself. Both of the clinicians are partners at GP practices in Peterborough that will be directly

³² Civitas. 2010. Refusing Treatment.

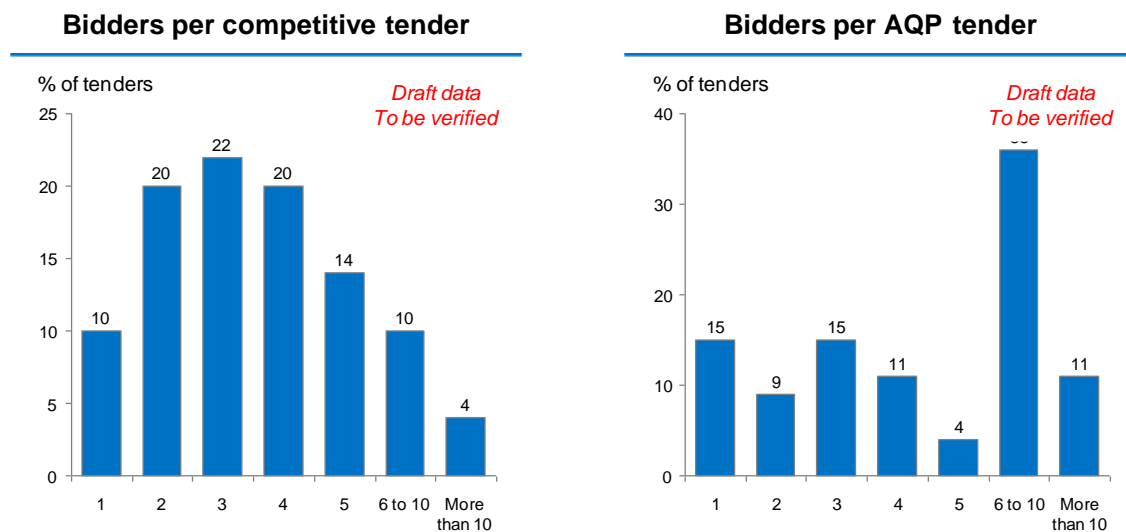
affected by, and might gain from the service reconfiguration process, and one of the clinicians also holds a senior position with an urgent care provider in Peterborough that will also be directly affected by the process. We concluded that NHS Peterborough’s management of potential conflicts of interest in its consultation process was not consistent with the requirements of the Procurement Guide in this regard.”
 (Co-operation and Competition Panel 2011, Peterborough PCT Conduct Complaint)

However, the report did note that commissioners face challenges in managing conflicts of interest, noting that “while government policy requires commissioners to involve local clinicians in service reconfiguration processes, commissioners must also ensure that the clinicians they involve are appropriate in the circumstances in order to comply with the terms of the Procurement Guide and the Principles and Rules.” [ibid]

3.3 Evidence on participation in tenders

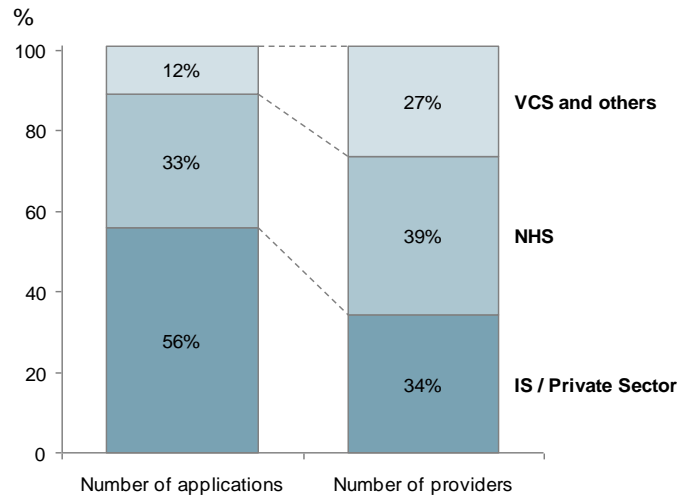
Notwithstanding the above points, available data suggests that the barriers above typically do not wholly deter bidders from engaging in tender processes, and indeed there are often a significant number of bidders. Figures 7 and 8 show that there are multiple bidders for most competitive tenders and AQP tenders.

Figure 7. Bidders for tenders



One key question is whether any types of providers are particularly advantaged or disadvantaged during the tender-assessment phase. Figure 9 shows the percentage breakdown of bidders and winners of AQP tenders.

Figure 8. Bidders and winners of AQP tenders³³



The data above indicates that, in AQP tenders, VCS and NHS bidders may have a higher likelihood of winning than private-sector providers do; however, without a more detailed assessment of the circumstances it is not possible to draw any significant conclusions on this.

³³ Source: Leonid Shapiro – “Level playing field?” in Healthinvestor November 2012.

4. Supporting choice

In those areas where there are multiple providers competing to provide services to patients, if patients are not aware of their choices, alternative providers may find it difficult to attract patients and may be unfairly disadvantaged. The review identified evidence that patient choice is not always offered, and even when it is, referral patterns can potentially still give rise to distortions. However, a key difficulty of assessing this area going forward is the lack of data collected on patient awareness of their rights to choice. Better information on this and on the operation of AQP services should assist in the development of commissioning approaches that provide benefits to patients.

4.1 How might patient choice arrangements have a fair playing field impact?

Under the NHS Constitution, NHS patients in England have formal rights to make choices about the services they receive³⁴. A patient may also “choose not to choose” and leave it to the GP to select a referral centre.

Choice of secondary-care provision is exercised through the referral system, when GPs refer patients to a particular provider using, for example, the Choose and Book system. Choice of GP is based on those with open lists and within specified catchment areas from someone’s residence.

Many services are funded on the basis of their level of activity or capitation, and over £17.4bn of the overall NHS spend is subject to AQP contracts (both local and national), allowing patients the freedom to choose between appropriate providers. When patients are not offered choice, or have their choices constrained, then the funding associated with them may not flow to the most deserving provider. This could happen because patients are unaware of their rights to choice, and thus can’t exercise them. Patient choices may also be influenced by third parties (e.g. by GPs), and this raises questions over factors that may unduly distort that advice (for example, conflicts of interest or inappropriate referral practices).

4.2 Evidence

Patients report that they are not routinely offered choice:

“In February 2010 [the last comprehensive national survey] around half of all patients (54%) recall being offered this choice by their GP. In June 2006, less than 1/3 (29%) recall being offered the choice.” [DH, 2010. National Patient Choice Survey]

This situation is compounded by the patients’ lack of knowledge that they have the right to choose.

34 <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Yourrightstochoice.aspx>

In some PCT areas, 70-80% of patients recalled being offered choice of hospital for a first appointment, compared to 10-20% in other areas³⁵. This variation is reflected in Choose and Book utilisation rates: in 2011, national utilisation of the system was 50% on average, ranging from 27%-100% by area³⁶.

While most GPs report that they offer choice, they also admit to not offering choice all of the time. Their most common explanations for this is that there is insufficient time, or that patients are not interested.

GP preferences can strongly influence referral patterns.

This theme of basing referral on previous experience has been highlighted elsewhere:

“GPs have ‘loyalties, often to where they were trained’ and [...] there may be ‘behavioural factors at play’ in the referral process.” Civitas, 2010, Refusing Treatment

If these patterns become ingrained over time, they can lead to systematic bias in referral patterns.

Another potential influence on GP referrals is that of local commissioners. For example, where a local provider is under a block contract, commissioners may have an incentive to channel activity to that provider, especially if overall activity levels are low.

We have also heard from stakeholders that the desire to fill block contracts and the use of Market Forces Factor payments can result in commissioners seeking to influence referral patterns (see MFF factor for further details). Where this happens:

“We saw many examples of PCTs excessively constraining patients’ ability to choose.” [CCP. 2011. Review of the operation of “Any Willing Provider” for the provision of routine elective care]

But commissioners can also be the force behind effective referral patterns:

“Where referral patterns are effective, this is driven by good PCTs who are clear about ‘this is how you refer’.” (Representative Body)

A final factor that may influence referrals is self-interest or, conversely, conflict of interests:

“Participants were also aware of numerous instances of self referral, where clinicians refer to themselves or to others in their organisation. Given the larger size and broader coverage of NHS organisations this is likely to disadvantage non NHS providers.” [DH. 2009. Fair Playing Field Review]

35 DH. 2010. National Patient Choice Survey.

36 <http://www.ehi.co.uk/news/ehi/7636/choose-and-book-use-on-downward-slope>

Within this context there is some evidence that the situation is improving in secondary care. The Nuffield Trust and Institute for Fiscal Studies reviewed the impact of patient choice between 2003 and 2011³⁷. Findings from their report include the following:

- Records of first outpatient attendance indicate a substantial decline in the proportion of patients who attended their nearest trust between 2006/07 and 2010/11. However, the majority of patients still receive care from the trust that is closest to them.
- The fall in the proportion attending their nearest trust was accompanied by a rise in the proportion of patients who attended appointments at private-sector providers.
- There is no statistically significant increase in the number of patients that attend other NHS trusts rather than the trust nearest them.

The report found that GP practices were, on average, referring to 50% more providers in 2010/11 than in 2006/07.

The report also found considerable variability in the referral patterns of different GP practices:

“In all years there is a considerable degree of variation across different GP practices in the number of providers to which they refer.”

Some of this could be explained by local differences:

“Around two-fifths of this variation is explained by PCT-level factors: for example, the concentration of providers in the local area or specific PCT policies [...] The share of the variation [...] that is explained by PCT-level factors fell from 41.8 per cent to 34.8 per cent between 2006/07 and 2010/11.” [ibid]

So a significant (and growing) proportion of the variation can be attributed only to individual practice behaviours.

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.

37 Nuffield Trust / IFS. 2012. Choosing the place of care – The effect of patient choice on treatment location in England, 2003-2011.

5 General practice and associated services

A number of stakeholders questioned the extent to which the current arrangements for commissioning and delivering primary care are operating in the best interests of patients, and could give rise to fair playing field issues.

The concerns we heard related to:

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

5.1 Findings

The issues that stakeholders told us about raise a number of wide-ranging and complex questions about the way in which primary care is commissioned and developed. We have not had time to do justice to these issues during the course of this review. More evidence gathering would be required to give these issues adequate consideration.

There are, however, a number of features of current primary care arrangements that point to the potential for material fair playing field issues to arise, and for this not to be in the best interest of patients.

Most established General Practices operate under general medical services (GMS) and personal medical services (PMS) contracts. Up until 1 April 2013, these have been contracts between GPs and local commissioners³⁸, although the GMS contract is negotiated centrally by the Department of Health and the British Medical Association.

More recently, new entry by public, private, and charitable sector providers has been possible via alternative provider medical services (APMS) contracts. In contrast to GMS and PMS contracts, APMS contracts are for fixed terms.

A number of stakeholders suggested that different contractual arrangements for new and existing providers are unfair on new entrants and do not serve the best interest of patients. For example, one contributor to the Review pointed out that the different contracts make it difficult for commissioners to get value for money as they each provide for different base levels of remuneration and different payments for additional services or quality improvements. They also create different powers for commissioners to adjust or end contracts.

³⁸From 1st April 2013 GMS and PMS contracts will be commissioned by the NHS Commissioning Board.

New practices can be set up with a contract from commissioners. Before deciding to commission a new service, commissioners will consult Local Medical Committees, which represent the views of local GPs. A number of stakeholders perceived that commissioners were reluctant to commission new services where this would be opposed by LMCs. While advice from LMCs is only one input into commissioners' decisions, stakeholders suggested that it is difficult to see how a new entrant could ever be viewed as something which is beneficial to the existing pool of contractors, which is who LMCs represent.

It was suggested that this is one reason why some patients experience limited access to primary care services. However, others argued that commissioners are wrestling with a tension between a desire to extend access at the same time as needing to manage costs and ensure continuity of care:

“My thinking as a CCG member is shaped by what will deliver the greatest whole system improvement in 3-5 years at a time when we have minimal capital or start-up investment available....I think the number one challenge is to get general practice to scale. From that could flow contracts with combined requirements for new services AND improved access AND improved quality standards. I'm happy for new providers to enter the ring – so long as they take on the list based services – not just the income-generating walk-in bits.” (GP)

“Jobs for the boys” is often executed with good intentions, i.e. save taxpayers the cost of tendering, however this means that value for money and quality are not necessarily being tested. (Social enterprise)

Finally, the review has also seen evidence that for a given set of GP practices there are relatively low rates of switching between them, making it difficult to attract new people to new practices. This encompasses two distinct issues.

First, in order to attract new people, practices may want to provide a range of services that go above and beyond the 'core' GP contract. Under the new Clinical Commissioning Group structure there is a risk of perceived or actual conflicts of interest between GPs acting in their dual role as commissioners and providers. We have been told of best practice behaviour where GP commissioners with a commercial interest in service provision remove themselves from CCG decisions about the commissioning of those services. However, it is not clear how widespread good practice will be, or the precise mechanism for ensuring it happens. The Review heard considerable concern about this subject.

“Conflicts of interest [are] a massively underestimated issue. Many practising GPs have an influencing role on CCGs. There is a high level of naivety by GPs about the impact of this.” (Private sector provider)

Second, the Cooperation and Competition Panel's working paper on the effects of GP choice provided an empirical assessment of how choice of GP is affecting quality³⁹. It

39 “An Empirical Analysis of the Effects of GP Competition”, Cooperation and Competition Panel, volume 1, number 2, August 2010.

concludes that GP practices located close to other GP practices provide higher-quality care but that levels of switching are low.

This may partly be a result of the fact that there are few readily available indicators of quality about healthcare outcomes or specific ratings related to treatment of long-term conditions, frail elderly patients, new parents or other important quality metrics. This makes the decision about whether to switch difficult.

The King's Fund "Inquiry into the quality of general practice in England"⁴⁰ also found that care for patients with long-term conditions is not always reliably delivered and increasing difficulty for patients in seeing their preferred GP. This suggests scope for improvements in quality of and access to GP services and emphasises the importance having patients have adequate choice of GP practice accompanied by relevant information on quality.

A detailed study specifically of GP services was not part of this review. However, evidence collected as part of the Review suggests a number of potential areas for concern. More evidence would be required to inform a thorough assessment.

40 "Improving the Quality of Care in General Practice", King's Fund, 2011.

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.

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.