CMA
Competition & Markets Authority

CENTRAL MANCHESTER UNIVERSITY HOSPITALS/UNIVERSITY HOSPITAL OF SOUTH MANCHESTER MERGER INQUIRY

Summary of hearing with NHS England on 20 April 2017

Background

1. NHS England has three main roles: it is the executive management function of the NHS, it regulates NHS commissioning bodies, and it directly commissions certain healthcare services on behalf of the population of England. The latter category includes specialised services, which are approximately 200 services which the Secretary of State considers should be centrally commissioned because of their rarity, their high cost and/or the scarcity of the personnel and facilities which can treat them.

2. The hearing was conducted with NHS England's Specialised Services commissioning team for the North West of England.

Choice and competition in the NHS

3. NHS England said that competition had originally been introduced into the NHS in England to try to drive up standards and drive down prices. However, the introduction of standard tariffs has since effectively ended price competition, and several centrally mandated regulatory standards now limit the extent of competition for some aspects of treatment timeliness and accessibility.

4. NHS England said that patient choice has not worked in the way it was originally intended to, as patients have limited information about the quality of healthcare at providers. Patients tend to choose to receive healthcare as locally as possible. GPs help patients to choose, however, using their experience with providers.

5. NHS England said that commissioners often commission elective services on an any-willing-provider basis, which is sustainable because of the large number of people and providers who respectively need and provide treatment. However, when commissioning specialised services NHS England must achieve good outcomes, provide wide geographical access and realise good value for money for services which have high fixed costs and relatively few patients. This involves balancing critical mass and accessibility. Patients and referrers therefore have less choice when using specialised services.

6. NHS England said that there is no competition for non-elective services, as patients go where paramedics decide to take them (taking into account a hospital's proximity, treatment capabilities and capacity).

7. NHS England said that it is increasingly using system management and collaboration rather than competition at the health-economy level. As set out in the Five Year Forward View, by 2021, there will be a £21 billion shortfall in the NHS, due to increased spending on drugs and consumables, greater longevity and increased treatment costs. The only way that, collectively, this can be managed is if commissioners and providers work together in each health economy to increase efficiency and effectiveness (eg through greater preventative care). The Sustainability and Transformation Plan (STP) footprints are the delivery vehicle for this.

Providers' incentives

8. NHS England said that hospitals face capacity constraints in the short to medium term, while struggling to meet NHS Constitution targets. Hospitals' ability to take on additional elective work is often limited by the difficulties involved in increasing surgical capacity (eg due to surgical theatre availability). Hospitals therefore do not seek large increased volumes of additional work, as this would hamper their ability to meet targets. However, they may seek to change the proportions of the work they do to use their available capacity. This generally involves competing for contracts from commissioners, rather than trying to influence patients' and referrers' choices. Such contracts are up to seven years long, although usually shorter, and typically allow providers to offer a service under payment-by-results, rather than a block contract. Although in principle hospitals can achieve more income by treating more patients under these contracts (eg waiting list initiatives), this is generally limited by providers' capacity constraints and by commissioners' finite funds.

9. NHS England said that National Tariffs are established on the basis of hospitals' annually submitted Reference Costs. In theory, if hospitals apply the NHS Costing Manual consistently, this allows the National Tariffs to accurately reflect the costs of providing treatments. This is largely the case. However, where there are discrepancies in how hospitals apply the NHS Costing Manual, this distorts the Reference Costs, and can mean that some providers are over- or under-reimbursed for particular health services.

Specialist services commissioning

10. NHS England said that for the vast majority of services which it commissions, competition is not the primary driver. Generally, NHS England decides how

many providers of a particular service should be present on the basis of the population distributions. It also takes into account which services need to be on the same site (eg cardiac surgery has to take place on a site where interventional cardiology and cardiac imaging services are available). For very high volume services, NHS England looks to increase access by having multiple providers. However, for most services, it tends to prefer to maximise the volume of treatment on a particular site to improve outcomes.

11. NHS England said that it does not usually need to use competition between providers to influence the quality of the services which they provide. Instead, they can benchmark a provider against other providers of a service, consult with clinicians and investigate using their own specialists. One technique they use is peer review; teams of clinicians assessing the quality of other providers. As a last resort, NHS England could develop an alternative local provider to an underperforming one, move patients to another health economy, or simply remove a service from a provider in breach of its contract, but these measures are extremely rare. NHS England's contracts with specialised services providers include financial penalty clauses for failed quality targets, but these are rarely used, as they are not usually needed to address provider problems.

12. NHS England said that roughly have of specialised services it commissions in the North West of England are on the National Tariff. For the other half, prices have been negotiated locally. Typically this means that at some point a costing exercise has taken place, so both provider and commissioner agree the price roughly reflects the costs. Price is not usually renegotiated when a new contract is signed, unless a particular service change is being requested by NHS England. NHS England's commissioning teams have specialist financial experts who carefully examine providers' costs to ensure value for money is being achieved. Each sub-regional commissioning team can also compare the prices they are paying to those negotiated in the other nine sub-regions in England.

13. NHS England said that under the vast majority of specialised services contracts, services are provided on a per unit costs-and-volume basis. Exceptions would include, for example, the commissioning of a service for high-consequence infectious diseases like Ebola, which is maintained on a precautionary basis.

14. NHS England said that it commissions each specialised service on the basis of a 'planning population' for that service which is large enough to maintain a volume of activity sufficient for a provider to achieve an appropriate level of expertise. This typically means commissioning services for a population the

size of Greater Manchester, a population the size of the North West, a population the size of the North of England or for the UK as a whole.

15. NHS England said that it would only seek to intervene to consolidate to a smaller number of providers where outcomes could be improved: where an increase in scale would achieve a critical mass that would provide a better service at a lower cost to the tax payer. This means that providers have an incentive to monitor their performance carefully; for most specialised services, providers have access to a quality dashboard which lets them compare their performance against their peers nationwide. Clinicians also want to provide the best care they can for their patients. Providers in the lower-quartile are actively engaged by NHS England and told that they need to improve – with the background threat that they are at risk of losing the service. Providers will usually also be anecdotally aware of their neighbours' performance. NHS England will also talk to providers who are considering buying expensive equipment to be able to provide a specialised service, to ensure that there will be a sufficient volume of patients undergoing that treatment to provide value for money.

Specialised services commissioning in Greater Manchester

16. NHS England said that as part of devolution in Greater Manchester, a £500 million annual budget for a subset of specialised services has been devolved to the Greater Manchester Combined Authority. The services involved are the tier 1 specialised services, with an appropriate planning population for Greater Manchester. The devolution is technically an internal delegation within NHS England, as responsibility for these services has been delegated to the Chief Officer of the Greater Manchester Health and Social Care Partnership (GMHSCP), who is an NHS England Employee. Greater Manchester must continue to meet national service specifications and national commissioning policies, but has more control over how the devolved services are provided and which organisations provide them.

17. NHS England says that it has a memorandum of understanding with the GMHSCP, under which the NHS England North West commissioning team provides advice and support, and undertakes contracting processes on behalf of GMHSCP.

18. NHS England said that the arrangements in Greater Manchester are more mature than in other STP footprints, as they were developed during the discussions around devolution.

19. NHS England said that it recently considered the configuration of a number of cancer surgical services in Greater Manchester, as national standards were

not being met due to there being too many providers to achieve the appropriate planning population per clinical team. NHS England ran a OJEU tender process with a view to consolidating the number of services in Greater Manchester from five providers to one or two in order to achieve national standards. The outcome of the exercise proved to be contentious and due to a number of questions raised during the award 'stand-still' period between communicating the outcome of the process to bidders and finalising contract award, NHS England felt that it would not be possible to safely award without significant risk of formal challenge despite the planned consolidation being in the best interests of patients in Greater Manchester.

Benefits of the merger

20. NHS England said that the culture has changed in Greater Manchester and that there is now a recognition that more collaboration is necessary to maximise the use of fixed resources. However, if the merger were not to happen, this would damage the collaboration between UHSM and CMFT, and between the clinical teams who deliver similar services at these providers. Planning for the merger has currently overcome relationship difficulties which existed in the past, both managerially and clinically. The merger would also involve significantly fewer transaction costs than making a large number of clinical partnerships and clinical governance arrangements, which would be much more burdensome to arrange between two separate organisations.

21. NHS England said that there are financial savings to be made from the merger, by reducing management and infrastructure costs.

22. NHS England said that at a very large scale there can be diseconomies, which has been the case at certain hospitals in America. However, hospitals have not reached this size in England. Even in the largest specialised service overlap between CMFT and UHSM, cardiology and cardiac surgery, there are economies of scale to be realised.

Teaching hospitals

23. NHS England said that teaching hospitals and university hospitals are not specifically advantaged by their statuses, when NHS England is considering which providers to commission services from. However, hospitals which are involved in teaching and research are often large, city-based hospitals which tend to be in population centres, and therefore by coincidence are often appropriate organisations to provide specialised services.