Cragg Ross Dawson

Research into provider decision making

Findings - highlights

Prepared for:

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353 Highlights

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A. BACKGROUND TO THE WORK

1. **This work was commissioned to explore and understand decision making among health care providers to the NHS**

- Which decisions are affected by choice and competition, and how those decisions improve services for patients
- What other factors affect those decisions
- Which decisions are not affected by choice and competition (and why)

2. **We conducted 41 interviews with people recruited from databases, supplied by Monitor**

- 26 face to face and 15 telephone interviews
- with people in 33 NHS Foundation Trusts, 6 NHS Trusts and 2 private providers to the NHS
- Of the NHS providers, 6 were mental health trusts

3. **The sample was structured as follows**

- By region:
  - London – 11
  - South of England - 12
  - North of England – 7
  - Midlands - 11
- By respondent roles:
  - 20 CEOs/acting CEOs
  - 13 finance directors/chief finance officers/heads of finance
  - 3 chairs
  - 2 directors of strategy
  - 1 director of commissioning
  - 1 director of NHS business
  - 1 director of resources

Interviews were conducted using a topic guide produced jointly by Monitor and CRD and reviewed by the Health Foundation (see annex). They lasted 45-75 minutes, depending how long respondents were able and willing to allow us. Interviews were carried out from March-May 2015 by [redacted]

B. HIGHLIGHTED FINDINGS

1. **The overarching goals of providers**

- Quality of services provided to patients
- Financial sustainability of the organisation
- Strong, positive reputation locally and within the NHS as a whole

2. **Choice and competition has an important effect on providers' decision-making**

- Choice and competition was leading to providers becoming more responsive and providing the type of services they believed patients and their GPs wanted:
  - Seeking to understand better what patients and GPs wanted, drawing on patient feedback
  - Opening new services to meet perceived demand
  - Moving services into the community where there was a demand for this
  - Investing in new technology to improve existing services
  - Expanding capacity or improving productivity to reduce waiting times, for example by deploying staff in more efficient ways
  - Closing services if they felt the price they were being paid for the services was too low to enable them to meet standards the standards expected

- Choice and competition was leading to providers becoming more responsive and providing the type of services they believed commissioners wanted.
  - Providers were making decisions to help them win and retain contracts:
    - ~ Seeking to understand better what commissioners wanted, through improved dialogue with them
    - ~ Setting up a service or improving an existing service to pre-empt tendering
    - ~ Building commissioners' confidence in their capability by improving the quality of their services and their reputation

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  - ~ Improving their efficiency to allow them to make more competitive bids
  - ~ Gauging the strength of competitors' bids for contracts, on the basis of experience and reputation
  - ~ Choosing not to bid for services they couldn't provide to high standards at a competitive price

- Choice and competition was also leading providers to respond to the actions (or potential actions) of other providers.
  - Where other providers had attracted volume away from them:
    - ~ Improving efficiency where possible
    - ~ Using the capacity that is freed up through improved efficiency to attract patients or commissioners in other services
    - ~ Investing in improving the service to win back patients
    - ~ Investing in improving the service and communicating this at local and regional levels to improve reputation
    - ~ Using reputation to attract staff, win back patients, increase patient and commissioner confidence
  - Where other providers were believed to be likely to win a contract, not bidding for it on the grounds that it would be futile
  - Where other providers were performing poorly:
    - ~ Attracting referrals or contracts away from them by expanding capacity, recruiting their staff, or opening more accessible services
    - ~ Acquiring the service or trust in order to expand into a new area
    - ~ Acquiring a trust before another provider does so
    - ~ Acquiring a trust to increase capacity and achieve critical mass in certain services, bring about economies of scale and enhance reputation

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- Where other providers might poach staff:
  - ~ working to recruit and retain staff by building research programmes and investing in new technology

3. **However the incentives that choice and competition create for providers appear in some areas to have been restricted by other factors**

- Access targets meant providers had an incentive to reduce their volume and share of elective referrals (since this made it easier to hit the target)
- Block contracts gave providers an incentive to reduce their share of referrals
- Providers felt they were unable to stop providing services that they cannot produce at the available price
- If a price was higher than the cost of delivering the service, they used that cross-subsidy to sustain less profitable/loss-making services
- Few contracts had been competitively tendered
- Some providers told us that commissioners focused on price competition rather than competition on quality
- One mental health provider told us that the systems supporting choice were not in place; the choice websites had not been designed to work in mental health
- Another said that political uncertainty on the future role of choice in healthcare led to them not acting on competitive incentives

4. **Competition, however, is not the only important factor: regulation through inspections and targets are also key drivers**

- Inspection
  - This was particularly important for trusts facing financial and/or clinical difficulties because it could result in reputational damage
  - It also had cost implications: addressing problems raised in inspection reports could involve substantial investment
- Access targets
  - 18 week and 4 hour targets were a particular focus for providers

  - the need to try to meet these targets and avoid the actions of Monitor or commissioners influenced decisions on bidding for/taking on more elective work
  - it could prompt investment to improve capacity and/or productivity
- Payment-for-performance (payment linked to achievement of quality levels) was important for some providers but often considered too small and/or ineffective to be influential

5. **Choice and competition is currently more important in some services than others**

- Services that the provider expects are profitable (and will make a contribution to fixed costs):
  - Elective and maternity services, including outpatient (but not non-elective services)
  - Some specialist services
  - However some providers are uncertain about prices in certain services, and how profitable they are
- Services where providers can set their own price at which to bid:
  - Mental health and community contracts
  - Contracts for commissioners outside the main health and social care, e.g. prisons, the armed forces
- Strategically important services:
  - Where maintaining a full range of services helps reputation, e.g. maternity services
  - Where those services carry clinical interdependencies, e.g. orthopaedics and musculo-skeletal services

6. **Choice and competition is currently more important for some types of providers than others**

- Those providing more of the services listed above
- Those with other providers in close proximity, especially in large cities and/or where there is rapid population growth
- Those with other providers close by proximity which are more active in seeking to increase volumes and which are believed to have better reputations
- Those providers without block contracts
- Those providers that are not in special measures

7. **Choice and competition is currently more important in some types of decision than others**

- It is more important in decisions on issues where providers have flexibility in what they do:
  - Location of services
  - Waiting times
  - Beginning to provide new services
  - Ceasing to provide certain services
  - Investment in equipment
  - Investment in capacity (including in staff)
- It is less important in decisions on issues in which provision of services, or features of the way in which services are provided, are effectively mandatory:
  - A&E and non-elective services
  - Staff ratios (e.g. nurse to patient ratios)
  - Investment in safety risks, e.g, removing ligature points in mental health settings which could create a suicide risk
  - Investment to address issues raised in inspections

8. **There is a tendency among some providers to play down the significance of choice and competition**

- Providers which believe they have strong reputations, at local and national level, feel they do not have to compete: they have more than enough work and do not have to exert themselves to get it
- Providers which regard collaboration as the current dynamic in the way providers interact, see overt competition as less salient than in the past

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Annex

Research into provider decision making - interview guide

Overall aims:

- *to understand how a drop in volume of patients (or loss of a contract or a failure to win a contract), or the threat of this, would encourage providers to improve the quality of the service they offer*
- *to identify the actions and decisions providers take to respond to drops in volumes of patients(or loss of a contract or a failure to win a contract), or the threat of drops in volumes*

Explain to respondents that we are interested in the view of the provider organisation at the corporate level; we are not seeking their personal opinion, though we are happy to hear this if they want to give it.

Background

1. Current role and responsibilities; length of time in post; previous positions

2. Role of the organisation in relation to providing services to the NHS: what types of services do you offer

3. How would you describe your relationship with the NHS commissioners you provide services for; to what extent are commissioners pro-active, engaged, or passive, distant

4. How would you describe your relationship with the referring GPs in your area; are GPs demanding on behalf of their patients?

5. Do you feel the GPs you deal with are actively interested in and engaged in local health provision

Everyday operations and identifying trigger events to focus on

6. Do you monitor your…
   - volumes of activity (or contracts, or both, whichever is appropriate)
   - levels of capacity utilisation

- surplus [*Note for interviewer: some providers may use the term profit*]
- patient satisfaction
- any other indicators/parameters of your performance?

7. [*If answer is yes to any of the above*] Why are these important for you to monitor?

[Potential follow ups:
- *What do you believe it means if things change in any of these areas*
- *Do you have concerns about how patients and commissioners might react if these indicators change]]*

8. Do you monitor performance of other providers of similar services in your local area
   - Which parameters of their performance? *[prompt if necessary - volumes, quality, capacity]*
   - Which providers; [*prompt if necessary - does location play a role*]
   - Why those ones; why not others
   - How do you use this information; which decisions does it inform

9. In the past 3-4 years, have you experienced any loss in volume (or contracts) or revenue that appeared to be caused by decisions made by patients, commissioners, other providers, or your staff? Or have you been under threat of losing volume, contracts or revenue?

   For example due to:
   - Patients choosing to use a different provider [*explain if necessary – here we mean GP referrals]*
   - Commissioners awarding (or intending to award) contracts to a different provider
   - Other providers setting up (or shutting down) a service that you provide,
   - Other providers merging, changing their capacity, or quality of their service
   - Your staff leaving, or recruitment becoming more challenging

[Refer to events list (or list of examples of significant volume changes) and prompt if necessary]

10. In general, what problems are created when you lose volume (or lose a contract, or fail to win a contract) of services; [*if needed, prompt:*

- *It reduces the revenue you receive (or not if block contract?)*
- *It increases the risks of regulatory problems*
- *It creates pressure to make additional cost savings*
- *It makes recruitment and retention more difficult? Probe: why is that a problem?*
- *It damages morale amongst staff? Probe: why is that a problem?*
- *It reduces your ability to fund other services]*

Response to events mentioned in Q9

Ask interviewee to identify the 2-3 events with the most significant impact on the organisation. Come back to this list if there is time at the end of the interview to discuss more events. Ask if interviewee can provide more examples by email after the interview.

If there are none, but their organisation has experienced a significant drop in volumes in one or more services in the past 3-4 years, ask these questions in the context of volume changes (asking first what was the reason of the volume change).

If there are neither events for the interviewee to discuss, nor significant volume changes, ask these questions in the hypothetical sense, i.e. 'if there had been an event such as a change in the provider landscape such as … [see specific examples in Q9] how would you have become aware of it, what would have been the impact…'

For each event:

11. How did you become aware of the event

12. Was there any immediate impact on your organisation [*prompt: for example, in terms of activity volumes, capacity utilisation, staffing, quality levels, revenue…]*

13. What did you consider was the likely effect of this event on your volumes (or ability to retain or win a contract)?

14. What action, if any, did you take in response to the event?

15. Who took the decision to take action; was there a business case?

16. Why did you decide to respond in that way

17. What would the consequence have been of not taking that action

18. What factors did you take into account when making the decision to take these actions; prompt if necessary:
    - How important was the service's contribution to covering fixed costs/surplus
    - What impact did targets, contract incentives, and quality regulations have on the decision
    - Did government initiatives or availability of central funding come into it

19. What was the effect of your actions, and what was the magnitude of that effect, eg on volumes, quality, capacity utilisation, efficiency, surplus, etc

20. What was the impact of your actions on staff

21. What was the impact of your actions on patients

22. How did you communicate this change to patients, referrers, or commissioners?

23. Do you know if other providers reacted to your actions; what did they do

24. Were there any actions you considered taking but then decided against; what were the arguments for and against

Pro-active steps taken to increase or retain volumes

25. In the past 3-4 years have you undertaken any pro-active steps to increase your volumes or retain volumes (or improve ability to win or retain contracts or to be a more attractive bidder for contracts)

26. What triggered your decision to take these steps

27. Who took the decision to take these steps; was there a business case [*Ask at the end of the interview if we can see a copy of it?*

28. Please briefly describe what these steps involved

29. What would the consequence have been of not taking these steps

30. What factors did you take into account in deciding to take these actions; [*prompt if necessary:*

- *How important was the profitability (or "contribution to covering fixed costs") of the service*
- *What impact did targets, contract incentives, and quality regulations have on the decision]*

31. What effect did taking these steps have

32. What was the impact on patients

33. How did you communicate this change to patients, referrers, or commissioners

34. Did other providers react to your actions; if so, what did they do

35. Were there any actions you considered taking but then decided against; if so, what were the arguments for and against

Investment decisions underlying decision-making

36. How do you prioritise which of your services to make investments in

[Prompt: Do you prioritise investment in services where you risk losing volume if the service performs poorly, or in services that have potential of growth]

37. What role does the surplus, or contribution to covering fixed costs, have in that prioritisation decision

38. What other factors influence the decision

[Prompt: What is the importance in your decisions of:

- *National targets*
- *Financial incentives within the contract*
- *CQC regulation*
- *Recruitment and retention [probe: why? Eg is it that this will reduce volume]*

- *Reputation considerations [probe: why? Eg is it that this will reduce volume]*

39. Are you planning any expansions/reductions in service volumes in the future

40. If so, what prompted these plans

Additional areas of discussion [time permitting]

41. How do you regard your relationships with other health providers in the local area

42. Do you feel you are competing with other providers:
    - for patients (GP referrals, contracts)
    - for staff
    - for research funds
    - anything else

Close, ask whether the interviewee is happy to be identified or remain anonymous