

## Commissioning through Competition and Cooperation

# Interim Report

October 2014

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Disclaimer:

This research is funded by the Department of Health. The views expressed are those of the researchers and not necessarily those of the Department of Health.

Acknowledgements:

We are grateful to our case study respondents for giving up their valuable time to be interviewed.

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## Glossary

AQP	Any Qualified Provider
AT	(NHS England) Area Team
BCF	Better Care Fund
CC	Competition Commission
CCG	Clinical Commissioning Group
CCP	Cooperation and Competition Panel
CHS	Community Health Services
CMA	Competition and Markets Authority
CQC	Care Quality Commission
FT	Foundation Trust
HSCA 2012	Health and Social Care Act 2012
ICO	Integrated Care Organisation
LA	Local Authority
LES	Local Enhanced Service
MH	Mental Health
NHSE	NHS England
OFT	Office of Fair Trading
PCT	Primary Care Trust
TDA	Trust Development Authority

# Introduction

## Policy background

A wide ranging set of reforms is being introduced into the English NHS. The reforms are designed to increase the market-like behaviour of providers of care with a view to improving efficiency, quality and responsiveness of services (DH, 2005; Health and Social Care Act, 2012; 'HSCA 2012') and they span the New Labour government and current Coalition government regimes. The idea behind these reforms is that competition between a wider range of providers will produce the desired results such as improved quality and greater efficiency. At the same time, it is still necessary for providers of care to cooperate with each other in order to deliver high quality care. There are many aspects of care quality where cooperation is needed, such as continuity of care as patients move between organisations, and sharing of knowledge between clinicians.

Documents such as the *Principles and rules for cooperation and competition* (DH, 2010) (and more recently, HSCA 2012) explained how the NHS was required to deal with competition and cooperation simultaneously. The principles included the requirement for 'providers and commissioners to cooperate to deliver seamless and sustainable care to patients' (principle 4), while also prohibiting commissioners and providers from reaching 'agreements which restrict commissioner or patient choice against patients' or taxpayers' interests' (principle 6). Similar principles are enshrined in the HSCA 2012, as supplemented by guidance issued by Monitor. Moreover, a Statutory Instrument was issued under the HSCA 2012 which set out the rules governing procurement of health services by NHS commissioners, indicating that competitive procurement is to be preferred (*The National Health Service Procurement Patient Choice and Competition No 2 Regulations 2013*). A national panel was established to interpret the principles (the Cooperation and Competition Panel, CCP) and advise the NHS on what behaviours were acceptable. Under the HSCA 2012, Monitor (as the new economic regulator) took over some of the functions of the CCP and along with the national competition authorities (being, since April 2014 the Competition and Markets Authority, and prior to that, The Office of Fair Trading, OFT, and the Competition Commission (CC) has powers to enforce competition law to prevent anti-competitive behaviour. At the same time Monitor is also responsible for promoting co-operation. HSCA 2012, section 66 (2) (e) states that Monitor must have regard to 'the desirability of persons who provide health care services for the purposes of the NHS co-operating with each other in order to improve the quality of health care services provided for those purposes'. It is the role of NHS commissioners (including Clinical Commissioning Groups 'CCGs'), however, to ensure that the appropriate levels of competition and cooperation exist in their local health economies (HSCA, 2012).

## Need for research

While studies have noted that incentives for competition and cooperation exist in healthcare (Goddard and Mannion, 1998; Kurunmaki 1999), few have researched the interaction between the two. Although there is research about the effects of competition in the NHS reforms introduced by New Labour (e.g. Cooper et al, 2010; Gaynor et al, 2011), there remains a need to investigate the way in which local health systems are managed to ensure that cooperative behaviour is appropriately coexisting with competition. Some specific forms of cooperation have been evaluated

(such as integrated care organisations, DH 2009, and clinical networks, e.g. Ferlie et al, 2010), but it does not appear that the general manner in which local health systems are being managed to balance competition and cooperation under the current reforms is being investigated.

### Study of commissioning through competition and cooperation

For this reason, PRUComm is undertaking a project to investigate how commissioners in local health systems manage the interplay of competition and cooperation in their local health economies, looking at acute and community health services (CHS). The research questions are:

- How do commissioners and the organisations they commission from understand the policy and regulatory environment, including incentives for competition and co-operation?
- In the current environment, which encourages both competition and cooperation, how do commissioning organisations and providers approach their relationships with each other in order to undertake the planning and delivery of care for patients?
- In particular, how do commissioning organisations use or shape the local provider environment to secure high quality care for patients? This entails examining how CCGs' commissioning strategies take account of the local configuration of providers and the degree to which they seek to use or enhance competition and/or encourage cooperation to improve services.

**This interim report deals with the first research question concerning commissioners' and providers' respective understandings of the policy and regulatory environment in which they operate.**

## **Study Design and Methods**

In-depth case studies are being used to investigate how commissioners approach their roles as shapers of the local health system in respect of competition and cooperation issues.

After agreeing the protocol for the study with DH in January 2013, we began a time consuming process of securing numerous research governance approvals necessary for undertaking this piece of research. Internal LSHTM Research Ethics Committee permission was granted in June 2013. We were also obliged to apply for NHS Research Passports for all researchers working on the project through one of our participating case study sites. Despite securing the NHS Research Passports we had to seek further separate research governance approvals from each NHS organisation that we intended to approach for interviews. Each NHS organisation, about 20 in total, had separate requirements and processes for granting research governance permissions. Only after securing an individual organisation's permission were we able to approach its senior staff for an interview. All in all, arranging research governance was a considerable task, as in many cases it was not immediately apparent which individual in a particular organisation was in a position to grant such an approval, or what procedures we were required to follow. This required a substantial research staff input and delayed the commencement of field work until the summer of 2013.

In the first phase of the field work for the study, between August 2013 and June 2014, we carried out 33 interviews with senior commissioners (13) and provider managers (20), including

independent providers, in four CCGs across England. Case study sites comprise a mix of rural and urban settings and are located in the North, North West, Midlands and London (see Table 1).

Table 1. Interviews in case study sites

Case study site	Location of CCG	No. of interviews
CCG1	Rural, North East	10
CCG2	Urban, Midlands	9
CCG3	Mixed, North West	7
CCG4	Outer London	7

All but one interviewed commissioner were senior level managers such as Chief Operating Officer, Finance Director or Head of Contracts. In one instance we interviewed a former GP commissioner. Similarly, the vast majority of interviewed provider managers did not have a clinical background and were senior managers working for provider organisations.

The interviews explored commissioners' and providers' understanding of policy and regulations regarding the use of competition and cooperation in commissioning NHS services. We also explored their experiences of tendering and bidding for tenders as well as collaborative working.

In this interim report we focus on outlining the views of commissioners and providers of the regulatory landscape, in particular their understanding of regulations, amount of local discretion, role of sector regulators, impact of HSCA 2012 and incentives to cooperate and compete. The final report at the end of 2015 will deal with the other research questions which we are currently investigating.

In order to give a context to the understanding and views of local commissioners and providers, we include a timeline of nationally reported key policy decisions, regulations, guidance and events pertaining to competition and cooperation in the English NHS covering the period between March 2013 and June 2014 (see Appendix 1). The timeline has been compiled by including official guidance and decisions from websites such as Monitor and the Competition Commission, as well as monitoring specialist press titles such as *Health Services Journal*, *Health Investor* and *Pulse* for relevant reporting.

Before moving to discuss the interim findings we provide a brief sketch of local health economies in the four case study sites.

## Case study sites

### CCG1

The CCG1 is located in the North of England and covers a population smaller than the average for CCGs in England. There is a diverse population – with areas of deprivation and affluence – as well as a very high number of older people. The area covered by CCG1 has areas of high population density in its largest town but also incorporates rural areas with low population density.

The CCG1 area crosses local authority (LA) boundaries, approximately two thirds of the population living in one Council area and one third in the other. CCG1 was formed with the abolition of two Primary Care Trusts (PCTs).

There is one main acute provider which is an NHS Foundation Trust (FT). It provides services from its main hospital site as well as community health services (CHS) from health centres and general practices in the community.

There are two main CHS providers one of which is the main acute provider and the other is an NHS trust dedicated to CHS. One trust provides community services to one district of CCG1 and the other provides it to the other two districts. The rationale for the configuration of these two providers is historical from the PCT. The CCG has carried out a CHS review and is considering the need to re-procure the community nursing service. It is still uncertain at the time of writing (October 2014) whether it will go out to tender.

At the end of 2013 CCG1 agreed to adopt the integrated care vision proposal and approach to improving the lives of local people, including frail and vulnerable people. The integrated care approach will capitalise on the investment by partners in a single shared electronic patient record giving people, their carers and health and social care professionals access to the information they need to deliver effective support.

Partners across the local health and social care economy have also signed up to the CCG's programme to deliver integrated care for adults. The CCG's strategic objectives focus on transforming planned care, MH services and urgent care.

## **CCG2**

CCG2 is located in the Midlands and crosses the boundaries of two local authorities, covering all of one and part of another. In both local authority areas served by the CCG, the health outcomes are relatively poor, with high levels of deprivation, health inequalities and reduced life expectancy compared with the England average. There are significant numbers of minority ethnic groups within this population who experience higher health needs.

The governing body papers indicate that the CCG2 is in financial balance. The major health issue for the CCG is transferring care from hospital to the community. A local programme has been running in the CCG's area for some years. This is a collaboration between the local authorities and CCG, acute hospitals, mental health and community health care trusts and could be seen as a precursor to the Better Care Fund.

There are several acute providers, many of which are FTs, to the CCG, with the major provider accounting for just over half of total acute spend by CCG2. This trust is undertaking a programme of transferring some services to community settings to support the vision of delivering care closer to home. CHS are provided also by several trusts. The major provider of CHS is an acute trust accounting for 57% of the CCG's spend.

Mental Health (MH) services are provided by three trusts. Two trusts take all but 0.5% of this and are FTs. All three provide services to other CCGs in the region.

The main challenge for commissioners in CCG2 at present is the continuation of the programme of shifting resources and services from acute providers to the community in the context of financial pressures and variable local health needs. At the same time, commissioners are obliged to contract with large acute providers with considerable market power.

### **CCG3**

CCG3 is located in the North West of England. The diverse population includes large urban conurbations through to rural villages. According to the Government's 'Indices of Deprivation', the overall quality of life is good for many residents (in the wider LA area); however there are areas of significant socio-economic deprivation and rural isolation.

There is one main acute care provider – a large district general hospital, split across two sites. The financial position of this FT is extremely tight. There is also one main FT provider of MH and CHS.

In addition, there are some small independent hospitals and a small independent out of hospital provider which hold (small) contracts with the CCG. However, there is no history of larger independent providers in the area.

The CCG has an overarching strategy for joint working between health and social care locally and for moving care out of hospital into a community setting where suitable.

A Better Care Fund (BCF) Plan has been agreed locally (between the local authority and multiple CCGs) which includes outcomes to support the overarching local commissioning strategy. The CCG's ambition is to incentivise collaboration across care settings to achieve its plans.

### **CCG4**

CCG4 is coterminous with an Outer London borough. Its population is generally wealthy and it boasts good health outcomes. The population is served predominantly by the two acute hospitals taking up the bulk of the CCG's acute spend. Due to the density of acute provision in this part of London, local patients also utilise other London hospitals to a smaller extent. The two main acute hospitals serving the population of CCG4 have been part of two different hospital reconfiguration programmes aiming to concentrate services onto fewer sites.

There is an NHS CHS provider which also provides services to the neighbouring CCG. The future of the CHS provider is somewhat uncertain as the plans to establish it as an Integrated Care Organisation (ICO) with a view to acquiring Foundation Trust status have fallen through. Recently, the CCG undertook an internal consultation amongst GPs on the quality of services provided by the CHS provider with a view to re-commissioning the service.

CCG4 has two MH service providers. The primary care MH services were retendered three years ago. A new provider won the tender and took some of the activity away from an incumbent one. According to the CCG's management this led to a considerable improvement in quality and responsiveness of the community MH services. Currently each organisation delivers different types of MH services for the population.

The commissioners have a long standing strategy to move more care out of hospital and into community settings. The need for coordination of a number of services which have been set up with a purpose of achieving this goal has been heightened by the requirements imposed by the Better Care Fund (BCF) policy initiative. For the purpose of the BCF commissioners decided to focus on services for the frail elderly population. This work runs in parallel with evaluation of the main CHS provider. The CCG adopted an outcome based commissioning approach to guide a process for re-commissioning the services provided by the community provider. At the time of writing (October 2014) it has not been decided whether this will involve a competitive tender.

## **Commissioners' views on regulations**

We begin by reporting the views of commissioners concerning the current regulatory structures.

### **Understanding of current policy**

As actors' understandings of the rules under which they operate are crucial in determining their behaviour, we started by asking commissioners what their respective understandings of the current policy rules were.

Commissioners considered the current policy confusing as they were being expected to both drive competition and integrate services which they found to be contradictory:

*Those two drivers can compete against each other. (Commissioner 3, CCG4, May 2014)*

One commissioner (CCG2) commented that he thought that current policy would cause problems in future:

*This looks like a fix to fix the thing they c\*\*\*\*d up the first time and it's going to cause problems as well. It really annoys me. (Commissioner 1, CCG2, November 2013)*

Additional inconsistency was seen by commissioners when they compared the types of services that could be subject to competitive procurement. One commissioner noted that there were services commissioned by the CCG with a turnover higher than the trigger for competitive procurement and she did not know how they could be competitively procured:

*you can look at the b\*\*\*\*y formula and say "It's more than 98 grand over a five year period... you've got to go out to competition"... I've got many [contracts] at the moment that are over 98,000 and have I got a route to procurement for them all? No. (Commissioner 1, CCG4, November 2013)*

Another commissioner made similar observations (CCG3) about the differences in the practicality of tendering between acute and community services. He considered that it was not realistic to tender acute contracts because there were no alternative providers and it would be "... a complete and utter waste of public money" (Commissioner 1, CCG3, August 2013). This commissioner noted that the rules appeared to be different for community services as there were alternative providers willing to enter the market. A commissioner in a different CCG (CCG2) reported that although they preferred to work collaboratively with providers to deliver service reconfiguration, large

partnerships between several providers were thought to restrict use of competitive procurement to reconfigure services as they were seen to be bureaucratic.

Some commissioners were awaiting guidance on how to implement policy, or commented that where there was guidance, interpretation was likened to “trawling through treacle” (Commissioner 1, CCG1, May 2014). This commissioner considered that the ambiguity led to people over-complicating policy implementation.

When asked about their understanding about whether the current policy configuration required them to tender all services, the interviewed commissioners were convinced that this was not the case. In their view the need to tender depended on whether the service was “extremely specialized” and could be provided only by a certain provider (Commissioner 4, CCG1, April 2014). Another commissioner (Commissioner 6, CCG1) from the same CCG made a distinction between expansion of existing services with good outcomes which, in their opinion, could bypass the procurement; and setting up new services with new specifications which ought to go to full tender. In general, there was an agreement that although there was no mandate to tender all services there was a requirement to justify why competitive procurement was not followed.

*We don't have to tender all services, there are exceptions. But I think the default position is that we are expected to tender services, as a generality. So we have to, I think, the expectation is that you will explain why you haven't* (Commissioner 1, CCG2, November 2013)

Commissioners from CCG3 drew attention to a perceived anomaly concerning the pressure commissioners experienced from regulators to put CHS out to tender, whilst acute services although based on 12 month contracts, were exempt from this pressure. Furthermore they mentioned that some acute providers were supporting opening up the community sector to competition as they saw it as “as an opportunity to drive out some of the efficiencies and take the benefit” (Commissioner 1, CCG3, August 2013).

The same commissioner felt that there was also a hindering lack of clear guidance as to whether Local Enhanced Services (LES) currently provided by GP practices ought to be put out to tender. According to the commissioner, primary care services were previously subject to the same “written/unwritten rule” as acute services excluding them from the need to tender but since the new regulations came into effect this ceased to be a clear cut case. This was because there were other providers capable of delivering LES services and of challenging CCG decisions.

*We've got three and a half million pounds worth of LESs. There's probably about 15 of them. We keep waiting for the guidance, and everyone just keeps ignoring it now. For me it is massive confusion, because if you talk to the procurement people who interpret the legislation they're saying that's what it says. But those with a bit of common sense are saying we can't do that, it's daft. But they're going what's the rules (...)? And you think okay, fine, so give me some definitive guidance then please. You can't get that guidance anywhere. It's a real confusion in the system.* (Commissioner 1, CCG3, August 2013)

CCG4 commissioners also agreed that there was no need to tender all services but emphasised that one had to be aware that not doing so might expose the CCG to risk of challenges from potential

providers. Furthermore the interviewed commissioner noted it would take time and a change of culture for NHS commissioners to embrace tendering as “customary practice” (Commissioner 1, CCG4, November 2013). Yet, another commissioner pointed out that there were practical obstacles, such as of lack of organisational capacity, meaning that CCGs were unable to tender all services even if they had to or wished to do so.

*We do not have to tender out all of those services, because if we do, actually it is a massive resource. So I think we have to be very careful about which services we decide to procure and how many procurement processes we go through in any one year, because they are a massive drain on resources and in time and people. So it is absolutely key that we take these decisions very carefully. (Commissioner 3, CCG4, May 2014)*

There were no differences between case study sites as to views about the need to tender all services. Commissioners pointed out that they have some discretion over such decisions yet they have to justify their decision making processes.

### **Amount of local discretion**

Commissioners were asked how much local discretion they had in the current policy set up to make commissioning decisions. The opinions varied as to the level of discretion they had and the matters over which such discretion could be exercised.

One commissioner from CCG1 spoke about heightened anxiety they experienced when having to decide whether to open some services to tender or not, in this case in relation to primary care services commissioned as part of the LES arrangement. The vagueness of section 75 and subsequent regulations (i.e. *The National Health Service Procurement Patient Choice and Competition No 2 Regulations 2013*) allowed for considerable discretion in taking decisions but at the same time heightened uncertainty for commissioners.

*It's really quite difficult to see whether you could actually do certain things; and I had to get a lot of guidance from more experienced procurement colleagues, sort of saying, 'am I going on the right track, am I okay just to keep it like this, am I breaching the rules by not opening it out to tender at this point but just keeping a status quo going?' (Commissioner 1, CCG1, May 2014)*

Another commissioner from CCG1 reflected that CCGs had no discretion over high level principles guiding their relationship with the local trusts. According to this interviewee, the mandate of commercialisation of relationships between commissioners and providers hampered attempts to take overall ownership of local “health and social care society” and promote collaboration. They went on to suggest that the move to some sort of lead provider model under which providers were given a set budget and were expected to coordinate service provision against agreed outcomes would be beneficial in remedying this negative effect of marketisation of NHS.

The experiences of other commissioners suggest that there is an inverse relationship between the lack of specific regulations and the amount of local discretion in commissioning.

*I think we've got the flexibility, because it's a locally commissioned service, so we commission for the needs of the population. It's perhaps more of a lack of support when we're needing*

*guidance, that we don't have. So flexibility-wise, I think we've got a mandate to be able to procure services appropriately, and with proportionality and transparency – having read the guidance on several occasions – to be able to deliver that. But it's dependent on the commissioning intentions and each CCG's priorities. But yeah, it's more around guidance and support where we've had particular issues, so in terms of...it feels like there's an unwillingness to put a line in the sand for something and say, this is our stance.*  
(Commissioner 5, CCG1, April 2014)

Lack of explicit, unambiguous guidance with regards to the role of competition and tendering in commissioning clinical services could in some cases play to commissioners' advantage by increasing their freedom. However it also increased the freedom of providers to challenge commissioning decisions and/or to interpret the regulatory uncertainty to *their* advantage. In particular, a Commissioner from CCG1 mentioned a case of a private provider offering maternity services in the region and expecting to be paid by the CCGs despite not being commissioned by the CCGs. Such provider behaviour, driven by patient choice and effectively bypassing commissioners, undermined the level of control commissioners had over their local health economies.

The same interviewee remarked that although the CCG had discretion over whether to tender the service or not, it spent a lot of energy on finding robust justifications for not having to go out to tender. The commissioner shared an example of a recent extension of coverage of a particular community health service which was available previously only in one part of the CCG. The CCG took the decision to extend the service from the current provider on a pilot basis rather than go through a lengthy and costly procurement process.

*I've commissioned it from Trust X as a pilot and I'm thinking about how I'm going to do it and I've done that on a clinical governance issue, but really I should procure it and I'm dreading it. (...) I'm dreading I'm going to have to go out to procurement, because I can't be...I've been doing it for a pilot for a year. (...) until I can get my head around how I can get around not procuring this.* (Commissioner 6, CCG1, November 2013)

A CCG2 commissioner noted that their default position or preferred option was to encourage local providers to cooperate and transform services through "the development of local planning" rather than by using tendering. However at the same time they were mindful that this could be deemed as "heresy" and they were cautious of publicising their approach.

*The overarching commissioning strategy is to progressively shift, over the next five years, resources away from hospital and into the community. And the plan to do that essentially is through a managed change process of working with existing providers using the independent and voluntary sector locally to supplement that and using the private sector occasionally around specific things.* (Commissioner 1, CCG2, November 2013)

The same commissioner commented on the lack of discretion in respect of some national policy initiatives, in this case a mandate to choose some CHS to be subject to the Any Qualified Provider policy (AQP), under which patients would be entitled to choose any licensed provider of such services which had been approved by the CCG. This policy did not make sense to them locally.

In general, the interviewee remarked that often commissioners' strategy was to comply with the national framework but immediately find ways round it to adapt to the local circumstances (Commissioner 1, CCG2, November 2013).

Another commissioner from CCG3 spoke in similar terms about trying to use the discretion not to tender the services, in this case LES services, and finding ways to "get away with it". One of such ways referred to bypassing the AQP policy mandate by interpreting that it applied to the wider cluster of CCGs rather than smaller former PCT footprint. The commissioner believed that on this occasion they managed to "get away with it" as AQP policy had lost the national priority status.

*It became a bit of a game, because you had to put the three [services] out [to AQP], and there was, is it three per PCT or is it three per cluster? We all went 'ah'. Because [CCG X] have done loads of these AQPs, so we said okay, we've done our three as [CCG X] have done them. Then it all went a bit quiet, and then they had the massive reorganisation, and the assumption is that department who are driving that through have gone because they've gone very quiet on it. So there is no national programme, there is no national list. They tried to create that list. That's gone. Now it's just a tool. And AQP is just a tool. (Commissioner 1, CCG3, August 2013)*

The same interviewee stressed that their first step was to identify local priorities and gather "local intelligence" about service provision (Commissioner 1, CCG3). Similarly to CCG2 they preferred to adopt a local plan through building strong relationships with local providers. In that sense the interviewed commissioner reflected on the already mentioned benefits that lack of clear top down guidance brought in terms of widening local discretion.

*You complain about the lack of guidance, but whilst we have a lack of guidance and nobody shouts at us about doing something wrong then it actually works to your benefit in a patch like this. (Commissioner 1, CCG3, August 2013)*

CCG4 commissioners also preferred to balance national policies with local considerations. According to one commissioner the decision to use competitive tendering or not was a matter of "judgement" (Commissioner 1, CCG4, November 2013). The competitive tendering itself was seen as one of the levers to improve services and thus a useful tool that should not be dismissed. The commissioner also pointed out the legal risks to which the CCG was exposing itself by not going down the tendering route. One can argue that CCG4 commissioners were most at ease about using competitive tendering out of all case study sites.

Overall, the commissioners agreed that there is some flexibility for local decision making within the current commissioning system but making use of such local discretion often depended on finding ingenious ways round the system. The use of local discretion was being undermined, on one hand, by the prescriptive, top down policies and, on the other hand, by potential challenges from providers raising a prospect of costly litigation. We noted a slight difference between case study sites, with London based CCG4 appearing to be much more at ease with using competitive tendering as part of their service transformation strategy than case study sites based in other parts of England. The latter group emphasised the importance of fostering relationships with the current providers and used tendering only as a last resort option. The difference may be due to the nature of markets, with CCG4 having a wider pool of potential providers than those based in more isolated, rural

communities. Yet it might also be due to commissioning styles of individual CCG leaders, as the geographical profile of CCG2 does not neatly fit this explanation.

## **Views on the role of sector regulators**

It was also important to find out commissioners' views of the various sector regulators, as this also had a bearing on their behaviour at the local level.

The recent policy changes combined with a lack of specific guidance resulted in commissioners having to consult sector regulators on some occasions. The interviewed commissioners from the four case study sites have been in contact with a number of regulators including the CCP (pre-April 2013), Monitor, NHS England (NHSE), Competition and Markets Authority (CMA), Trust Development Authority (TDA) and Care Quality Commission (CQC). Commissioners were often quite critical of the role of sector regulators, mainly due to their alleged inability to provide clear guidance in particular cases.

According to one commissioner from CCG1 Monitor's approach has changed since it took on more powers post-April 2013. Whereas before the attention was mainly on managing providers, now the CCG experienced a more hands on, direct scrutiny of commissioning practices.

*[Monitor's] role's changed now, and it used to be just that they spoke to the provider and we didn't really get involved, but now it's everybody; and they're very, quite directive really, and they will ring up and say, what's happening (Commissioner 2, CCG1, March 2014)*

Another commissioner expressed the view that the system as a whole, and sector regulators in particular, as interpreters of the policy could not seem to decide whether the priorities lay with increasing competition or with fostering integration among providers. In the commissioner's perception the regulatory forces pulled in opposite directions, which left local commissioners in a difficult place. Such a view was a consequence in part of the decision to reject a merger proposal between the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust hospitals taken in October 2013 by the Competition Commission (see Appendix 1, item 17), which sent shock waves through commissioning world.

*You know, the debacle of Poole and Bournemouth, crikey. You know, ten years ago that merger would have just happened. They'd have done a public consultation and whatever, but it would have just happened because it was the right thing from a quality patient side of things and the right thing from a commercial viability, and recognising really in Poole and Bournemouth, (...), there's no choice. Do you know what I mean? You've got two DGHs a few miles apart from each other, Poole going to Poole, Bournemouth going to Bournemouth. And for them to both do everything a DGH does, considering the scarce resources there are in workforce and cost, it makes no sense at all. So you've got to have bigger cost effective teams in one location, not two. So it was absolute bonkers to say, oh, well, actually you need two hospitals because patients need choice. But they don't because they don't choose choice now, they go one or the other. So you're not taking that choice away, you're just...so it's all bonkers, all absolutely bonkers, choice. (Commissioner 3, CCG1, April 2014)*

Another CCG1 commissioner expressed their disappointment over the lack of clear guidance from Monitor after the CCG came across a private maternity provider billing them for activity which had not been contracted.

Commissioners perceived Monitor's stance as "very wishy-washy" and saw their interventions as not "effective" or "timely" (Commissioner 4, CCG1, April 2014). CCG1 had spent a lot of time answering lengthy inquiries from Monitor and having to defend their position after being accused of preventing competition. The protracted discussions gained an additional sense of urgency for the CCG as they also had some quality concerns about the provider.

*If Monitor say, you have to pay for that and you are breaking the anti-competition laws, any private provider anywhere in the whole of the country can come and on our patch say, 'we're going to start doing cataracts on your patch and we're paying for it under non contracted activity.' (...) So I'm not confident in Monitor actually in what do they understand what they're doing, to be honest with you, I don't quite know, because they keep ringing us and saying, 'what's your interpretation of the PBR Rules?' We're not quite sure...and I'm just thinking, Lord, we have got women at risk here and Monitor are dithering around about it. (Commissioner 6, CCG1, November 2013)*

A different CCG1 commissioner noted instances of passing responsibility between different regulators, in this case between Monitor and NHSE, which frustrated commissioners searching for clear cut answers. The commissioners were also engaged in discussions with Monitor and the TDA about opening up some services to competition which might destabilise the acute providers.

Another complex issue on which the CCGs wanted to consult the regulators related to opening up services to competition which were not a commissioning priority. Commissioners from CCG1 were approached by potential providers (in this case a GP practice) willing to provide such services in the community. The issue was further complicated by the fact that CCGs are GP membership organisations giving rise to potential conflicts of interest due to GPs' dual role both as commissioners and providers of services.

*We've got another practice that wants to provide a community ophthalmology service, but actually it's not a commissioning priority for us, ophthalmology, so how do we balance that? I don't know. Monitor would say we have to go out to AQP for that, for a community ophthalmology service, but actually I'm not unhappy with the ophthalmology service we get at the moment, but as far as Monitor's rules are, if there is an appetite to provide a service in the community, then those GP practices that want to do that under AQP have every right to do that, but do I have to commission it? I don't know. Do I have to commission that service from them? Monitor would say maybe you do, the same as the maternity one. So it's chaos... (Commissioner 6, CCG1, November 2013)*

Despite acknowledging that the purist view of competition in the NHS appeared to have been watered down recently, one commissioner from CCG3 was concerned that Monitor might intervene and put a stop to the "controlled market approach" which the CCG3 pursued (Commissioner 1, CCG3, August 2013). The worry remained that if one followed a strict interpretation of the rules, the decisions, such as not putting CHS out to tender, would not be possible. The commissioner was also

concerned about the lack of guidance with regards to LES services, tendering of which had a potential to destabilise GP practices and undermine relationships with GPs.

CCG4 commissioners had been engaged with Monitor's predecessor, the CCP, seeking advice on the future model for their community services. At the time, commissioners were seeking clarification from regulators on how they could set up an integrated care organisation bringing together services delivered by the NHS and the LA which would not fall foul of competition rules. The advice consisted of finding the way round it by offering a three year period of protection to the new organisation under an aspiring FT status. However, such a workaround did not protect the CCG from the risk of legal challenge from other potential providers.

*The Co-operation and Competition's view was, (...) 'We can give you this advice, but you must be prepared to say and stand up and answer if Virgin Health or another provider came and said, 'Hang on, you've got a 55 or 120, 55 million pound Health contract with your community service provider, why haven't you tendered it?' (Commissioner 1, CCG4, November 2013)*

Although the commissioners found the CCP's stance supportive of their proposal to set up an integrated provider, they felt quite exposed to the danger of potential legal challenges. The interviewed commissioner pondered the "what trumps what?" question – greater opening to competition or move to integration of services, both of which seemed to be pursued concurrently as government policies.

Overall, commissioners in different case study sites differed in nature and frequency of their engagement with different sector regulators. The CCG1 commissioners were quite critical of the regulators' role, citing examples of not offering timely advice when it was requested or actively challenging commissioners' decisions. Commissioners from CCG3 and CCG4 had a more neutral or positive view of the regulators. It is not clear from our data what CCG2's view of the regulators was. Arguably, one could discern certain wariness of sector regulators on part of commissioners, seeing them as not always on the commissioners' side. The interviews with commissioners give an impression of a volatile system prone to unintended consequences and conflicts of interest which they tried to make sense of in their daily practice, but over which they feared losing control.

## **Impact of HSCA 2012**

Given that pro-competitive policies had been in effect prior to its enactment, we asked commissioners their views of the specific impact of the HSCA 2012.

Commissioners in all four case study sites were fairly unanimous in expressing their views on the impact of the HSCA 2012. The majority of comments reflected a conviction that the HSCA 2012 had had a profound impact in terms of changing commissioning structures. Although the structural changes instigated by the HSCA 2012 made commissioning work more challenging, interviewed commissioners noted at the same time that the HSCA 2012 *per se* had relatively little impact on their day to day work as many policies and regulations preceded the Act or were seen as independent of it.

A CCG1 commissioner noted that the new commissioning architecture instigated by the HSCA resulted in increasing fragmentation, complexity and bureaucratisation of the commissioning

system. These comments were echoed by commissioners from CCG2 and CCG4. In particular, the way the commissioning responsibilities, previously within the remit of PCTs, had been divided between different bodies was raising a number of accountability issues and seen as extremely unhelpful. Commissioners shared a number of examples of fragmentation of commissioning functions which put CCG commissioners in the position of ‘responsibility without power’. In one case the transfer of commissioning responsibilities and a resulting change in eligibility criteria had had a direct impact on patients for whom the CCG was responsible while having at the same time little commissioning power.

*Bariatric surgery is commissioned by NHS England as a specialist service, we had 70 patients in the system pre April when NHS England took it over as a specialist commissioning that were on a waiting list for bariatric surgery, NHS England, from the 1st of April changed the specification nationally to that patients who had a BMI of less than 50 had to go into a two year programme, tier three weight management, all our patients had a BMI of over 45, but under 50, so they said, you can't have your bariatric surgery, from when they said they could have, they were on the waiting list, so they were taken off the waiting list and, yet, in the whole of [area], there isn't a tier three weight management process, so I have got 70 complaints from patients, 10 of which are with MPs and NHS England won't budge. Is that barking? (...) to complicate it even further, we are not responsible, as a CCG, for weight management services, Public Health England are, Public Health England are saying, no, it's not us, NHS England said, no, it's not us, but we're being told, it's not you either. So I've got 70 patients floating, waiting. (Commissioner 6, CCG1, November 2013)*

Similarly a commissioner from CCG4 reflected on the fragmentation of commissioning of cancer services with specialist services commissioned by NHS England; screening services – by Public Health; GPs being responsible for identification; and none of these services commissioned directly by the CCG which nevertheless had overall responsibility for reduction of cancer mortality in the population. The commissioner concluded that “the Health and Social Care Act, the way that it divided up all of the commissioning responsibilities, has been for me a disaster” (Commissioner 3, CCG4, May 2014).

The increased fragmentation of commissioning was seen as “unhelpful in supporting cooperation” (Commissioner 3, CCG4, May 2014) between different service providers. The CCG2 commissioner commented in a similar vein that losing control over the commissioning of walk-in services, which transferred to NHSE, constrained the CCG’s ability to influence urgent care strategy. Another example related to creating disparity for the CCG2 population which was covered by two different LAs which had different public health services in their respective commissioning portfolios. Finally, one commissioner from CCG4 noted that the HSCA 2012 had had a direct impact in terms of transfer of estates from PCTs to NHS Property Services and community service providers which might have led to some localised discontent.

As the CCGs were being encouraged to collaborate with each other to increase their efficiency, one commissioner from CCG1 noted that this was tantamount to yet another reorganisation of commissioning bodies and ultimately to admission of the failure of the HSCA 2012 to come up with a workable commissioning structure. In their opinion, a trend to merge CCGs into larger units might result in going full circle back to the PCTs at least as far as the population coverage was concerned.

On the other hand, commissioners were in agreement that the HSCA 2012 had relatively little impact on the day to day commissioning decisions. This was because such considerations were guided by a number of specific regulations and policy documents some of which predated the Act.

*My view is that the Health and Social Care Act had had no impact at all, because it was happening anyway, because a lot of the procurement rules for us were just introductions of best practice, national legislation, and European law. So this whole notion that we were bringing in a whole new industry of competition in the private sector, it was happening anyway, and for me the thought processes we go through have not changed for the last two or three years. They've not been affected at all. (Commissioner 1, CCG3, August 2013)*

One commissioner from CCG1 noted that the HSCA 2012, due to its emphasis on competition and formal procurement, might give commissioners greater freedom in taking decommissioning decisions with regards to underperforming services.

Another commissioner from the same CCG was sceptical about the impact of the HSCA 2012 on fostering competition within the NHS. This is because in their opinion there were a number of systemic barriers currently preventing 'true competition' from taking hold, such as patients' preferences for local hospital services; the private sector's unwillingness to provide services deemed unprofitable, such as emergency services; and the fact that most consultants who offer private services also work in the NHS.

Despite raising these concerns about the impact of the HSCA 2012, one commissioner, echoing wider sentiment, emphasised that commissioning managers were trying to work through "this imperfect structure as best we can" (Commissioner 3, CCG4, May 2014) even though it made their daily jobs more complex and challenging.

### **Incentives to cooperate and compete**

As the study aims to find out how commissioners are using competition and cooperation as mechanisms in commissioning local services, we were interested in exploring their views on the incentives in the current NHS system to cooperate and compete.

Amongst many existing incentives to cooperate and compete within the commissioning system, commissioners in CCG1 emphasised the current lack of adequate funding as being the strongest incentive for providers to cooperate. One commissioner from CCG1 contrasted current funding pressures with the past availability of funding, which had allowed the main local providers to grow their businesses concurrently through competition. In contrast, a finite amount of money in local health economies resulted in restricting competing tendencies and in forcing existing providers to adopt a more collaborative approach.

*Stop paying them, decommission something. Take something off something that actually fundamentally destabilises one of them financially. Then it may get them to start talking. (Commissioner 3, CCG1, April 2014)*

According to this commissioner such moves are supposed to encourage the providers to examine and identify their own inefficiencies and biggest pressure points in order that they could be addressed holistically by the local health economy.

However as insufficient funding combined with the Payment by Results funding structure made service provision more akin to a zero sum game for providers, it could also promote competitive tendencies.

*Both [Trust X] and [Trust Y] are mindful that really there should only be one provider of community services and it's me, I want to be it, sort of thing. So there are tensions in that they are overwhelmingly friendly, but you can cut the atmosphere with a knife at times when we're discussing things on the table that might mean that some business is taken off them, but the actual terms of reference are in the [provider commissioner group] actually states that we'll all, as a community, do what's best for patients, regardless of which organisation it is. So they say that, but when you start talking about the money, you can see the body language, you know. (Commissioner 6, CCG1, November 2013)*

## **General views on competition and collaboration**

Commissioners discussed their general views of the use of competition and collaboration in the procurement of services, in the context of the HSCA 2012 and the National Health Service Procurement, Patient Choice and Competition Regulations no 2, 2013.

Commissioners expressed differing views of competition, although all participants considered that competition was not the most productive way to use limited resources to procure services, or to provide the best service to patients. Commissioners considered that the current government policy was confusing, inconsistent and stifling innovation. Some aspects of the government policy for competitive procurement was seen by commissioners as coercive. Overall, current policy did not appear to help commissioners achieve their objectives. There was general lack of enthusiasm for competitive procurement, particularly where it was seen as prescriptive, for example:

*Dogmatically following one particular approach is almost always unhelpful. (Commissioner 1, CCG2, November 2013)*

Commissioners appeared to conflate views about competition between providers to enter the market with patient choice, where patients had a choice of provider. Commissioners reported finding ways around the policy to do what they thought best; commissioning despite, rather than with, the assistance of policy.

Collaborative working with providers was favoured by all participants as a means of transforming services, with the important caveat that providers knowing that their services could be open to competitive procurement could be useful to stimulate collaborative working. One commissioner noted that a local change management programme that the local health and social care economy had instituted prior to the HSCA 2012 had achieved service reconfiguration by commissioners and providers working together:

*It's a long term change programme, which has been achieved through partnership and collaboration and which I would argue could not have been achieved through competitive procurement. (Commissioner 1, CCG2, November 2013)*

The requirement in policy for both for competitive procurement and for integration was seen to be inconsistent. Commissioners thought competition and integration were incompatible and that

competition was not “helpful” in service transformation. One commissioner reported feeling caught between the policy objectives while trying to implement the CCG objectives:

*It's almost like half the system wants there to be competition and half the system doesn't ... and we're stuck in the middle, working out what we do and don't want (Commissioner 3, CCG1, April 2014)*

When discussing competition for the market, the commissioners' views were underpinned by their beliefs about the NHS in general and their views on procurement:

*It just creates all sorts of stupid anomalies that are much more to do with trying to deliver political doctoring that they are about ... delivering patient care. (Commissioner 1, CCG2, November 2013)*

*The entrepreneurial thing just leaves me completely cold ... I find it difficult to contemplate the privatisation ... it is the political context that we're in and those are the values of that context. (Commissioner 2, CCG4, February 2014)*

*I don't get the idea of competition for health services ... so you're saying there's competition but only in these areas which then makes it a bit of a mockery ... (Commissioner 3, CCG1, April 2014)*

The third of these quotations also refers to the inconsistency of competitive procurement, both geographically and for the type of service. In terms of geographical location of providers, participants referred to the number of providers available to deliver services such as acute hospital services. In areas with a small number of acute hospitals, commissioners saw no reason to tender services as there was a limited number of providers.

Commissioners associated the number of acute providers with patient choice. Where there was a small number of acute providers, commissioners noted that patients had less choice of provider than in areas with many providers. However, commissioners in CCGs 1 and 2 assumed that most people wanted to use their local hospital, regardless of the availability of other providers.

Regarding the type of service tendered, commissioners did not expect to competitively procure services such as emergency care. This was partly because they had existing acute providers and partly because there was an expectation that no new provider would want to enter the market as the costs of entry would make the service financially unattractive. On the other hand, where the cost of market entry was expected to be low and the potential financial rewards from service provision high, fragmentation of services was expected. The opportunity for commissioners to break services down into small lots combined with providers wanting to bid for specific parts of the service was expected to result in greater fragmentation.

One commissioner viewed competitive procurement as one tool in their toolbox, and chose what they considered as the best tool to procure the service they wanted:

*As a commissioner you've got to have a variety of tools in the toolbox, competitive procurement is one of them ... you certainly don't want to rule out whole areas and say: "Well you can't collaborate" or "You have to competitively procure" or "You must use AQP".*

*All you're doing ... is shooting yourself in the foot. So I think you keep as many options as you can.* (Commissioner 1, CCG3, November 2013)

When Government policy was seen as prescriptive, it was seen to be stifling innovation in procurement and service reconfiguration. For example, one commissioner (CCG2) commented on units of planning<sup>1</sup> and questioned why CCGs were allowed to be in only one unit of planning. His view was that some services, such as patient transport, should be commissioned by larger units as they were operating across a geographical area larger than one CCG.

There was a belief that other commissioners would be “cheating” in the face of “dogmatic approaches to commissioning” (CCG2), by complying with government policy and then finding ways round the system to do what they want to do. In such a case, commissioning would be in spite of the policy, rather than the policy supporting the commissioning choices.

Notwithstanding the foregoing views, competition was seen to have some benefits. One commissioner (CCG3) felt that the competitive process helped commissioners think about how they chose providers because they had to show that they had not chosen their “local favourite” provider.

In addition, as mentioned above, one commissioner (CCG2) thought it was useful to have competitive procurement available to use in their toolbox. Furthermore, two commissioners (CCG1 and CCG4) noted that one benefit of the policy encouraging competition was that the threat of competitive procurement could encourage existing providers to discuss service reconfiguration, rather than risk losing the service. Thus, the threat of competition was used to encourage collaboration.

One commissioner considered that competition appealed to the “small business mentality of GPs” (Commissioner 2, CCG4, February 2014) who were attracted to bid for the work.

Collaboration was seen by all commissioners as preferable when working towards integration of services and service transformation. Integration through collaboration was seen as desirable for the NHS as it avoided the costs associated with tendering and bidding (CCG4). The workload associated with competitive procurement was seen as bureaucratic and demanding on the CCGs’ limited resources. There was a view the bidding process favoured large providers who could write a good bid, and could exclude small providers with fewer resources, from the market. Collaboration was also seen as beneficial in developing a sense of ownership of health and social care between commissioners and providers (CCG1). One commissioner thought that service redesign could be handled by commissioners and providers working collaboratively to agree the content of the contract:

*You need some form of contract management ... to say “this is the amount of money, these are the outcomes we want, this is the sort of market we use, you tell us what that [service] is* (Commissioner 3, CCG1, April 2014)

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<sup>1</sup> A unit of planning was expected to be larger than a CCG area and its purpose was to prepare five year strategic plans for integration of services, taking acute trusts and local authorities into account. <http://www.ntda.nhs.uk/wp-content/uploads/2013/10/Paper-J-Annex-1-Joint-Planning-Letter-4th-November-2013-28-November-2013.pdf>

In summary, the overall view of commissioners was that although competition had some advantages, and could be a useful commissioning tool, the service transformation required of commissioners and providers was more easily and financially efficiently carried out by working collaboratively.

### **Summary of commissioners' views**

Commissioners across the four case study sites found it hard to pinpoint exactly what the rules on application of competition within the English NHS were and thus whether or not they had to change their commissioning practices. The HSCA 2012 itself had no major impact on their day to day practices as commissioners already had to balance cooperation and competition policy pressures. Some observed that the system seemed to be pulling in opposite directions of trying to instigate both collaboration *and* competition while avoiding giving guidance on the issue of which aspect was more important. Although the HSCA 2012 itself did not have major impact on commissioning practices, commissioners felt that it might change in future, as rules about using competition became clearer and were more robustly enforced.

Although all sites preferred to use collaborative approaches to achieve transformation of services, CCG4 appeared to have greater experience of tendering and willingness to use competition as a potential commissioning tool. It is unclear whether this was due to having access to greater number of potential providers or due to personal preferences, experiences and convictions of senior managers and leading GPs.

### **Providers' views on regulations**

Alongside commissioners we interviewed a number of senior managers from acute and CHS providers in the four case study sites about their views of competition and cooperation in the NHS. This included both NHS and independent sector organisations. This section reports providers' understanding of the regulatory landscape surrounding competition and cooperation, and their views about these issues.

### **Understanding of current policy**

Rather than tracing the differences between providers' views at each of the four sites we have compared the views of different *types* of provider, as they face different sets of problems and opportunities.

Some of the acute providers we interviewed had FT status whilst others did not. One FT acute provider noted that understanding of and adherence to the regulations about competition was one of the conditions of providers' licensing regime introduced by Monitor. Yet being familiar with the regulations in itself did not solve the conundrum of fostering both competition and service integration. In particular one provider gave an example of issues posed by the proposal to concentrate specialist services in 15 to 30 centres.

*The question is, is how does that work with the laws as they're currently...or how does that work with the guidance as it currently stands and it's a...it's dynamic, there's no nice neat answer to that, it has to be a judgment call and, you know, there will have to be the*

*appropriate amount of consultation, public consultation (Provider 1, NHS, acute, CCG1, April 2014)*

Another acute provider manager was not optimistic in assessing their own knowledge of the current regulations due to their complexity and vagueness.

*It's an absolute nightmare and I don't pretend to keep on top of it all, but what I will do is Google the latest bulletin or go to my procurement team or go to [name of person] from a legal point of view. When they cut out the stuff about Section 75 and saying that everything had to go out to competition that certainly put the wind up us to think, everything? But truly, how are you going to facilitate that and is that really in the right...is that right for patients? So, no, I don't keep on top of everything, but what I do do is I keep in touch with the FTN bulletins and it's the FTN bulletins and the Monitor bulletins that I use as my source for things like that. (Provider 4, NHS, acute, CCG1, June 2014)*

The same interviewee also noted that apart from difficulties in trying to understand the regulations fully, another question arose as to whether this was really necessary, as in their opinion it was not clear "how much attention do people truly pay to procurement law" (Provider 4, NHS, acute, CCG1, June 2014). They gave an example of being involved in tendering process and investing substantial resources in it, just to be told that commissioners had decided to abandon the whole procurement exercise and award the service to an incumbent provider.

*So, in my eyes, absolutely against the law, but would an NHS body ever challenge another NHS body when you're talking significant funds, legal, a legal challenge? (Provider 4, NHS, acute, CCG1, June 2014)*

Another acute provider manager from CCG2 was concerned about overall "lack of clarity about the role of the market" in the NHS. In their opinion it was difficult to pinpoint a consistent policy direction in this respect which left a lot of space for inertia within the system as nobody seemed to understand where it was heading to or how it was supposed to work.

*Does the Government fundamentally believe in a purely market driven system or a managed system and if so – or a mixed system? (Provider 2, NHS, acute, CCG2, March 2014)*

CHS and MH provider managers also emphasised the general confusion about current policy regulations. One provider from CCG1 noted that the intention of some of the guidance was hard to discern. In particular, they were unsure about the aim of offering longer, five year contracts when tendering services. Giving a successful bidder a five year contract to get the service provision up to the standard which commissioners expected made the tendering exercise questionable in the first place.

*I was trying to get my head around whether in that the intention was that you really nailed down what you really wanted the end position to look like, but you were going to give somebody five years to get there, type of thing, in order to have the stability (Provider 2, NHS, community and/or mental health, CCG1, April 2014)*

Another CHS manager stated that lack of understanding of rules about competition and collaboration and how to use them effectively to improve outcomes remained a major obstacle to commissioning system.

*There's no clear framework, so people have got misconceptions (...) there's a huge misinterpretation, misconception, and I think what would really help would be some very clear guidance on what this is really all about, rather than it all being a bit cloak and dagger. (Provider 2, NHS, community and mental health, CCG3, November 2013)*

We interviewed a small number of independent CHS providers. One independent provider from CCG4 hoped that the number of services open to tendering would be increasing and would include all those which were currently delivered on block contracts where payments are agreed in advance for a set amount of care. Yet they also expressed some uncertainty about the policy direction and the degree to which independent providers would be welcomed to deliver NHS services. This meant that the outlook for his company remained uncertain.

*So the landscape, as we see it, we're somewhat uncertain where people like ourselves will lie, whether we exist in three years or whether we exist when a new Government comes into power, we don't really know. (Provider 2, Private, community and/or mental health, CCG4, January 2014)*

Providers reported that there was a widespread confusion among commissioners about whether they were obliged to tender all services. One provider reported that it was difficult to keep up to date with national policy and relied on the bulletins from the Foundation Trust Network and Monitor.

In three areas (CCG1, CCG2 and CCG3) provider managers reported experience of CCGs informing them that they had to tender all services. One provider reported that the CCG was saying that it had to tender all services, although Monitor and Government Ministers were refuting that statement:

*It was a CCG commissioner saying "Oh, I've been on a Monitor conference and we're meant to, in any contract over this size, we've seen the regulations, it's meant to be an OJEU<sup>2</sup> advert and we're meant to advertise it and do it in that way." Monitor and Government Ministers are saying, "Oh no, we didn't say that. We're not privatising the NHS." Yeah, but their commissioners are. (Provider 1, NHS, community and mental health, CCG2, April 2014)*

A provider manager in CCG3 considered that the policy had gone awry. His view was that commissioners had misunderstood the policy and interpreted it as meaning that everything had to be tendered, rather than think about the purpose of tendering:

*People have got misconceptions, mixed messages: "It's all got to be tendered ... it's all about how do you get competition" ... and that's not what it's all about at all ... all the time we should be saying, how is this actually going to improve care... population outcomes ... make sure that the taxpayers' money is being used effectively ... it's a tool that can be used, it's not a must do. (Provider 2, NHS, community and/or mental health, CCG3, November 2013)*

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<sup>2</sup> The Official Journal of the European Union.

The same provider manager perceived tendering an “aggressive, negative tool” that was being used in some places instead of solving problems collaboratively by commissioners and providers (Provider 2, NHS, community and/or mental health, CCG3, November 2013).

A provider manager in CCG4 thought that the policy for putting all services out to tender was “muddy”, although his interpretation was that the imperative to tender all services was reducing:

*My understanding is that it's now less of a requirement that it used to be ... you have to show ... value, which doesn't necessarily mean that you have to put everything out to competition.*  
(Provider 1, NHS, community and/or mental health CCG4, January 2014)

To summarise, providers were also confused about the meaning of the current set of competition rules, and what they meant for them and their future in NHS service provision. They reiterated commissioners’ concerns about the vagueness and complexity of formal rules and a need for better guidance. The NHS providers reported that some of their CCG commissioners thought they had to tender all services, although one commented that he thought that commissioners had misunderstood the role of the competitive market. In one CCG, two NHS providers thought mental health and community services were not treated in the same way as acute and GP providers by commissioners tendering for services. The independent provider manager who commented on the view of their local CCG that there was an imperative to tender all services reported that their organisation did not want to bid for all services and that if some specialist services were open to tender, commissioners would find it hard to find new providers willing to enter the market.

### **Amount of local discretion**

It was also important to understand the views of provider managers about the degree of discretion available for commissioners at local level, as those views are likely to affect providers’ behaviour.

Provider managers reported that the extent of commissioners’ local discretion to act was affected by several factors, which overall, indicated that commissioners faced challenges in using their local discretion in commissioning services. Individual provider managers made a variety of observations including: different commissioners were interpreting discretion in different ways; commissioners were choosing not to use competitive procurement where services were working well; there was differing levels of involvement of NHS England Area Teams (AT) in commissioning; and there had been a reduction in local discretion over the last five years, with a move towards a more centralist approach.

Local discretion was reported by two participants in one provider organisation in CCG4 to be interpreted in different ways by different commissioners, who were basing their decisions on the cost of services. They thought that commissioners were looking for quick financial “wins” and were looking at marginal financial benefits rather than considering service redesign:

*I think that different commissioners are interpreting that in different ways ... if I were a commissioner and thought there were some quick financial wins and I've got financial pressures, then the temptation would be to do it* (Provider 1, NHS, community and/or mental health, CCG4, January 2014)

*I think they're still looking more or less at the margin than at the fundamental (Provider 1, NHS, community and/or mental health, CCG4, January 2014)*

A manager in an independent provider in CCG4 also commented on variation between areas, and commented that GPs' views about independent providers in the health system affected their use of providers:

*It's a very mixed landscape. Some areas ... where the GPs are very receptive and if you say: "Look, we've got an excellent clinical team with no waiting lists," they will ... embrace it and use it, and in other places ... they are very happy to use services which have ... triple the waiting time, simply because they're ideologically opposed to an independent provider. (Provider 2, Private, community and/or mental health, CCG4, January 2014)*

Commissioners in CCG3 were reported to have used their local discretion in deciding to avoid competitive procurement where the existing service was delivering what they required. This was seen as a "brave decision" by one provider manager, which he considered was unusual nationally:

*Nationally that's not the way that things are going... it seems to have generated ... interest from other parties, either how have you got away with doing that? Or, why have you done that, to them? (Provider 1, NHS, community and/or mental health, CCG3, November 2013)*

However, the commissioners' view was reported by a different provider manager in CCG3:

*His line ... is, "when we have to do it [competitive procurement], we'll do it and when we don't, we won't. (Provider 5, NHS, acute, CCG3, December 2013)*

This provider manager was unhappy about the CCG's decision to avoid competitive procurement and had taken advice about challenging their decision not to tender for a service. He had been informed that the provider had an argument which it could take to Monitor, with a high expectation that the decision would be overturned. However, the provider decided not to challenge the CCG's decision because they wanted to have a good working relationship with the CCG in the future. Thus, local discretion was exercised by the CCG without challenge.

The role of the NHS England Area Teams was reported as being more open to local interpretation, because there was no framework for its role in commissioning. A provider manager in CCG3 reported that some ATs were more involved than others with CCGs and this was affecting how "hawkish" or "doveish" CCGs were in their approach to commissioning. Thus, there appeared to be discretion at AT level too.

A provider manager in CCG1 commented that in his view the amount of local discretion had reduced over the previous few years. This provider manager indicated that the reduction in local discretion he had experienced had had an impact on the collaborative working relationship between his organization and the CCG.

*My frustration is, we have a very good relationship with our local CCG ... we're completely on the same page ... but one of things I've found at an increased level over the last five years is the ability to locally do things seems to be gradually being diminished. There feels to me to*

*be more of a centralist approach being over this, the flexibilities locally feel less. (Provider 1, NHS, acute, CCG1, April 2014)*

A provider manager in CCG2 also commented on central government's relationship with acute providers and how it affected local discretion. His view was that acute hospitals were too politically sensitive to be allowed to fail financially, and as the public hold central government to account for local health services, central government found it hard to relinquish control over acute trusts.

*what happens to your local hospital ... how good your local health service is, is always going to be a Political, with a big P, issue ... there'll always be votes in it. And I think politicians find it very, very hard to let go ... because the voters will hold them to account for it. Particularly here [England] where it's still seen as a national treasure. (Provider 2, NHS, acute, CCG2, March 2014)*

An independent provider manager commented on her experience of local discretion. Her view was that the rules forced the commissioners to award contracts based on bids matching criteria that did not take the desirability of the provider into account:

*I think there are rules there that people – you can't bend the rules and I'm not saying you should bend the rules, but there are rules that ... you have to get this score, that score, that score, that score, okay ... I think you need to say: "... that's fine, but you need to look at who the company is, who's won it? Are they somebody you really want?" But ... this has been my experience, because they've ticked all the boxes, they've got it. I'm not saying the commissioners were happy, 'cause they were not, but they've got it. That's wrong. (Provider 6, Private, community and/or mental health, CCG2, May 2014)*

In summary, local discretion was seen by several provider managers as having been reduced, and by other provider managers as being affected by factors outside local control, and by the approach of ATs to their involvement in commissioning by CCGs, which varied.

## **Views on the role of sector regulators**

Managers in providers in three of the four case study sites (CCG2, CCG3 and CCG4) commented on the range of organisations that they considered to be involved in regulating the health sector. The organisations and people involved in regulation named were: Monitor; CQC; NHSE through the agency of ATs; OFT, replaced by the CMA; the TDA; the Prime Minister; and Secretary of State. Monitor was the most widely mentioned regulator.

One provider manager felt that the relationship between the different regulators was not clear and there was no overall organisation responsible for regulation:

*The interactions between the different regulators is confused. No, there used to be ... an organisation that was clearly responsible for ... holding the ring, in the shape of SHAs, that's disappeared. (Provider 2, NHS, acute, CCG2, March 2014)*

The same participant commented that Monitor was expected to promote cooperation, competition and integration, which he thought could not be combined. A provider manager in CCG3 expressed a similar view:

*I know that Monitor has the duty both to ensure cooperation, but also to develop competition and the great ... debate from the commentators on the NHS is whether it's possible to do both. (Provider 5, NHS, acute, CCG3, December 2013)*

Another provider manager (CCG3) considered that there was confusion about Monitor's actions, described as "misinformation" and "misunderstanding", which commissioners were using as an excuse for their actions.

*Monitor would say, that's not what it's about, and people are ... using it to do other things, rather than to say what are we all here to do? (Provider 2, NHS, community and/or mental health, CCG3, November 2013)*

The interaction of different organisations involved in regulation had an impact on the work of providers, according to an acute provider manager who pointed out that different organisations had different reporting requirements from providers:

*There are also issues in terms of the relationship between Monitor, CQC and NHS England and certainly very practically with winter as an example and as we're told, the Prime Minister's personal involvement and the Secretary of State's personal involvement in winter, we're getting very confusing and disorganised behaviour in terms of the requirements from Monitor as our regulator, the requirement from NHS England, which is transacted through the area team, through the CCG to us and I'm sure, at some point, the CQC, certainly with the first two, just to, kind of, give you an example, where now all foundation trusts are on weekly reporting for winter with Monitor, we also do daily reporting for NHS England through the CCG and those two returns collect different data, which is farcical, absolutely farcical! (Provider 5, NHS, acute, CCG3, December 2013)*

This provider manager noted the role of the AT in translating requirements from Monitor to the CCG, before these were received by the acute trust. Therefore the variable role of ATs observed in influencing local discretion of CCGs was also apparent in the regulation of providers.

Participants in the CCG2, CCG3 and CCG4 commented on service reconfiguration being held up by disagreements between regulatory bodies. One provider in CCG3 talked about the approval of Foundation Trusts being delayed because Monitor and CQC were "wrangling". An acute provider manager in CCG2 thought that the failure of plans to merge acute hospitals in Bournemouth and Poole was evidence that the CC did not understand the health sector, and were trying to treat hospitals the same way that they would treat 'Marks and Spencer' or 'Sainsburys'. A provider manager in CCG4 also commented on this proposed merger and reported having taken advice about the potential impact on local hospital provision of service reconfiguration:

*The Office of Fair Trading [sic] can take a view on this as well. And they'll go, 'cause it's their job, they'll go, "Well, this isn't competition, is it? If you're saying we're going to, on a planned basis, reshape the services ... so that you get critical mass and standards go up because of centres of excellence ... then you're reducing competition." Yeah, we absolutely are. So they're [laughter] not going to like that. (Provider 1, NHS, community and/or mental health, CCG4, January 2014)*

An independent provider in CCG4 reported that they had contacted Monitor to ask if pressure could be put on commissioners. They found that Monitor were interested in acute trusts and not in independent providers because they were too small. This provider manager commented that they would not "place much faith in Monitor".

A provider manager of CHS in CCG2 commented that local services on the boundary of health and social care, such as domiciliary visits, were affected by regulation of the LA. Severe financial constraints in the LA were described as resulting in a reduction of social service provision, both in terms of the content of services and the number of people receiving them. The community trust found that its workload had increased because health care staff were dealing with service users' problems that would previously have been handled by social care staff.

In summary, in common with commissioners, the regulation of the health sector was seen as muddled by provider managers, with the regulatory organisation Monitor having conflicting duties. The interaction of regulatory organisations had an impact on service reconfiguration and workload for providers. An independent provider manager noted that Monitor did not show much interest in the place of small providers in the NHS market. One community trust had experienced the impact of regulation of another sector, in this case, the local authority, on the services it provided.

## **Impact of HSCA 2012**

The changes to the English NHS in general, including the HSCA 2012, have led to uncertainty amongst providers. Some providers saw the HSCA 2012 as a distraction to the NHS; the system had seized up for over two years and they considered that there were more important priorities for the NHS, such as dealing with financial pressures and quality of patient care.

Provider managers thought that the NHS market was developing prior to the HSCA 2012 and that the legislation made little difference to competition and cooperation, except that it legitimised increased competition that some commissioners had wanted to introduce in any event.

However, provider managers saw that some providers (e.g, large FTs) with great market power were a block to integration of care. The continuation of the disparity of the funding mechanism of acute trusts and GPs by a form of fee for service payment, compared with block funding for MH services and CHS was seen to be a barrier to service reconfiguration. This was linked to the HSCA 2012.

Cooperation was widely seen to be essential for service reconfiguration, and the HSCA 2012 was seen unhelpful in enabling cooperative working across the health economy. Provider managers noted that there were recent policy moves to rejoin parts of the health economy fragmented by recent restructuring.

Benefits of the HSCA 2012 were seen as being that it created a legal requirement to deliver contracts and encouraged pooling of resources. Competition could be seen as helpful where it led to improved quality and efficiency, but there was doubt about whether competition would have this outcome in practice.

Provider managers saw the CCG commissioners' roles established by the HSCA 2012 as difficult and challenging. Clinical leadership of commissioning was seen as having an impact, although there was the potential for conflict of interest for GPs. The approach of LAs to commissioning services had

changed the contracting environment for providers. LAs were seen to place more emphasis on the cost of service than the quality of service than the previous NHS commissioners had done. This particularly affected the boundary between health and social care, where services overlapped, such as domiciliary visits.

### **Incentives to cooperate and compete**

Provider managers recognised that they navigated the system which included incentives both to cooperate and to compete. Providers exercised their own judgement which strategy was more advantageous in particular circumstances. For instance, a provider manager from an acute trust in CCG1 explained their competitive stance regarding provision of CHS which may involve some form of collaboration with another trust to increase their competitiveness:

*There will be things and some things coming up that we will be fiercely competitive on and we do not want to partner, whether that's right or wrong from a patient's point of view, I don't know, but there will still be things that we will not collaborate on.*

Can you give me any examples of such?

*Well, we've got community services... (...) Now that tender is due out back end of this summer into autumn ready for an April start in 2015, big contract, big value, we want it, but, of course, I should imagine, so does the care trust and so does umpteen private sector providers as well. So in that scenario, we absolutely would not collaborate with the care trust, we may collaborate with [another acute trust] to come together as a bigger body to try and squeeze some of that competition out. (Provider 4, NHS, acute, CCG1, June 2014)*

A different provider manager from CCG4 expressed a similar view suggesting that the way the incentives were aligned in the current institutional environment forced providers both to compete *and* cooperate with each other, rather than rely on one single strategy.

*So in a formal sense, yes there is cooperation [between providers] in the patients' interest. But there will be some things that they won't want to share with us and some things we won't want to share with them.*

And what would those things be?

*Well, anything that is going to give a commercial edge, isn't it? So any ideas that we might have for innovation or any ideas that they might have for innovation, details of their cost structure or our cost structure, you know, the usual commercial things. (...) the example people always use is the sort of oil industry and so on, isn't it, where, you know, all the firms are in competition with each other, but they all share flights out to the rigs and so on, because it's in everybody's interest to do so. (...) So there'll doubtless be things where it's mutually to do things together is better than doing them apart, but it doesn't – it won't – it'll never be total. (Provider 1, NHS, community and/or mental health, CCG4, January 2014)*

The institutional environment with dual incentives and pressures to behave both competitively and cooperatively put some providers in precarious position as they could not be entirely sure whether the course of action chosen by them would prove beneficial.

*It's almost like the Sword of Damocles, kind of thing. So right, here you go, here's the big, mad, axe wielding whatever over here, saying you have to do the following, but we also need you to work together. (Provider 1, NHS, community and mental health, CCG3, November 2014)*

One CHS provider manager pointed out that there is a long history and culture of collaboration between different providers in the NHS especially in respect of patient pathways.

*There has always been cooperation between different parts of the NHS. So, you know, clearly, as patients travel through the system, there has always been cooperation between if you like, hospital services and community services and so on and so forth, so, you know, we've always had that. (Provider 1, NHS, community and/or mental health, CCG4, January 2014)*

More recently the push for collaboration and partnerships was thought to be due to growing financial pressures within the NHS, which resulted in providers having to look for efficiencies. Where providers were involved in bidding for tenders, they could choose to work in consortia to cover more of the patient pathway. A number of other factors militated against competitive behaviour in some circumstances: for example, there were no alternative providers in some areas; and some services were viewed as unprofitable lessened.

On the other hand, the incentives to compete were introduced by fee for service payment mechanisms, the patient choice agenda, opening up some services to tender and the transfer of some services from acute to community settings. One provider manager suggested that a fear of being seen as colluding by the regulators might also serve as an incentive to behave in a more competitive manner.

Depending on particular circumstances, interviewed provider managers behaved both competitively and cooperatively, reflecting the dual nature of incentives embedded in the current system.

## **General views on competition and collaboration**

Provider managers shared their general views on competition and collaboration in shaping services and provider landscape. They discussed the view that tendering and cooperation were mutually exclusive activities; the role of patient choice in driving competition within the market; pricing issues such as lack of fee for service tariffs in community settings making competition difficult; and the destabilising effect on existing service providers of tendering more profitable services.

An acute provider manager from CCG1 spoke at length about the biggest driver of competition within the NHS being patients becoming more vocal and better informed and taking advantage of their right to have a choice of services. Although generally seen as a positive thing, the respondent was wary about its potential to undermine the viability of other services and providers. The respondent gave an example of the increasing number of patients from neighbouring areas opting to choose the respondent's trust for treatment. It raised concerns at what point this would have a negative impact on neighbouring trusts which provide services to areas beyond the reach of the respondent's trust.

*If it's what the patient wants then, yes, it's right, but not if it's at the cost of an organisation that delivers services way further over into [name of the area] than we're interested in? (...) I just don't know how you solve that enormous jigsaw puzzle, I think the future absolutely is patients choosing more of where they want to go and patients creating that pull. (Provider 4, NHS, acute, CCG1, June 2014)*

However a manager from a different acute trust in CCG3 remarked that although the choice agenda had been in the NHS for a long time, only some patients were aware and took advantage of it. The majority preferred to follow their GP's recommendation.

*When we talk about Patient Choice because when you...certain people really get that and they really move it. A lot of patients don't, the doctor, the man in the white coat is the power, you know, they trust everything he says so they don't necessarily take that choice on. (Provider 4, NHS, acute, CCG3, December 2013)*

The issue of conflict between promoting competition and cooperation in the NHS simultaneously was of concern to some respondents. One respondent took the view that the origins of the elements of competition, such as tendering for clinical services, which have been introduced into the NHS so far were "political with a small 'p'". They were a "middle ground territory" which crystallised not as a result of clear ideological preferences for market principles but rather as a piecemeal introduction of European procurement law and other regulations.

*I worked in the middle of the Labour government and this policy was coming in, you know, so it's middle ground territory now and actually it's European procurement law, quite a lot of it as well (Provider 5, NHS, acute, CCG3, December 2013)*

Another respondent from an acute provider in CCG4 remarked that the balance between competition and collaboration was hard to undertake satisfactorily following the decision on Bournemouth and Poole Hospitals in favour of competition. He reported that there was a lot of concern in the NHS about the competition rules preventing change from being able to be undertaken at local level. There was a need to rebalance the weights of competition and collaboration.

*I think we need to see a bit of a rebalance between understanding the benefits of competition. I think we're all sold on the risks of competition but there are benefits to it, but also getting some balance between that and how collaboration works, because we have to do both, if you see what I mean, and that's quite challenging. (Provider 4, NHS, acute, CCG4, April 2014)*

Another respondent pointed out the difficulties in identifying the public benefit of both using competition in procuring clinical services and also in avoiding it. They thought the public benefit of either of these actions remained poorly understood and defined.

Even where acute service manager respondents were in principle in favour of competition, they did not always exercise their rights to insist on it. They were afraid of damaging their relationship with the commissioner. An acute trust in CCG3 pondered about challenging the CCG about not putting their community services to tender.

*We made an argument to say that those services should be put out to tender. The CCG decided that the process would be too disruptive for the community services and so decided not to do that, to leave them where they were. Now we took some advice on the rules around that (...) And basically he said what they'd done was outside the scope of the regulations and actually we could make a very good strong argument to Monitor to challenge it, as he described it, with a high likelihood that Monitor would overturn their decision. Now we decided not to do that for a whole host of reasons (Provider 5, NHS, acute, CCG3, December 2013)*

Several provider managers were critical of increasing competition in the NHS for a variety of reasons. One acute provider manager from CCG4 was concerned that tendering out profitable services had adverse effect on other services and that commissioners deciding to tender out some services do not appreciate fully the interdependencies of different services based in a hospital. There could be unintended consequences. One example was given of tendering cataract service out to a private provider which resulted in financially destabilising the ophthalmology service run by the local hospital. As a result the hospital had to shut down the emergency part of their ophthalmology service and local patients had to travel further away to get emergency eye care.

*So competition isn't new; had competition for a while now. But I think it's inappropriate in the Health Service and I think there are too many interdependencies in the Health Service. So the minute you start leasing a bit out somewhere else then you don't think about the impact that has on all the other bits, or the whole and that increases costs. So I think everything that we do is just – it doesn't understand the interdependencies that there are in running a hospital. (Provider 3, NHS, acute, CCG4, March 2014)*

Another reason given by the same respondent was that increasing competition in the NHS internal market was unaffordable as it produced higher overall costs for the financially challenged NHS.

*I went to a mergers and acquisitions talk and they talked about petrol station companies and how they – when one – you know, it's easy for one of them to open up a petrol station at – under the same principles next to a competitor and charge a slightly lower price 'cause it doesn't cost them a lot because they've only got their marginal costs. But the way they deal with that is that then you retaliate. So you then say, "Okay, well I – if you've opened up right next to me I'm going to open up right next to you." And then both your providers have additional costs and no-one's won. So there's only a certain amount of money in the Health Service and I think we are wasting money on these things. (Provider 3, NHS, acute, CCG4, March 2014)*

CHS provider managers we interviewed expressed a range of views on competition within the NHS, from critical to accommodating. One provider manager from CCG2 agreed that tendering was not compatible with tight financial situation within the NHS as lack of money was pushing different providers towards greater cooperation with each other. But a respondent from another community provider in CCG2 saw a place for competition in the NHS yet claimed that existing governance boundaries restricted the changes which could be made by it. The lack of clear pricing structures for MH and CHS was mentioned by a number of respondents as an impediment to competition.

*If you get the balance right, you know, between private sector principles, you know, motivation on one level – I appreciate that it's a difficult balance, profit versus patient care, but motivation on certain levels from the private sector and certain aspects of, you know, large organisations succeed in certain respects – buy-in power, etc., etc. – then the economies of scale, and you applied some similar model to the NHS, then that agenda, you know, that procurement competition agenda would fundamentally, you know – well, it'd be delivered, but it'd be delivered in a non-fragmented, dismantled way. I think it'd be delivered in a controlled, balanced and fundamentally more successful way (Provider 5, NHS, community and mental health, CCG2, June 2014)*

A CCG4 provider manager echoed the point made above by an acute provider manager about interdependencies between services. They expressed a preference for a whole system approach and raised concerns about the ability of private providers to cherry pick profitable services and undermine the unprofitable but vital services.

*Whether it be in hospital or Community Services and what they're not cited on is the problems that that gives when you strip out that from, if you like, an overall bigger organisation and you undermine the sustainability of what's left. Now if you're doing it at the margin, you know, in a sense that's fine and it's an irritant, but it's not fundamental. But if you do it to any large degree then you have a problem. (Provider 1, NHS, community and mental health, CCG4, January 2014)*

The view was also expressed that the operation of internal market jeopardized the trust built up between different actors, and thus decreased the quality of services commissioned. For example, there were cases where commissioners required extensive input from a provider to write a new or change an existing service specification, only then to decide to put the service to open tender.

*We have had some difficulties, I think, with looking at developing services in line with Commissioners. For example, nursing home proposals, whereby it's difficult to work something up and then, at the last minute, it's been put out to private sector when we've done a piece of work in good faith, to get it to a point where we could pilot something and then, for various reasons, it's gone out privately. So there have been some instances where we've been a little bit bitten by the competition element (Provider 1, NHS, community and/or mental health, CCG4, January 2014)*

Concern was also raised about the transaction costs of competitive tendering, both in terms of resources dedicated to the process, and the delays caused by it. Several providers (in CCG3) saw competitive procurement as adding a cost to the NHS in the context of financial pressures, and slowing procurement, at a time when speedy decisions about service transformation were required. One provider commented that there were other ways to work:

*In some health economies we're getting it right .. and the length of the [tendering] process, we would introduce inertia. We would stop that progress for ... 18 months to two years. Why would we want to do that ... when there are so many strong drivers, like the fiscal environment? ... there are lots of other mechanisms that can drive us to look at things differently. (Provider 2, NHS, community and mental health, CCG3, November 2013)*

The independent provider managers who expressed views on competition were more positive. One noted that the introduction of competition made commissioners better at managing existing contracts and extracting value for money from existing services as a result of having an option of procuring services in an open market. This made commissioners focus on whether they were getting the best possible deal from providers. Another independent provider stated that in their opinion the NHS was “inefficient”, but independent providers struggled to overcome barriers to market entry such as IT or lack of engagement from NHS providers.

*It's something to be proud of within the country, but is inefficient. You've got 'Spanish practices' that partake or basically work within the NHS. It was seen as a job for life. There was no reward for innovation or to strive for clinical excellence, and we think it's an outdated model for service delivery. What the Government's trying to do is bring in innovation through third party providers, but there's quite a lot of hurdles to overcome, whether it be IT, infrastructure, finances or whether it's just to try and overcome hurdles where, I suppose, providers such as the Acute Trusts or even basically community based Trusts are reticent to engage with us, 'cause they see us as competition. (Provider 2, independent, community and/or mental health, CCG4, January 2014)*

One respondent viewed the NHS as too politicised a system for it to ever embrace purely commercial principles.

*At the very, very top of, I don't know if you can still call it an organisation, of the system, the lens through which success or failure is viewed, the lens through which patient satisfaction is viewed, the lens through which financial transactions are viewed, it's entirely a political thing and never a commercial point; all about electoral cycles, electoral popularity, electoral geographies. And that's endemic. (Provider 2, NHS, acute, CCG2, March 2014)*

The findings show that provider managers hold a wide range of views on the place of competition within the NHS from highly critical to more accommodating, seeing potential benefits of transplanting some elements of independent sector thinking into the NHS. Unsurprisingly, independent provider managers were more in favour of competition than NHS incumbents.

## **Summary of providers' views**

Providers shared many concerns that were expressed by commissioners about the rules governing competition with the NHS. In particular providers talked at length about a sense of confusion surrounding rules and many misconceptions that this led to. Some providers also noted the weaknesses of sector regulators, in particular Monitor, in trying to clarify the rules. Despite being concerned with negative effects of competition within the NHS causing fragmentation of services and increasing costs, many providers were seeing competition as happening ‘at the margins’ rather than infiltrating their core businesses and strategies. They were preoccupied with the pressing issues of structural changes in the configuration of NHS services in the face of growing financial pressures. According to some providers that we interviewed such changes could not be delivered through greater use of competition due to additional costs that accompany operation of the market within NHS. Our interviewees did not know how the existing rules on competition, procurement and patient choice could be aligned with the greater push for partnerships, mergers and collaboration between providers.

## **Interim Conclusions**

The HSCA 2012 came into effect in April 2013, setting out a complex regulatory scheme to govern the use of competition and collaboration in the English NHS quasi market. The field work for this interim report was carried out early in the life of the new system, and may not represent how actors will understand the system after time has passed. Nevertheless, the findings are useful for policy makers and regulators.

It is government policy that there should be a 'fair playing field' for all providers of care to NHS patients in order to enable the quasi market to operate effectively, with the aim of producing efficient high quality care (Monitor, 2013). One prerequisite for such a 'fair playing field' is that all actors understand the rules governing that market. Our preliminary findings concerning the understanding of the regulatory context of the NHS market by both commissioners and providers of care indicate that there is much work to be done to ensure that the 'rules of the game' are clear to all 'players'. Not only was the plethora of written material seen as unclear, but the regulators of the system (especially Monitor) were not perceived as giving adequate guidance to actors. In this context, local commissioners were exercising a degree of discretion about how to interpret the rules concerning the use of competition, which may, in fact, have been (and continue to be) advantageous to the urgent process of reconfiguring services currently under way.

Actors in the system held differing views about the efficacy of competition as a mechanism to improve services. Although there was a general preference among commissioners to use collaborative approaches, many acknowledged that the fact that they could use competitive techniques if they wished has been useful in encouraging providers to collaborate. Competition was seen as a useful 'tool' to have at their disposal. Incumbent NHS providers were less enthusiastic about competition as a method to improve services than new entrants. The complexities of interdependent services and differing methods of payment were cited as reasons to be wary of using competitive tendering without careful thought. But small and medium size independent providers faced significant barriers to market entry in terms of the costs of tendering and difficulties of slotting into existing NHS infrastructure such as IT systems.

Our study continues to collect data on what commissioning decisions are being made at local level, and whether the use of competition as a mechanism to improve services is increasing over time. We are investigating the extent to which planning and collaboration are also being used as mechanisms to undertake complex reconfiguration of services to move care out of hospital. We will also re-interview commissioners and provider managers in mid 2015 to find out if their respective understanding and views on the rules concerning competition have changed as the new system introduced by the HSCA 2012 beds down. We will report our findings in late 2015.

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Appendix 1. Timeline of policies, rules and regulatory decisions on competition and cooperation

**Table 1. Timeline of policy, regulation, guidance and key events pertaining to competition and cooperation in the NHS commissioning process, England, (March 2013 – June 2014)**

Item No.	Date	Year	Document title	Type	Summary of information pertaining to competition and cooperation in the NHS	Source
1	6 March	2013	Neurosurgery at the Royal Free and UCLH: advice on transfer of services	Decision / guidance	Monitor's advice to the Office of Fair Trading on moving neurosurgery services from the Royal Free to University College London Hospitals. The report gives Monitor's view on whether the transfer would result in benefits to patients. Monitor concluded that "it is therefore not appropriate to treat the potential benefits submitted by the parties as relevant customer benefits for the purposes of the Office of Fair Trading's assessment under the Enterprise Act 2002."	Monitor
2	22 March	2013	Reviewing mergers involving NHS trusts and NHS foundation trusts	Guidance	Monitor published guidance setting out the roles of Monitor, the Office of Fair Trading and the Competition Commission in reviewing mergers (or proposed mergers) between: <ul style="list-style-type: none"> <li>• 2 or more NHS foundation trusts</li> <li>• an NHS foundation trust and an NHS trust</li> <li>• 2 or more NHS trusts</li> </ul>	Monitor
3	27 March	2013	Guidance on Monitor's approach to market investigations in the healthcare sector in England	Draft guidance / consultation	Monitor announced a consultation of guidance on Monitor's approach to market investigations in the healthcare sector in England	Monitor
4	27 March	2013	Draft Guidance for providers of NHS-funded services: choice and competition licence	Draft guidance / consultation	Monitor announced a consultation of the draft guidance on choice and competition licence conditions for providers	Monitor

			conditions			
5	27 March	2013	Guidance on application of the Competition Act 1998 in the healthcare sector	Draft guidance / consultation	Monitor announced a consultation of the guidance on the Application of the Competition Act 1998 in the healthcare sector	Monitor
6	27 March	2013	Merger benefits for NHS foundation trusts: Monitor's draft guidance	Draft guidance / consultation	Monitor announced a consultation of the Monitor's guidance regarding merger benefits for NHS foundation trusts	Monitor
7	1 April	2013	Health and Social Care Act 2012	Act of Parliament	Health and Social Care Act comes into force. It includes Section 75 clause which among other things may impose a requirement for the commissioners to use competitive tendering when procuring services and adhere to best practice in procurement	<a href="http://www.legislation.gov.uk">www.legislation.gov.uk</a>
8	1 April	2013	The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013	Statutory Instrument	Regulations in exercise of the powers conferred by sections 75, 76, 77 and 304(9) and (10) of the Health and Social Care Act 2012 come into force	2013 No. 500
9	20 May	2013	Substantive guidance on the Procurement, Patient Choice and Competition Regulations	Draft guidance / consultation document	Monitor issues a consultation document paving the way for guidance to clarify how the rules contained in the on competition in the NHS apply in practice	Monitor
10	20 May	2013	Hypothetical case scenarios – Procurement, Patient Choice and Competition	Draft guidance / consultation document	Monitor publishes six hypothetical case scenarios considering how the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 might apply in these cases	Monitor

			Regulations			
11	3 June	2013	Briefing note on the application of merger control rules to pathology service reconfigurations	Guidance	Monitor publishes guidance on circumstances in which pathology services reconfiguration can be viewed as a merger and therefore subject to review by OFT or Monitor.	Monitor
12	11 July	2013	The Royal Bournemouth And Christchurch Hospitals NHS Foundation Trust/ Poole Hospital NHS Foundation Trust Merger Inquiry Provisional findings report	Report	Provisional findings into the proposed merger published by the Competition Commission stating that “the proposed merger, if carried into effect, would result in the creation of a relevant merger situation because it would result in the parties ceasing to be distinct pursuant to section 79(1) of the Health and Social Care Act 2012 (HSCA 2012) and because the turnover of each of RBCH and PH exceeded £70 million in the UK and the turnover test was therefore met.”	Competition Commission
13	13 August	2013	Case: Proposed merger of Royal Free and Barnet and Chase Farm Hospitals	Decision/guidance	Monitor published a review approving a proposed merger between Royal Free London NHS Foundation Trust and Barnet and Chase Farm Hospitals NHS Trust. “The report concludes that the merger would be unlikely to result in significant costs to patients or taxpayers as a result of a loss of choice or competition.”	Monitor
14	20 September	2013	Case: Proposed merger of University Hospitals Bristol and North Bristol NHS Trust	Decision / guidance	Monitor published its decision to reject the proposal of merger between University Hospitals Bristol and North Bristol NHS Trust. “The report concludes that the proposals would reduce patient choice and competition and affect a substantial number of patients in the Bristol area on a long term basis. It states that the benefits of the merger would not outweigh these costs.”	Monitor
15	10 October	2013	Case: Investigation into the commissioning of elective services in	Formal investigation	Monitor opens first investigation into commissioning elective services in Blackpool area following provider’s complaint that patients are being directed to other hospitals. “In particular, the complaint alleges that the two CCGs have sought to direct patients requiring elective care away from	Monitor

			Blackpool		Spire Fylde Coast Hospital (Spire FCH) and towards Blackpool Victoria Hospital (BVH)."	
16	11 October	2013	Monitor to probe CCGs' block contract	Press article	Monitor to investigate first two CCGs (Blackpool CCG and Fylde and Wyre CCG) over a breach of competition rules following allegations by Spire Healthcare Limited that CCGs are directing patients away from Spire Fylde Coast Hospital after entering into block contract with another hospital (Blackpool Teaching Hospitals Foundation Trust)	HSJ
17	17 October	2013	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust A report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust	Report	Competition Commission rejects a proposed merger between The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust on the grounds that it reduces competition in the market	Competition Commission
18	17 October	2013	Ensuring that patients' interests are at the heart of assessing public hospital mergers. Joint statement from the Office of Fair Trading, the Competition Commission and Monitor	Statement/ Guidance	Statement outlining the joint working between OFT, CC and Monitor in reviewing hospital mergers, in particular aiming to reduce the number of mergers proceeding to formal review stage (by involving Monitor at the early stages of merger proposal) and to reduce the length of review process itself.	Office of Fair Trading, the Competition Commission and Monitor

19	17 October	2013	Competition watchdog sees sharp rise in inquiries from CCGs	Press article	Monitor deluged by inquiries from CCGs unsure whether they need to tender services on open market. Monitor to publish guidance containing a series of scenarios to help commissioners decide whether rules apply or not.	<i>BMJ</i> 2013;347:f6137
20	22 October	2013	Monitor asked to consider hostility to new GP providers	Press article	Monitor held a "call for evidence" about the commissioning and provision of general practice. Monitor to publish the outcome of this exercise by the end of the year. In response some private providers complaining about GPs crowding out private providers from the market and general hostility.	HSJ
21	24 October	2013	Analysis: Merging trusts caught in 'catch-22'	Press article	Monitor has moved to address concerns that competition rules are thwarting much needed service reconfiguration. It follows warnings that clashing regulations are leaving trusts trying to merge in a "catch-22" situation.	HSJ
22	30 October	2013	Update on Monitor investigation into cancer services in Greater Manchester	Press release	Monitor's investigation into the commissioning of specialised cancer surgery services in Greater Manchester is to focus on whether NHS England and local providers broke NHS rules, which came into force on 1 April 2013	Monitor
23	8 November	2013	OFT clears London pathology services merger	Press article	The Office of Fair Trading has given merger control clearance for a pathology services joint venture between two London foundation trusts (UCLH and Royal Free London) and a private sector provider (The Doctors Laboratory)	HSJ
24	11 November	2013	Monitor suggests changing primary care payment	Press article	Monitor published the preliminary findings of its review of closures of primary care walk in centres. It followed concerns being expressed by independent providers which have been running the centres. The preliminary review suggests changing primary care payment mechanisms to increase competition between walk-in centres and GP surgeries. Also it remains to be decided who will have the responsibility for commissioning walk-in primary services (NHS England or CCGs)	HSJ
25	11 November	2013	Walk-in centre review: preliminary report	Report	Preliminary findings: In some cases, walk-in centre closures may adversely affect patients' access to primary care. The division of commissioning responsibilities for walk-in centres is causing	Monitor

					<p>confusion and could lead to decisions that do not take a system-wide view of the potential impact of changes to walk-in centre provision</p> <p>Walk-in centres would work better for patients if payment mechanisms were reformed</p> <p>Final report to be published in January 2014</p>	
26	14 November	2013	CCGs told to work together as 'too small' for major change	Press report	<p>A letter sent by NHS England and other national bodies is asking CCGs, local authorities and providers to draw up detailed plans for 2014-16, and high-level strategic plans covering five years.</p> <p>The five-year plans are expected to be a platform for major service change. The letter says of them: "As CCG sizes and local configurations differ, a larger unit of planning is required for the development of consistent and integrated long-term strategic plans." It adds: "CCGs will contribute to a larger footprint where one CCG is too small."</p> <p>The strategic plans should include quantifiable targets against seven quality indicators such as life years lost from treatable conditions, time spent avoidably in hospital, avoidable deaths in hospital and patient experience of inpatient and primary care.</p>	HSJ
27	21 November	2013	Providers looking to challenge CCG decisions in blow to integration agenda	Press article	<p>Reports of smaller providers looking to challenge CCGs' tendering decisions (especially relating to service integration and consortia forming) on the grounds of breaching competition regulations</p>	Pulse
28	25 November	2013	OFT chief rejects need for law change on NHS merger controls	Press article	<p>Clive Maxwell, CEO of OFT rejected the suggestion by NHS England chief executive Sir David Nicholson that the law needs to be amended to prevent the new system of competition regulation from obstructing improvement to NHS services. In his opinion early engagement of would be merger parties with Monitor and OFT – key to making sure the existing system works effectively</p>	HSJ
29	2 December	2013	Practices 'could miss out on enhanced services' as CCGs begin putting them	Press article	<p>CCG in Essex plans to put out LES to AQP tender in order to avoid any potential legal challenges and accusations of conflict of interest</p>	Pulse

			out to AQP			
30	4 December	2013	A healthy market? Lack of transparency raises doubts about NHS commissioning	Feature article	<p>“At least £6bn worth of work is out to tender in England’s NHS. But in the “arms race” between commercial providers vying for NHS contracts, there is much secrecy around how these contracts are awarded and how they’re really performing, reports Jane Deith”</p> <p>Article comments on secrecy surrounding Cambridgeshire’s £800m tender for older people’s services. Other tendering where private providers won by outbidding NHS providers on price (e.g. Suffolk/Serco). Reports on Monitor investigating NHS England area teams specialist tendering or lack thereof following complaints from providers</p> <p>“Some, including private providers, are beginning to doubt whether competitive tendering is really transparent and whether the winners are ever really accountable”</p>	BMJ
31	5 December	2013	Trust super-merger shelved	Press article	A merger that would have created the largest provider organisation in England has been shelved. King’s College Hospital, Guy’s and St Thomas’ and South London and Maudsley foundation trusts along with the university King’s College London decided to halt the process citing doubts that such a merger would have been approved by the regulators	HSJ
32	6 December	2013	Exclusive: Health Act to be changed to boost joint commissioning	Press article	The Department of Health is proposing to change the Health Act 2012 to allow CCGs to delegate decisions to joint committees featuring two or more of them, or with NHS England. It would make it easier to make decisions spanning specialised and primary services – which are the responsibility of NHS England – and community and general hospital care, which is funded by CCGs. “The DH is proposing to use a legislative reform order, a mechanism which can change the law without a new bill, to “reduce burdens” resulting from legislation”.	HSJ
33	13 December	2013	Controversial Serco GP contract cut short	Press article	Serco contract for GP OOH in Cornwall will terminate in May 2015 as CCG moves to new model of OOH care. Issues with falsifying records and understaffing	HSJ

34	13 December	2013	Leading foundation trusts explore moves into primary care	Press article	University Hospitals Birmingham and Newcastle Upon Tyne Hospitals foundation trusts plan to take over primary care providers in their cities and establish vertically integrated provider organisations; The Newcastle foundation trust already runs a minority of primary care services in the city, through Freeman Clinics – a joint venture with local GPs set up in 2008 and is a community provider. It wants to move into provision of GP OOH care as well. These aspirations raise concerns of existing community provider (Birmingham)	HSJ
35	13 December	2013	Julie Moore: leading trusts could run hospital chains	Press article	“Dame Julie Moore (CEO of University Hospitals Birmingham) told <i>HSJ</i> she wanted to see top providers running chains of hospitals, arguing the district general hospital could be “redefined” as an outpost of a larger trust”. Analogy with Tesco superstore and Tesco metro.	HSJ
36	13 December	2013	Public turns against NHS use of private providers	Press article	“The public is turning against the NHS’s use of private providers to deliver care, even when the care remains free at the point of delivery, a recent poll has found. Ipsos Mori asked 1,009 people if they agreed with the statement: ‘As long as health services are free of charge, it doesn’t matter to me whether they are provided by the NHS or a private company.’ It found that 47% of people disagreed with this statement, an increase of 11 percentage points on the number of people who disagreed when asked in February 2011. However, it also found that people are less likely to be against external providers who are charity or voluntary organisations.”	Pulse
37	17 December	2013	NHS procurement standards updated	Press release	“NHS England has beefed up procurement guidance with new documents covering peer review and the evidence used to support procurement processes. The evidence tool provides suggests what evidence should be reviewed to meet procurement standards. The associated peer review guidance provides NHS organisations with an objective review process.”	NHS Networks website <a href="https://www.gov.uk/government/publications/nhs-procurement-">https://www.gov.uk/government/publications/nhs-procurement-</a>

						<a href="#">standards</a>
38	18 December	2013	Science centres to be 'hubs' of specialised services	Press article	NHS England plans to concentrate provision of specialised services into 15 to 30 centres where "the highest quality can be delivered" from current level of over 300 organisations commissioned to provide such services. Academic health science centres should become the "hubs" of specialised services.	HSJ
39	19 December	2013	Procurement, patient choice and competition regulations: guidance	Statutory guidance	Monitor finalised and published the guidance on application of Procurement, Patient Choice and Competition Regulations 2013. It consists of Substantive Guidance on the Procurement, Patient Choice and Competition Regulations, Briefing Note, Enforcement Guidance, Hypothetical Case Scenarios and Consultation Response	Monitor
40	19 December	2013	Competition rules still impeding service change, say hospital bosses	Press article	According to HSJ/Capstick survey "Hospital chief executives still feel the competition and merger control rules introduced under the government's NHS reforms are making it difficult to carry out important reconfigurations. Asked to rate out of 10 how obstructive the current regulations were to service change, with one being no impediment and 10 indicating impossibility, the average across chief executives was 6.8."	HSJ
41	19 December	2013	Primary care commissioning is 'a mess' admits NHS England director	Press article	Proposal by NHS England that CCG should commission primary care (in particular OOH care) jointly with NHSE area teams, as the latter are too removed from the local situation to be effective commissioners. Yet BMA voices concerns over conflict of interest this will create and that GPs will have to performance manage own contracts.	Pulse
42	23 December	2013	CCG tells local GPs to federate or face loss of enhanced services contracts	Press article	GPs in Newham were told that "they have to federate or face the removal of local enhanced services worth up to 15% of their practice income". This is in order to achieve economies of scale to be able to win the contracts for services. "Under the new competition regulations, CCGs will need to procure LESs from April, unless they can prove that the services can only be provided by a single provider."	Pulse
43	3 January	2014	Local enhanced services worth millions	Press article	Some CCGs and local authorities are planning to put local enhanced services out to tender from April 2014 using AQP or full tender route. "Pulse	Pulse

			to be opened up to competition from April		approached every CCG in England asking them how they plan to recommission existing local enhanced services (LESs) from April. Some 48 CCGs replied, with 23 having made a decision so far. Of these, nine said they plan to put some or all of their LESs out to tender – with the contracts collectively worth just over £2m.”	
44	4 January	2014	Bournemouth and Poole agree not to merge for a decade	Press article	Royal Bournemouth and Christchurch Hospitals and Poole Hospital FTs “whose planned merger was blocked last year have signed an undertaking not to attempt to merge again for the next 10 years”.	HSJ
45	6 January	2014	Monitor to protect essential services by licensing independent providers	Press release	<p>“Monitor will regulate independent providers of NHS-funded services for the first time through the expansion of its provider licence regime. (...)</p> <p>Independent providers of NHS-funded services, including charities and hospices, need to check if they need a licence and, if required, hold one from April 1, 2014. The licence requires the provider to be led by fit and proper persons and registered with the Care Quality Commission. From April 2014, independent providers needing a licence and registration with the Care Quality Commission can get both through a joint process.” This is in order to protect essential services in cases of provider failure</p>	Monitor
46	7 January	2014	Circle mulls bid to partner Peterborough with Hinchingbrooke	Press article	“Private provider Circle could table a rescue bid for debt-stricken Peterborough and Stamford Hospitals Foundation Trust involving partnering it with nearby Hinchingbrooke Health Care Trust”	HSJ
47	7 January	2014	Monitor kicks off independent provider licencing process	Press article	“From April 2014 all independent providers with a turnover from NHS-funded care exceeding £10m or delivering services deemed “essential” by commissioners will need a licence to operate.”	HSJ
48	10 January	2014	Legal challenge issued after out-of-hours firm	Press article	“Northern Doctors Urgent Care has issued a challenge to the process followed by clinical commissioning groups in selecting out-of-hours providers	HSJ

			loses bids		in the North of Tyne area. (...) The grounds for Northern Doctors Urgent Care’s legal challenge are unknown.” Northern Doctors Urgent Care has lost provider status in two out of three areas where it previously provided OOH. It was the recommended bidder for the North Tyneside, but North East Ambulance Service Foundation Trust was the recommended bidder for Northumberland while a joint bid from Gateshead Community-based Care Limited and Newcastle upon Tyne Hospitals Foundation Trust was recommended for Newcastle. This move may be part of a vision by Newcastle FT CEO to deliver “primary, secondary, community specialist and super-specialist [care] under one umbrella.”	
49	10 January	2014	Northamptonshire Healthcare drops out of £800m contract race	Press article	Northamptonshire Healthcare Foundation Trust withdrew from bidding for older people services contract in Cambridgeshire. Other bidders to have dropped out of the Cambridgeshire process include Serco, and a consortium between Cambridgeshire Community Services Trust, outsourcer Capita and private health firm Circle. The five remaining bidders are: Accord Health (Interserve with Provide, formerly Central Essex Community Services, and North Essex Partnership Foundation Trust as Mental Health Lead) Care for Life (Care UK with Lincolnshire Community Health Services Trust, and Norfolk Community Health & Care NHS Trust) Optum (formerly United Health UK) with Cambridgeshire Community Services Trust Uniting Care Partnership (Cambridgeshire and Peterborough Foundation Trust with Cambridge University Hospitals Foundation Trust) Virgin Care Ltd.	HSJ
50	13 January	2014	Private firm withdraws George Eliot bid	Press article	Ramsey Healthcare has withdrawn their bid to run George Eliot Hospital Trust. “Ramsey’s withdrawal leaves four bidders: South Warwickshire Foundation Trust, University Hospitals Coventry and Warwickshire Trust, Care UK and Circle Partnership.”	HSJ

51	16 January	2014	Private hospital groups forced to sell sites	Press article	<p>“Two private hospital operators (HCA and BMI Healthcare) have been told by the Competition Commission that they must sell off nine hospitals between them in order to improve competition in the private healthcare market.(...) Further proposals announced by the commission yesterday include a ban on private hospitals using incentive schemes to encourage consultants to refer patients to their facilities.”</p>	HSJ
52	20 January	2014	CCG backs down in patient involvement procurement row	Press article	<p>“A law firm acting for campaign group Stop the NHS Sell Off in Cambridgeshire accused Cambridgeshire and Peterborough CCG of acting unlawfully by failing to allow opportunities for meaningful public engagement in the tender of a multi-million pound contract for older people’s services.” Following a threat of legal action the CCG agreed to publish some tendering documents. Commissioners are put in a difficult situation having to both protect commercial confidentiality and satisfy legal obligations of public engagement during tendering.</p>	HSJ
53	21 January	2014	Legal challenge issued over £16m service tender	Press article	<p>Bexley CCG is facing a legal challenge over the procurement of £16.6m in services using the innovative prime contractor model. The award of the contract for the borough’s musculoskeletal work had been halted following a legal challenge from Lewisham and Greenwich Trust, which runs services in neighbouring boroughs.</p> <p>“The challenge came after the CCG overrode the recommendation of the trust special administrator appointed to oversee the break-up of South London Healthcare Trust that Dartford and Gravesham Trust should run high-volume elective services at Queen Mary’s Hospital in Bexley until April 2015. Instead, the CCG issued a tender for musculoskeletal work due to begin last month.</p> <p>The CCG awarded “preferred bidder” status to King’s College Hospital Foundation Trust in November. Lewisham and Greenwich Trust were the sub-contractor in Dartford and Gravesham Trust’s subsequent bid.”</p>	HSJ
54	23 January	2014	Bennett sets out new approach for merger and failure	Press article	<p>“David Bennett revealed details of how Monitor plans to act as a “translator” between the NHS and competition authorities when plans were devised for trusts or individual services to merge.” “without falling foul of the</p>	HSJ

					competition authorities.” Monitor blamed “differences in “language”” for the rejection of merger between Royal Bournemouth and Christchurch Hospitals and Poole Hospital foundation trusts by CC. He said Monitor would support trusts to build a “robust” case for merger by engaging with trusts informally when they first considered a merger and again, more formally, once a trust had identified its preferred form.	
55	23 January	2014	Monitor watching CCG procurement decisions 'closely'	Press article	“Monitor is closely observing the decisions clinical commissioning groups are making about transforming community services contracts”. Monitor’s CEO expressed concerns that proper procedures may not be followed to ascertain whether services require retendering or not and that CCGs opt to automatically roll on the existing contracts.	HSJ
56	24 January	2014	Ricketts: CSU privatisation 'doesn't fit with NHS values'	Press article	“Commissioning support units will not be sold off when they are made independent, in part due to a lack of support for full scale privatisation from clinical commissioning groups, NHS England has confirmed.”	HSJ
57	24 January	2014	CCGs tell Serco to improve service	Press article	“Commissioners have insisted community services in Suffolk run by Serco are “safe”, a week after a council said they could be deteriorating. Ipswich and East Suffolk CCG and West Suffolk CCG said that after completing a four-month probe they had found “no evidence of harm to patients” but they told the private provider to improve in a raft of areas.”	HSJ
58	24 January	2014	Arrangements to support NHS foundation trusts contemplating mergers	Letter	CEO of Monitor sent a letter to NHS trusts contemplating mergers outlining how Monitor can help in “Making sure any merger is based on a sound analysis of the clinical and other sources of patient benefit that should accrue from the merger, and that there are robust plans in place to make sure those benefits are realised in practice.” And “Ensuring that any statutory review of a proposed merger can take place swiftly and without excessive cost”.	Monitor
59	28 January	2014	Oxfordshire CCG compromises on		Oxfordshire CCG will accept a set of concessions, which reflect the DH’s recommendations and demands made late last year by Oxford Health	HSJ

			controversial contracting plan		Foundation Trust and Oxford University Hospitals Trust to scrap plans to introduce “outcomes based contracting” for maternity services – one of three service areas it was planning to radically redesign. DH’s review “proposed that the CCG collaborates with existing providers, and only revert to going to tender if this proves unsuccessful”.	
60	29 January	2014	Integrated care pioneer voted out by GPs	Press article	Dr Stephen Richards, CEO of Oxfordshire CCG and a driving force behind attempt to introduce outcome based commissioning has been voted out of the post by GPs. The plans to go to tendering to find lead provider for adult mental health, maternity and older people’s services were halted when DH backed two local trusts’ complaints and recommended more collaborative approach.	HSJ
61	31 January	2014	CCG considers seven-year community services contract	Press article	Bath and North East Somerset CCG “plans to re-commission its community health and social care services on an unprecedentedly long contract of up to seven years”. The annual value of the future contract is estimated to be £45m. “The CCG and council will share equally the funding of the procurement process, which is expected to cost £100,000 over a two year period.	HSJ
62	31 January	2014	Case: Investigation into the commissioning of cancer services in Manchester	Formal investigation	Monitor closed an investigation into commissioning of cancer surgery services in Greater Manchester by NHS England (formerly NHS Greater Manchester) following complaints by University Hospital of South Manchester NHS Foundation Trust and Stockport NHS Foundation Trust. The investigation was launched in August 2013. The investigation was closed as NHS England decided to change the commissioning process in this case. Closing investigation meant that Monitor did not make any specific findings in this case.	Monitor
63	31 January	2014	Monitor competition probe closed after NHS England changes process	Press article	Monitor has closed its investigation into the commissioning of specialist cancer surgery services in Greater Manchester and Cheshire after NHS England halted the commissioning process. Original investigation has been instigated following concerns from two hospitals (University Hospital of South Manchester Foundation Trust and Stockport Foundation Trust) about NHSE	HSJ

					commissioning process. NHSE confirmed that it is developing new service specification and process. "In late 2012, providers in the region came together to form the "Greater Manchester Services Provider Board" to oversee a reconfiguration of cancer surgery services onto a smaller number of sites. South Manchester and Stockport believed the board's process had not been fair. (...) NHS England has now told Monitor it would become "solely responsible for all decisions taken in relation to the Greater Manchester commissioning process", and that the provider board would be "retained in a consultative capacity only", according to the regulator's statement. (...) A competitive tender to procure urological and upper gastrointestinal cancer surgery services will start next month. A contract for liver, pancreas and gall bladder cancer surgery services will be awarded to Central Manchester University Hospitals Foundation Trust."	
64	5 February	2014	Serco pledges commitment to direct care role	Press article	Serco confirmed its commitment to providing community care services after signing a deal with social enterprise Bromley Healthcare to advise it on its troubled Suffolk contract. "Serco won a £140m three-year contract to run Suffolk Community Healthcare in 2012, although its work has been beset with performance problems".	HSJ
65	5 February	2014	Fifth of GPs intend to work with other practices to win enhanced services contracts	Press article	Pulse survey reveals that 22% of GPs are planning to form alliances with other practices to bid for enhanced service contracts.	Pulse
66	20 February	2014	Local authority keeps all public health LESSs with local GPs	Press article	Brent decided to allow GPs to retain all public health enhanced services without them being put out to full tender or be subject to AQP. "LMCs lobby other councils to follow suit".	Pulse
67	21 February	2014	New strategy for south west London reconfiguration	Press article	Six CCGs (Croydon, Kingston, Merton, Richmond, Wandsworth and Sutton) in South West London "have formally dismantled their Better Services Better Value programme designed to reconfigure acute services. However, they admit service change is still required.	HSJ

					<p>Surrey Downs CCG pulled out of the programme in November when its GPs voted against plans that could have led to a reduction in services at Epsom Hospital and St Helier Hospital. (...) While the BSBV programme solely focused on acute reconfiguration the revised strategy will more closely involve primary care providers, mental health trusts, community services and health and wellbeing boards".</p> <p>A five year strategy is due to be published in June.</p>	
68	26 February	2014	Case closure decision on the commissioning of radiosurgery services Case CCD 01/13	Formal investigation	<p>In June 2013 Monitor opened investigation into commissioning "of radiosurgery services after receiving a complaint from Thornbury Radiosurgery Centre Limited (Thornbury), a provider of gamma knife radiosurgery services (gamma knife services). The complaint related to the conduct and procurement practices of the North of England Specialised Commissioning Group and of its successor from 1 April 2013, NHS England. The conduct and procurement practices that Thornbury complained of took place either side of a change in the relevant rules. Matters occurring before 1 April 2013 were subject to the Principles and Rules for Co-operation and Competition, while those occurring since 1 April 2013 are subject to the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (the Regulations). We decided to focus our investigation on NHS England's compliance with the Regulations rather than the conduct of its predecessors before 1 April 2013. (...) Since we opened our investigation, NHS England has confirmed that it has now entered into a contract with Thornbury. (...) Closing our investigation prior to a final decision being taken means that we have not made findings in relation to the matters under investigation."</p>	Monitor
69	5 March	2014	NHS England accuses Monitor of "unpicking" choice and competition framework	Press article	<p>NHS England and Monitor disagree over the principles of choice and competition in the NHS resulting in delays in publishing a common "choice and competition framework" which is meant to help commissioners decide how and when to use these policy levers to improve patient outcomes. NHSE board papers reveal that Monitor sees their own guidance as "the key resource for commissioners to understand choice and competition in the NHS."</p>	HSJ

70	6 March	2014	Analysis: Increase in procurement and competition challenges	<p>“Providers are increasingly willing to use the procurement, patient choice and competition regulations to challenge decisions” as they become more familiar with the regulations introduced in April 2013. Monitor “had received 166 enquiries about the choice and competition rules “from a wide range of different organisations” since last April. Only 3 have proceed to become formal cases.</p> <p>Some providers claim that as there is “only a 30 day window to lodge legal claims, and Monitor would not complete an investigation within that timeframe, legal challenges were the best approach”.</p> <p>“Procurement and competition challenges since April 2013:          Spire Healthcare against Blackpool CCG and Fylde and Wyre CCG (to Monitor; ongoing). Spire claims commissioners are directing patients who require elective care away from Spire Fylde Coast Hospital towards Blackpool Victoria Hospital.          University Hospital of South Manchester Foundation Trust and Stockport Foundation Trust against NHS England (to Monitor; closed). The two trusts referred NHS England to Monitor over the commissioning of its specialist cancer services. Case was closed after NHS England said it would develop a new service specification.          Thornbury Radiosurgery Centre against NHS England (to Monitor; closed). Complaint against NHS England for not commissioning gamma knife radiosurgery services from the provider. Case was closed after NHS England entered into a contract with Thornbury.          Northern Doctors Urgent Care against Newcastle North and East, Newcastle West, North Tyneside and Northumberland CCGs (legal route; ongoing). CCGs split the out-of-hours provision into three parts. Northern Doctors Urgent Care was the preferred bidder for North Tyneside but not the other two areas.          King’s College Hospital Foundation Trust against Dartford, Gravesham and Swanley CCG (legal route; ongoing). Dartford, Gravesham and Swanley CCG agreed that Moorfields Eye Hospital Foundation Trust could set up a clinic at Dartford and Gravesham Trust’s Darent Valley Hospital. King’s complained that a tendering process should have been held to provide ophthalmology services.</p>	HSJ
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					Lewisham and Greenwich Trust against Bexley CCG (legal route; ongoing). Lewisham and Greenwich issued legal challenge after the CCG issued a contract for musculoskeletal work in the borough, overriding the South London Healthcare Trust's trust special administrator's recommendation".	
71	7 March	2014	Community trust out of running for £800m integrated care contract	Press article	<p>"Cambridgeshire Community Services Trust's bid for a £800m older people's services contract for Cambridgeshire and Peterborough has been rejected, while implementation of the project has been delayed by six months. The trust, which is the main current provider of the services affected by the tender, had jointly bid for the contract with Optum, formerly UnitedHealth UK. (...) The four bidders which have made it to the final stage are: Accord Health (Interserve with Provide, formerly Central Essex Community Services, and North Essex Partnership Foundation Trust as mental health lead)</p> <p>Care for Life (Care UK with Lincolnshire Community Health Services Trust, and Norfolk Community Health &amp; Care Trust)</p> <p>Uniting Care Partnership (Cambridgeshire and Peterborough Foundation Trust with Cambridge University Hospitals Foundation Trust)</p> <p>Virgin Care Ltd</p> <p>They are now expected to develop and refine the proposals they submitted in January. The preferred bidder will be selected in September, with the contract beginning in January 2015. It had previously been due to start in July this year".</p>	HSJ
72	11 March	2014	Integration 'pioneers' issue tender for 10 year contracts	Press article	<p>"Commissioners in Staffordshire are inviting providers to bid for two ten-year contracts for integrated services worth a total of £1.2bn. Four clinical commissioning groups last week issued a pre-qualification questionnaire for a single provider for end of life care and cancer care services. (...) The tender process is being run by Strategic Projects Team, which is currently hosted by Greater East Midlands Commissioning Support Unit". The entire care pathway for cancer will be tendered at a value of £687m over 10 years under the 'prime provider' model. End of life care contract is for part of pathway at a value of £535m.</p>	HSJ

73	11 March	2014	Competition rules may need to be applied differently to healthcare, says Hunt	Press article	“England’s health secretary has urged competition authorities to go easy on the NHS after the costly, failed merger of two trusts in the south of England last year. Speaking on 6 March to an audience of health service leaders, Jeremy Hunt admitted that the new competition regime introduced by the Health and Social Care Act last year had not been “smooth sailing.” He suggested that the competition authorities may have been overinterpreting their role in such hospital mergers as the one that fell foul of the authorities in Dorset last year”.	BMJ
74	12 March	2014	Brighton and Sussex and Surrey and Sussex pathology services: advice on proposed merger	Decision / guidance	Monitor published the results of its review into proposed merger between Brighton and Sussex and Surrey and Sussex pathology services approving the merger. “Monitor completed this review to advise the NHS Trust Development Authority on how the merger could affect choice or competition. It concludes the merger is not likely to have a negative effect on patients and taxpayers as a result of a loss of choice or competition.”	Monitor
75	14 March	2014	CCG wins legal battle over contract suspension	Press article	Lewisham and Greenwich Trust and Dartford and Gravesham Trust were unsuccessful in their attempts to challenge a procurement exercise run by Bexley CCG which awarded £16m in musculoskeletal work to King’s College Hospital Foundation Trust. They had previously been awarded these services in the special administration process which dissolved South London Healthcare Trust in October 2013. Yet Bexley CCG put the services to tender and awarded them to KCH FT. All parties agreed to discontinue the “legal challenge.	HSJ
76	19 March	2014	Richmond CCG pioneers outcomes-based commissioning of community health services	Press article	Richmond CCG governing body agreed to re-commission its community health and social care services on the basis of outcomes. “The CCG says such contracts transfer appropriate risk to providers and create the circumstances and incentives that allow them to innovate and profit from success, provided they can manage costs and deliver the outcomes commissioners want. To deliver those outcomes and make the efficiency savings necessary to stay within the allocated budget, providers must collaborate, problem solve and deliver efficient, integrated services.”	Inside Commissioning

77	21 March	2014	Cornwall integration pioneer planning county wide roll out	Press article	<p>“A partnership between the NHS and voluntary sector which is credited with reducing emergency admissions by nearly a third is set to be rolled out across Cornwall over the next 18 months.</p> <p>The Newquay Pathfinder, which was central to Cornwall’s successful bid to be a Department of Health integration pioneer, also led to a reduction in social care costs of almost 6 per cent.</p> <p>Under the pathfinder the 100 Newquay residents most at risk of hospital admission and with at least two long term conditions received targeted support aimed at improving their overall wellbeing.”</p>	HSJ
78	27 March	2014	GP commissioners given green light to sidestep competition process for well-performing services	Press article	<p>“GPs have been given a boost in their bid to hold on to enhanced service income after the healthcare regulator told CCGs they can avoid putting services out to competitive tender if providers are already meeting the needs of patients.</p> <p>Speaking at the Commissioning Live conference yesterday, David Furness, a competition adviser at Monitor, said CCGs should continue services that are ‘working well’ without putting them out to a full tender process or via the ‘Any Qualified Provider’ route.”</p>	HSJ
79	27 March	2014	Competition to run district general hospital is abandoned	Press article	<p>“A tender process for the running of George Eliot Hospital Trust has been abandoned, it was announced today.</p> <p>The three remaining bidders in the process, run by the NHS Trust Development Authority, were South Warwickshire Foundation Trust, which wanted to take the trust over, and Circle and Care UK, which had both submitted bids to run it as a franchise. (...)</p> <p>George Eliot chief executive Kevin McGee, speaking to HSJ about the decision to scrap the process today, said it was due to recent improvements in clinical performance, particularly in its emergency department and avoidable harm. However, he also indicated that an ongoing national review of how hospital “chains” could be established in the NHS was a factor.”</p> <p>“The tender process began when the George Eliot board decided it could not reach foundation trust status on its own. Mr McGee today said he did not know whether it could gain foundation status, and that its focus was on improving clinical quality and finances.” The tender was stopped not as a result of quality of bids received.</p>	HSJ

80	27 March	2014	Bristol CCG plans £250m community services tender	Press article	“Bristol Clinical Commissioning Group has approved plans to tender the city’s community health services and said it anticipates “significant” interest in the contract from providers across the country. The services are currently provided by Bristol Community Health, a social enterprise created from the former provider arm of Bristol Primary Care Trust in 2011. Last year the CCG voted to extend the social enterprise’s three year contract by two years to September 2016. However, a paper to the CCG’s 25 March governing body meeting warned it could not be extended further without risk of legal challenge. It said there was an “expectation in the market” the contract, worth £37m a year, would be tendered when it came to an end.”	HSJ
81	28 March	2014	Major pathology reorganisation to go ahead after OFT all clear	Press article	“The NHS’s biggest pathology reorganisation will take place in May, after the Office of Fair Trading ruled it would not be investigating the plan further. The competition watchdog announced this week that the consolidation, which involves six trusts and will be hosted by Cambridge University Hospitals Foundation Trust, does not “qualify” for OFT scrutiny. The plan is a collaboration involving six trusts. Cambridge University Hospitals and Ipswich Hospital Trust will be hubs carrying out most pathology work for the area. East and North Hertfordshire and Hinchingsbrooke Health Care trusts, and Colchester Hospital University and West Suffolk foundation trusts will retain host satellite laboratories which will carry out only urgent work.”	HSJ
82	31 March	2014	Nicholson: Competition “confusion” holds back change	Press article	The outgoing head of NHSE in the final speech expressed his regret that “he did not manage to make clear how competition can be used to improve the NHS.” “He said: “The confusion around competition, and the current way it’s being dealt with is holding back the NHS from making the changes that are needed. “It’s becoming a disincentive to making ambitious change. I wish I’d got that sorted earlier – I just haven’t had a chance to do it.””	The Commissioning Review
83	March	2014	The Legislative Reform (Clinical Commissioning Groups) Order 2014	Draft Statutory Instrument	The purpose of the order is to enable joint commissioning and co-commissioning between different CCGs and CCGs and NHS England. The order comes into force on 1 <sup>st</sup> of October 2014.	Legislation.gov.uk

84	March	2014	Explanatory Document to accompany draft Legislative Reform Order 2014. Amending the National Health Service Act 2006	Guidance	<p>“The purpose of the draft Order is to amend the National Health Service Act 2006 (“the NHS Act”).”</p> <p>“The Department wishes to remove this burden by amending section 14Z3 of the NHS Act to provide that, where any two or more CCGs are exercising their functions jointly, they may do so by way of a joint committee.”</p> <p>“There is also an identified need for CCGs and NHS England to be able to jointly exercise a CCG commissioning function and to form a joint committee when doing so.”</p>	Department of Health
85	1 April	2014	Exclusive: NHS trust under private management faces deficit again	Press article	<p>Hinchingbrooke Health Care Trust managed by Circle “is likely to record a year end deficit in the region of £600,000 to £700,000 for 2013-14. Such a figure would be a considerable improvement on the £3.5m deficit recorded by the trust in 2012-13, the first full financial year in which Hinchingbrooke was under Circle’s management.”</p> <p>“However, it would also mean the company will have injected more than £4m into Hinchingbrooke in two years, having originally pledged to bring the trust into the black in the first year of the management contract.</p> <p>Under the terms of the landmark 10 year franchise deal, Circle is responsible for balancing the trust’s books. The agreement stipulates that if Circle is forced to put more than £5m into Hinchingbrooke, either the trust or company can terminate the contract early.”</p>	HSJ
86	1 April	2014	Two CSUs advertise for long term commercial partner	Press article	<p>“Greater Manchester CSU and Cheshire and Merseyside CSU, which plan to merge later this year, have received 30 expressions of interest after placing an advertisement on the NHS Supply2Health website” looking for third party strategic partner. The exercise according to Leigh Griffin, managing director of Greater Manchester CSU “was not a tender or formal procurement”. They received submissions from “the private sector, charities and NHS organisations, ranging from niche providers to large scale consultancies.”</p>	HSJ
87	3 April	2014	Commissioner serves notice on East Sussex contract over quality	Press article	<p>“A Sussex Clinical Commissioning Group has voted to serve notice on its community services contract with East Sussex Healthcare Trust after flagging concerns with the current offering.</p>	HSJ

			concerns		<p>High Weald Lewes Havens CCG has served 12 months' notice on its £18m a year community services contract with the financially troubled provider." "The CCG is hoping the 12 month window will give them a chance to work with East Sussex to develop a long-term plan for improving the area's community services.</p> <p>However, the board report stated that successful service redesign of the may "include the need for procurement".</p>	
88	4 April	2014	Second proposed FT merger under competition scrutiny	Press article	<p>"The Competition and Markets Authority has begun a review of the proposed merger between Frimley Park Hospital Foundation Trust and its troubled neighbour Heatherwood and Wexham Park. (...) The planned merger is being sought as a means to assure the future of services at Heatherwood and Wexham Park, following long-running financial problems and repeated care failings."</p>	HSJ
89	4 April	2014	CCGs open services to competition out of fear of rules	Press article	<p>"More than a quarter of clinical commissioning leaders say they have opened NHS services up to competition – or are currently doing so – only because they fear they would fall foul of competition rules if they did not, an HSJ survey has found.</p> <p>And a fifth of respondents to <i>HSJ's</i> latest CCG Barometer, carried out with PwC, said their groups' decisions had been formally challenged under controversial NHS competition regulations."</p> <p>"Around 20 per cent of respondents said they had experienced formal challenges to commissioning decisions or arrangements under competition, patient choice and competition regulations, while 57 per cent said they had experienced informal challenge or questioning (see chart).</p> <p>Some 65 per cent said they had experienced increased commissioning costs as a result of the regulations, while 46 per cent said they had not been able to change services in the way their CCG would otherwise have wished to due to the regulations, or concerns about them.</p> <p>The survey found 36 per cent said their plans for the organisational future of their areas' providers – such as merging or becoming foundation trusts – had been hampered because of the regulations."</p>	HSJ

90	4 April	2014	CCG leaders: Reforms have not improved control of cost and activity	Press article	CCG Barometer survey conducted by HSJ/PwC found that “the ability of the NHS to control costs and curb hospital activity has not improved with the government’s reorganisation of the NHS”. , according to many leaders of the clinical commissioning groups created by the reforms.” It also found increase in commissioning costs as a result of competition regulations. Furthermore respondents complained about “fragmentation of commissioning” between CCGs, NHS England and local authorities” and “dysfunctional relationships and arrangements” between national oversight bodies and regulators.”	HSJ
91	4 April	2014	Commissioning of radiosurgery services: guidance following case closure Case CCD 01/13	Guidance	Monitor has published guidance to commissioners based on the learning from Case CCD 01/13. The guidance “covers the following areas: <input checked="" type="checkbox"/> prioritisation and commissioning <input checked="" type="checkbox"/> using evidence in decision-making <input checked="" type="checkbox"/> acting transparently <input checked="" type="checkbox"/> publishing details of all contracts awarded.”	Monitor
92	4 April	2014	CCG awards £2.3m worth of enhanced services to new GP federation	Press article	“NHS South Worcestershire CCG intends to continue all of the current local enhanced contracts, which have a total value of £2.3m, by contracting SW Healthcare Limited - the provider arm of the local GP federation, which is jointly owned and run by all 32 member practices of the CCG - as one ‘prime provider’ of all services. This is the first known instance of a CCG commissioning all its enhanced services out to a new GP-led provider organisation”.	Pulse
93	4 April	2014	Commissioning services through any qualified provider: an HSJ survey	Press article	HSJ launched an online survey on use of AQP	HSJ
94	7 April	2014	NHS England planning new choice and competition research	Press article	“NHS England is planning to conduct new research on choice and competition in the NHS, according to the organisation’s latest business plan. (...) A central goal of this work is for NHS England, in cooperation with Monitor and the Department of Health, to develop and implement a policy research programme focused on choice and competition by March 2015. (...) Paul	HSJ

					Baumann, chief financial officer of NHS England, and Barbara Hakin, chief operating officer and deputy chief executive, are the national directors responsible for the work stream.”	
95	7 April	2014	Preferred bidder named in Bristol mental health tender	Press article	<p>“A mental health trust which faced losing business worth £30m due to quality concerns has been named as the preferred bidder for the main lot in a highly contested tender for the services.</p> <p>Commissioners in Bristol decided to tender services provided by the £195m turnover Avon and Wiltshire Partnership Trust in November 2012, following repeated failed attempts to get the provider to improve service quality. The contract was split into five lots. The first and largest lot, for community mental health services, was worth about £17m a year.</p> <p>That lot also included a contract for a “system leader”, which would be responsible for co-ordinating provision between the five lots.”</p>	HSJ
96	8 April	2014	CCGs 'restricted' by competition rules	Press article	<p>“Dr Michael Dixon, chair of the NHS Alliance and president of NHS Clinical Commissioners believes clinicians are currently too restricted by an "over-prescriptive model" of how to bring continuity of care to patients. (...) "We must free clinical commissioning from rules, regulations, competition restrictions and conflict of interest issues so commissioners and their constituent practices can plan and implement “general practice at scale”. This will then allow them to take on the ‘out of hospitals services’ agenda that we have all been talking about for so long," he said.”</p>	The Commissioning Review
97	9 April	2014	Serco estimates £18m losses on health contracts	Press article	<p>“Serco has estimated it will rack up losses of nearly £18m on three flagship NHS contracts in the coming years”. “The company has made provisions in its 2013 accounts for substantial future losses on contracts in Suffolk, Cornwall and Braintree – two of which it is terminating early.” “Serco told HSJ last May that it expected to make a profit on its £140m three year contract to provide community services in Suffolk, but has since admitted it is heading for a loss.”</p>	HSJ
99	10 April	2014	New NHS England chief 'more sympathetic' to	Press article	<p>“Monitor’s chief executive has told <i>HSJ</i> it will be easier for the regulator to assuage commissioners’ concerns about NHS competition rules now that Sir David Nicholson is no longer in charge of NHS England. (...) David Bennett said</p>	HSJ

			competition, says Bennett		Simon Stevens, who took over as NHS England chief executive this month, was probably “more sympathetic to the role that competition and choice can play” in the health service”.	
100	16 April	2014	Circle awarded £120m MSK contract	Press article	<p>“Private provider Circle has become Bedfordshire Clinical Commissioning Group’s prime contractor for its integrated musculoskeletal service after scooping a £120m five-year contract.</p> <p>The CCG named Circle as its preferred bidder to consolidate 20 separate contracts into a single service in August.</p> <p>Circle has said it is the first such integrated service in the country led by a prime contractor.”</p> <p>“Earlier this month Sheffield CCG agreed to commission city-wide integrated musculoskeletal services on a five year outcome based contract, which could be worth £40m a year.</p> <p>However, the CCG awarded prime contractor status to Sheffield Teaching Hospitals Foundation Trust rather than put it out to tender.”</p>	HSJ
101	17 April	2014	Serco well positioned for combined call centre contract	Press article	<p>“These reveal that the board discussed a paper outlining exploratory plans for a “health and social care coordination centre” last month. Under the proposals, the call centre would field its NHS 111, out-of-hours and community services contracts, all of which are up for renewal. The centre would direct patients to new “urgent care hubs”, potentially based at one or both local acute providers, and community-based “spokes” which would also deal with urgent care matters. The CCG stressed the plans were only formative and that it had not yet decided what kind of contracting model to use or how many providers it would want to provide the services.”</p> <p>“Serco, which already provides all the CCG’s community services including the care-coordination function, has already built in the area what it calls a “care co-ordination centre”.</p>	HSJ
102	23 April	2014	Consortium wins £210m MSK contract	Press article	<p>“A four-strong consortium of Sussex providers has scooped a five-year musculoskeletal contract worth £210m.</p> <p>The group was formed as the Sussex Musculoskeletal Partnership and includes Brighton and Hove Integrated Care Service; Horder Healthcare; Sussex Community Trust; and Sussex Partnership Foundation Trust. The</p>	HSJ

					contract was awarded by Brighton and Hove, Crawley and Horsham and Mid Sussex clinical commissioning groups.”	
103	24 April	2014	Independent sector profits from lack of NHS secure beds	Press article	“A lack of secure inpatient NHS beds has driven a £21m overspend in NHS England’s budget for independent sector mental health providers. <i>HSJ</i> analysis reveals the organisation overspent £21m on independent mental health providers, 5 per cent more than its planned spending on this sector.”	HSJ
104	29 April	2014	NHS chief will take 'pragmatic' approach to competition	Press article	“NHS England chief executive Simon Stevens has told MPs he does not share his predecessor’s concerns that competition law is standing in the way of health service reform.”	HSJ
105	1 May	2014	Stevens invites CCGs to bid for primary care commissioning role	Press article	“Simon Stevens has confirmed he plans to give some clinical commissioning groups the ability to co-commission primary care with NHS England.”	HSJ
106	6 May	2014	Pioneering pathology joint venture posts multi-million pound profit	Press article	“One of the first public-private joint venture pathology services for the NHS has posted its first multi-million pound profit since its launch in 2009, its accounts reveal. GSTS Pathology, a joint venture set up by Guy’s and St Thomas’ Foundation Trust and outsourcer Serco, posted a £3.8m net profit for the year ending December 2013, up from £300,000 in 2012. Revenues increased by 6 per cent from £87.6m in 2012 to £92.5m in 2013, according to the accounts which were released as the majority-owned NHS joint venture rebranded itself Viapath.”	HSJ
108	12 May	2014	Supporting NHS foundation trusts considering a merger: proposed approach	Consultation outcome	Monitor published an outcome of its consultation on “the introduction of new arrangements to support NHS foundations trusts contemplating a merger or acquisition navigate the relevant regulatory processes”.	Monitor
109	14 May	2014	Competition authority gives green light to Heatherwood and	Press article	“The proposed acquisition of Heatherwood and Wexham Park Hospitals Foundation Trust by Frimley Park Hospital Foundation Trust has been cleared by the Competition and Markets Authority” “The CMA concluded	HSJ

			Frimley Park merger		<p>competition would not be significantly weakened because of “strongly-performing NHS hospitals located nearby which offer similar services”. It listed Royal Berkshire Hospital Foundation Trust, Ashford and St Peter’s Hospitals Foundation Trust, Royal Surrey Country Hospital, and the Royal Buckinghamshire Hospital.”</p> <p>It said the “majority of third parties supported the merger” and that Monitor has told the CMA “in its view the merger represents the best available solution to improve patient services at Heatherwood and Wexham”.</p> <p>Monitor said in a statement it had advised “that the merger was likely to deliver a quicker and more sustainable solution to the issues faced by the trust than further regulatory intervention”.</p>	
110	14 May	2014	Monitor welcomes CMA's swift decision on NHS foundation trusts' merger	Press article	<p>“The Competition and Markets Authority (CMA) has cleared the proposed merger of Heatherwood and Wexham Park NHS Foundation Trust and the neighbouring Frimley Park NHS Foundation Trust.</p> <p>Monitor advised the CMA that the proposed acquisition was the best available solution to the problems faced by Heatherwood and Wexham Park, and the most likely way to achieve improvements in services for patients.”</p>	HSJ
111	16 May	2014	NHS 111 procurement timetable will be 'challenging'	Press article	<p>“NHS England will spend £33m on reprocurement of technical elements for NHS 111 in order to meet a ‘challenging’ deadline of April 2015, it has said. It aims to find a provider for the technical ‘telephony’ system, which routes calls to NHS 111 through to the correct local NHS providers.”</p>	Pulse
113	20 May	2014	DH defends reconfiguration process after foreign secretary's 'intervention'	Press article	<p>“The Department of Health has defended the national review system for NHS reconfiguration proposals after a local councillor claimed the foreign secretary had lobbied officials involved in the controversial plan.</p> <p>John Blackie, the independent leader of Richmondshire District Council, claims William Hague had intervened by speaking to both the health secretary and to the Independent Reconfiguration Panel, which is considering whether to conduct a full review of a planned shake up of hospital services in North Yorkshire.</p> <p>Under the proposed reconfiguration by Richmondshire and Whitby Clinical Commissioning Group, the children’s and consultant-led maternity services at</p>	HSJ

					<p>Friarage Hospital in Northallerton, North Yorkshire would be centralised at the James Cook University Hospital in Middlesbrough.</p> <p>Although the change has been welcomed by all GP practices and South Tees Hospital Foundation Trust, the plan was referred to the Jeremy Hunt by North Yorkshire Council in March.”</p>	
114	20 May	2014	Trusts should 'twin' to boost income abroad	Press article	<p>“NHS organisations are being encouraged to ‘twin’ with hospitals in countries like China as part of an effort by the government to help them secure international business deals.</p> <p>Howard Lyons, the chief executive of Healthcare UK, a UK Trade &amp; Industry body, has also pledged to draft new guidelines to help hospital trusts open up new income streams by offering advice to their counterparts overseas.”</p>	HSJ
115	21 May	2014	Strong bond' between Wirral's health authorities must be looked into, says Birkenhead MP	Press article	<p>“THE decision making process of a Wirral health authority has come under fire, with Birkenhead MP Frank Field calling for an urgent inquiry into its operation.</p> <p>In a letter to Health Secretary Jeremy Hunt, Mr Field questions Wirral Clinical Commissioning Group's (CCG) relationship with the Wirral University Teaching Hospital NHS Foundation Trust, claiming relationships between senior members of the CCG and Arrowe Park Hospital may have dented the "independence" and "integrity" of local health services.”</p>	Wirral Globe
116	29 May	2014	Urgent call for clarification on commissioning rules	Press article	<p>“A row between commissioners and a private midwifery service in Leeds has sparked calls for “urgent clarification” around commissioning rules.</p> <p>The dispute has arisen between three clinical commissioning groups – Leeds South and East, Leeds West and Leeds North – and One to One Midwives, a private provider currently commissioned by four CCGs in Merseyside and Cheshire.</p> <p>While the Leeds CCGs said that they have not commissioned the firm, One to One told <i>HSJ</i> that the CCGs had told them in writing they would fund referrals from GPs.”</p> <p>““Some women who have been refused by some GPs, based on the CCGs’ message [have] individually complained to NHS England via the local area</p>	HSJ

					<p>team, Monitor and Healthwatch Leeds,” she said.</p> <p>Cathy Warwick, chief executive of the Royal College of Midwives, said “urgent clarification” was required around commissioning rules. She said: “Recent information about One to One Midwives, such as a Care Quality Commission report, indicates that the service is of a high standard. One to One... are also recognised as an NHS provider.”</p>	
117	May	2014	Our new approach to transactions: consultation responses and next steps	Consultation	<p>Monitor announced the results of consultation on proposed changes to its assessment of mergers between NHS organisations.</p> <p>“The key changes proposed in the revised approach to transactions risk assessment include:</p> <ul style="list-style-type: none"> <li>☐ a revised threshold for ‘significant’ transactions requiring a detailed review, bringing other risk factors into consideration in addition to a transaction’s relative size</li> <li>☐ for transactions that cross this revised threshold, undertaking some elements of our detailed review at an earlier stage as part of the new support arrangements outlined above</li> <li>☐ the introduction of more clarity and transparency on the scope of Monitor’s detailed reviews, along with guidance on best practice for transactions</li> <li>☐ the introduction of a single transaction risk rating, in place of the previous dual ‘indicative’ risk ratings for continuity of service and governance.”</li> </ul> <p>“Overall, there was broad support for Monitor’s new approach to mergers.”</p>	Monitor
118	3 June	2014	CCG makes "substantial concessions" in judicial review case	Press article	<p>“Bristol Clinical Commissioning Group has offered to make a series of “substantial” changes to its policy on patient and public engagement as part of a proposed out of court settlement.</p> <p>The proposal is now being considered by lawyers acting for Protect Our NHS, a campaign group challenging the legality of the CCG’s current policy in a judicial review.</p> <p>Protect Our NHS alleged that Bristol’s procurement policy breaches the Health Act 2012 by failing to require public involvement in its decision making process. Bristol denies the allegation.”</p>	HSJ

119	3 June	2014	CCG pioneers outcomes-based contract for community health and social care services	Press article	Richmond CCG is looking to use the outcomes based contract for re-commissioning their community health services. "NHS Richmond CCG has voted to look with Richmond Council at services including district nursing, paediatric speech and language therapy, podiatry for people with long-term conditions and cardiac rehabilitation it buys from Hounslow and Richmond Community Healthcare NHS Trust (HRCH)." "Richmond CCG spent £20m on community care with HRCH in 2013/14. Richmond Council has budgeted for £70m of adult social care services in 2014/15." The CCG decided to review the services because of the 'variability of access to and engagement with the current service.'"	Inside Commissioning
120	4 June	2014	Heatherwood and Wexham Park Hospitals NHS Foundation Trust: advice on proposed merger	Decision / guidance	Monitor published its advice to the Competition and Markets Authority on the anticipated acquisition by Frimley Park Hospital NHS Foundation Trust approving the merger.	Monitor
121	5 June	2014	CCG proposes awarding community contracts without competition	Press article	Consultation paper prepared by Northern, Eastern and Western Devon CCG, proposes that "the bulk of community services, including community hospitals, would be awarded without competition." "The CCG aims not to tender services currently provided by Northern Devon Healthcare Trust in the north and east, and Plymouth Community Healthcare Trust in the west. It proposed that Plymouth and Northern Devon continue to provide services in the west and north respectively. However, the CCG wants Royal Devon and Exeter Foundation Trust to take on services in the east."	HSJ
122	11 June	2014	NHS England mulls young people's mental health tender	Press article	"NHS England is considering putting inpatient child and adolescent mental health services out to tender in a bid to tackle "out of area" placements for vulnerable young people."	HSJ
123	11 June	2014	CCGs could be caught out by 'technical' legal challenge	Press article	"A South West clinical commissioning group has reached an out of court agreement with NHS campaigners who claimed its policies on patient and public involvement were unlawful – in a legal challenge lawyers warn could	HSJ

					<p>cause problems for other CCGs.</p> <p>Bristol CCG maintains that “in substance” it has had “proper” arrangements for public involvement in place since its inception in April 2013. However, following the challenge by Protect Our NHS it has agreed to amend its procurement policy and constitution to describe the arrangements for public involvement in more detail”</p> <p>“The complaint began back in February as a demand that Bristol CCG halt all procurement activity under threat of injunction. At the time the CCG was in the final stages of the multimillion pound procurement of the city’s community mental health services.”</p>	
124	16 June	2014	GP commissioners consider diverting funding to APMS contracts under 'frightening' proposals	Press article	<p>“A CCG is considering using directed enhanced service funding for a new model of primary care that would see practices switching to APMS contracts in proposals described as ‘frightening in the extreme’ by local leaders. In its plans to co-commission primary care, NHS Basildon and Brentwood CCG wants to pilot a ‘Prime Provider’ model of primary care by 2015/16, which would involve practices working as part of an umbrella organisation involving mental health, acute care and social care professionals. The CCG would fund this through combining budgets currently used for DESs, CCG funding and money from the local authority in a bid to try to improve care for people with long-term conditions or frail older people. The CCG says the contracts would be ‘entirely voluntary’, and would be commissioned under an ‘outcomes-based’ APMS contract.”</p>	Pulse
125	17 June	2014	Optum and Capita bid for lead provider framework	Press article	<p>The private firms Optum and Capita have placed bids to join NHS England’s lead provider framework for commissioning support services, HSJ understands.</p> <p>Under the framework NHS England is expected to award quality assured status to between 10-15 support service providers. It is expected to go live in January next year.</p>	HSJ
126	17 June	2014	Bidder for £800m integrated care contract pulls out at	Press article	<p>“One of the bidders in the running for Cambridgeshire and Peterborough Clinical Commissioning Group’s £800m integrated older people’s services contract has dropped out at the final stage.</p>	HSJ

			final stage		<p>Accord Health is no longer in the running for the contract, the CCG has confirmed. Accord Health is a consortium including construction and support services giant Interserve, North Essex Partnership Foundation Trust and Provide, which was formerly Central Essex Community Services.</p> <p>The three remaining bidders are:</p> <p>Care for Life (Care UK with Lincolnshire Community Health Services Trust, and Norfolk Community Health and Care Trust);</p> <p>Uniting Care Partnership (Cambridgeshire and Peterborough Foundation Trust with Cambridge University Hospitals Foundation Trust); and</p> <p>Virgin Care.</p> <p>The preferred bidder is expected to be announced in September. The contract is due to begin in January 2015."</p>	
127	20 June	2014	Sheffield aims for single health and care budget	Press article	<p>Sheffield's CCG and city council plan to pool "£237m more than required by national rules in 2015-16, with the "ultimate aim" of establishing a single budget for health and social care." They also are "developing a single large contract for intermediate care in the city, which is currently dispersed between several services and providers." "Commissioners will draw up the plans during 2014-15. A decision will be taken about whether there will be an open procurement to run them. The specification will consist mainly of outcomes desired, rather than the processes or services required. It will bring together a current set of around 20 separate but linked services."</p>	HSJ
128	20 June	2014	FT subsidiary takes over Circle clinic	Press article	<p>"A private firm wholly owned by a foundation trust is to take over the running of a private clinic from Circle, <i>HSJ</i> has learned. SWFT Clinical Services, a subsidiary of South Warwickshire Foundation Trust, will take over the clinic in Stratford-upon-Avon next month. The clinic, previously known as Circle Clinic Stratford, is attached to a local GP practice. The practice will retain ownership of the facility, which provides outpatient services including diagnostics and day surgery to private patients. Circle stopped providing services at the clinic in April to focus on inpatient services."</p> <p>"<i>HSJ</i> understands the venture will help the trust decide whether it can support its NHS services by moving into the private sector, and whether to offer private services at the redeveloped Stratford Hospital, due for</p>	HSJ

					completion in 2016.”	
129	25 June	2014	Around 180 CCGs bid for primary care co-commissioning	Press article	“Bids to co-commission primary care have been submitted by around 180 of England’s 211 clinical commissioning groups”	HSJ
130	26 June	2014	Exclusive: Monitor launches probe of community service contracts	Press article	“Monitor has launched an investigation into clinical commissioning groups’ intentions for the £10bn community services sector.” The questionnaire was sent out to every CCG “to scope the current state of the market in a bid to gather intelligence about how commissioners plan to improve community services. Most of the services are provided on contracts established under the transforming community service programme in 2010-11 and 2011-12. Many of these agreements expired at the end of 2013-14, but had an option to extend for a further two years and so are yet to be retendered.” “Monitor is expected to publish the findings of its research in the autumn.”	HSJ
131	26 June	2014	Delay to merger increases costs by £3m	Press article	“A proposed merger between Ealing Hospital Trust and North West London Hospitals Trust has been delayed by three months at a cost of £3m. The delay cost - revealed in North West London’s June board papers - will allow the trust to ensure the financial model for the merger takes account of a 2014-15 contract agreement between the two providers.”	HSJ