Choice, cooperation and competition in the NHS: lessons to date

Lord Carter of Coles
Chair, Cooperation and Competition Panel

Kings Fund - Board Leadership Programme

7 June 2011
Overview

• The CCP: its introduction

• The CCP: work to date

• The CCP: lessons learned

  - integration and mergers
  - choice, competition and commissioner behaviour

• Competition in the NHS: now and in a possible future

• Some thoughts on possible implications
The CCP: its introduction

• “...a team of hanging judges positioned to mete out brutal retribution to any NHS organisations which seek to collaborate, plan or integrate services...”
The CCP: its introduction

CCP characterised as “a bent umpire”, “hard-nosed”, “draconian”, “forcing the pace of privatisation”

Prof Chris Ham – Kings Fund: CCP guidance written by “...neo-liberal economists on speed”
The CCP: a reminder of what it is we do

• Principles and Rules for Cooperation and Competition cover four areas:
  – procurement of NHS services
  – anti-competitive conduct by providers and commissioners
  – mergers between NHS organisations
  – false and misleading advertising of NHS services

• CCP considers formal cases in each of these four areas, and in addition:
  – offers informal advice to commissioners, service providers and others on the application of the Principles and Rules
  – market studies at the request of DH/Monitor

• CCP works within the policy framework set by the DH
CCP work to date: merger reviews

- CCP has reviewed 131 NHS mergers since January ‘09
- Vast majority involved acquisitions of PCT community services providers
  - followed a decision by DH that all PCTs divest their provider arms
  - 66 acquisitions by acute trusts, 43 by mental health trusts, 17 by community services providers (to form community trusts)

- **Other mergers:** mental health/mental health, acute/acute, and acute/GP

### CCP merger reviews

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Count</th>
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<tbody>
<tr>
<td>Clearance</td>
<td>58</td>
</tr>
<tr>
<td>Conditional clearance</td>
<td>66</td>
</tr>
<tr>
<td>Prohibition</td>
<td>1</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>3</td>
</tr>
<tr>
<td>Ongoing</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>131</td>
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![Pie chart showing CCP merger outcomes]

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**Note:** The chart illustrates the distribution of merger outcomes, with various phases indicated and numbers of cleared, conditional cleared, prohibited, withdrawn, and ongoing mergers. The total number of mergers reviewed is 131.
CCP work to date: conduct cases

- North West Specialist Commissioning Group
  - Four year exclusive framework agreements for secure mental health services
  - **Finding:** limited NWSCG’s choice of provider/ability to react to market changes

- Kingston Primary Care Trust
  - Review of PCT’s decision not to allow a GP practice to open a new branch surgery
  - **Finding:** potential adverse effects of new surgery small, outweighed by benefits, so recommended PCT’s decision was reversed and branch surgery allowed to open

CCP work to date: procurement disputes

- NHS North of Tyne
  - Specialist orthodontic service procurement
  - Complaint around lack of transparency and bias of evaluation panel member
  - **Finding:** complaint not upheld - commissioner's decision within range of reasonable decisions

- King’s College Hospital Foundation Trust
  - Pathology services procurement
  - Complaint from bidder that process was not carried out fairly or transparently
  - **Finding:** complaint not upheld
CCP work to date: market studies

• Study of the use of NHS consultants’ non-contracted hours
  – Restrictions imposed by a hospital on a consultant’s ability to work for other providers of NHS care likely to be in breach of the Principles and Rules
  – only two limited situations in which patients and taxpayers might benefit overall from a restriction placed on consultants
    • to address legitimate patient safety concerns arising from the specific performance of a consultant; and
    • to prevent a consultant from holding a strategic management position in more than one organisation providing NHS-funded care, or working on competing bids.

• Study of the operation of the ‘any willing provider’ model (ongoing)
  – Interim Assessment (Feb 2011)
  – patterns of behaviour by PCTs that could breach the Principles and Rules
  – will focus on the costs and benefits to patients and taxpayers of certain examples of commissioning practice
Lessons learned: integration and merger

Main issue in community services mergers has been with acquisitions by acute trusts
- Concerns about merged entities limiting patient choice
- CCP has put in place measures to address this
- Assurances sought concerning referral practice

Couple of mergers where increasing local concentration has been a concern
- Remedies considered in respect of divestment
- Prohibition recommended in one instance

ICO pilot has also been the subject of a review
- ICO found not to undermine primacy of the GP gatekeeper function
- Decision allowed the possible benefits that might be realised from an ICO to be explored.

Beginning to see large increase in merger activity – FT pipeline a key source
Lessons learned: integration and merger

- Key challenge facing the system is the CCP’s application of a cost-benefit analysis to transactions where the rationale for merger/integration is seemingly weak

- Proposed clinical and financial benefits have been articulated very poorly and often suggest a naive approach to merger fulfilment/post-merger planning

- We are working with documentation that often does not explicitly link benefits to an evidence base and the intention of the organisation to realise them

- Organisations struggle to provide basic information to enable analysis

- Tension around additional burden to the organisations if we request more detail and pressures from policy to drive mergers mean organisations are approaching the transactions from a particular perspective
Lessons learned: commissioner behaviour

Review of the operation of ‘any willing provider’ has demonstrated a range of behaviours that appear to be inconsistent with the PRCC, including:

• restricting patient choice of provider for routine elective care through directions to GPs, waiting list requirements, and referral processes which direct patients to particular providers;
• inserting provisions into contracts with providers that restrict patient choice including, activity caps and reductions in the types of procedures that providers can offer;
• creating incentives that undermine patient choice, for example, setting different prices for different providers, local price negotiations, and block contracts.

The evidence and submissions to date reinforce themes routinely encountered during formal and informal CCP activity: perceived conflict between choice, competition and ‘managing demand’

The review will therefore provide for a focused examination of the apparent tension between policy promoting choice/competition and challenge of managing a cash-constrained system.
Lessons learned: commissioner behaviour

The CCP continues to hear regular complaints of poor procurement practice by commissioners. Examples include:

• different evaluation criteria being applied to different bidders
• evaluation criteria being used to assess tenders when these criteria were not included in the tender documentation
• a bidder being told by the commissioner prior to a tender how much it expected to pay for a service
• a tender being awarded to someone who was not the highest scoring bidder according to the explicit assessment framework
• a PCT ringing around for additional bidders after the tender had closed when it had received a single bid for the service and then going on to accept late submissions.

Problems of scale and scope

• areas where innovation and efficiency could take hold suffer from commissioners' reluctance to ensure that the scale and scope of tendering is sufficient.
Competition in the NHS: now and in a possible future

**Primary**
- Competition for patients
- (constrained by practice boundaries and entry restrictions)

**Acute**
- Competition for patients
- & Competition for contracts

**Community**
- Competition for patients
- & Competition for contracts

**Mental Health**
- Competition for contracts

**Future**
- Competition for patients
- (fewer constraints on patient switching and entry)
- & Competition for contracts
- & Competition for contracts

Competition for patient pathway contracts?
Competition in the NHS: how might the rules change?

### Existing rules

A merger is allowed to proceed where:

(a) it has no material adverse effect on competition; or

(b) where the benefits to patients and taxpayers arising from the merger outweigh any adverse effects arising from a loss of competition.

Merger rules contained in PRCC and CCP guidance.

### New rules

a. Enterprise Act will provide framework for FT mergers – similar to existing rules administered by the CCP.

b. Monitor to agree with SoS and publish a framework for advising on non-FT mergers – expect that it might be similar to existing arrangements.

### Mergers

Various provisions of the Principles and Rules cover both provider and commissioner conduct.

### Conduct

a. Competition Act prohibitions will apply to providers.

b. Small number of provisions in provider licenses aimed at facilitating competition.

c. Regulations put in place under new Health Bill covering anti-competitive behaviour by commissioners.

### Procurement

Procurement rules included in the PRCC and the Procurement Guide.

a. Regulations under the Health Bill will set out procurement rules for commissioners – expect these to be similar to existing obligations.
Institutional arrangements for competition oversight:

<table>
<thead>
<tr>
<th>Present</th>
<th>Future</th>
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<tbody>
<tr>
<td><strong>Mergers and conduct</strong>: CCP advises SoS and Monitor (for FTs). Conduct investigations triggered by complaint to CCP.</td>
<td><strong>Mergers</strong>: OFT and CC decide whether FT/FT mergers can proceed. Monitor advises SoS on non-FT mergers.</td>
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<tr>
<td><strong>Procurement</strong>: CCP advises SoS on disputes (on appeal from SHA processes).</td>
<td><strong>Conduct</strong>: Monitor investigates and decides how anti-competitive behaviour by providers and commissioners should be remedied and/or penalised.</td>
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<tr>
<td><strong>Market studies</strong>: CCP makes recommendations to SoS and Monitor (eg non-contracted hours, PCT referral restrictions)</td>
<td><strong>Market studies</strong>: Monitor able to undertake short studies and ask the CC to conduct more detailed studies.</td>
</tr>
<tr>
<td><strong>Procurement</strong>: Monitor decides on disputes (on appeal from Commissioning Board).</td>
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Implications for mergers and integration:

Merger activity likely to increase over the coming few years. Few things to consider:

• Level of scrutiny likely to be of different order to CCP process
• Efficiency arguments will need to be much more robust
• Important shift from CCP advisory function to OFT determinative role
• Expected tensions in respect of FT pipeline aspirations and common view that merger is a ready solution to both economic and clinical poor performance

Integration will be scrutinised either through the merger control regime or under the Competition Act with regard to prohibition of anti-competitive agreements which prevent, restrict or distort competition:

• Again, benefits case will need to be robust and evidenced
• Going forward there will need to be a consultative process in respect of producing guidance on the application of competition law in respect of service integration
Implications for commissioning

• Commissioners will be subject to procurement law and regulations produced by Monitor concerning anti-competitive behaviour and procurement (the latter similar to obligations set out in the PRCC)

• Monitor will be responsible for investigating anti-competitive conduct by commissioners and deciding how should be remedied and/or penalised

• But, a concern must be that we end up with policy and regulation that promotes and polices choice and competition, but a residual mindset in parts of the NHS which is resistant to this policy, or lacks the ability to execute effectively = ‘culture eating policy for breakfast’

• Also, key concerns around conflicts of interest arising from new commissioning arrangements, e.g. GPs acting as both commissioner and provider, will need to be carefully managed so as not to fall foul of regulations
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