

Commissioning through Competition and Cooperation

Final Report

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Executive Summary

Background

Following several versions of the NHS quasi market since 1990, a wide ranging set of reforms was introduced into the NHS under the recent Coalition government by the Health and Social Care Act 2012 (HSCA 2012). The idea behind these is the same as that behind previous versions of the NHS quasi market: that competition between a wider range of providers will produce the desired results of improved quality and greater efficiency. The HSCA 2012 made a direct correlation between competitive behaviour in the NHS and competition law. The Procurement, Choice and Competition Regulations No.2 2013 relate to sections 75-77 and 304 (9) and (10) of the HSCA 2012, and indicate that competitive procurement by commissioners is to be preferred, although not in all circumstances. Monitor (the former NHS Foundation Trust regulator) took on the role of economic regulator for the whole of the NHS. Along with the national competition authorities (being, since April 2014 the Competition and Markets Authority, and prior to that, The Office of Fair Trading and the Competition Commission), has powers to enforce competition law to prevent anti-competitive behaviour.

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. Monitor is also responsible for promoting co-operation. 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.

During the course of this study, an important policy document, *The Five Year Forward View* (5YFV) was published by NHS England in October 2014. This did not mention competition between organisations and instead focussed on how organisations in the NHS need to cooperate with each other, and in fact at times merge to form larger organisations. And it should be noted that there have been no relevant legislative changes, so the HSCA 2012 remains in force.

While studies have noted that incentives for competition and cooperation exist in healthcare, few have researched the interaction between the two. There was a need to investigate the way in which local health systems were managed to ensure that cooperative behaviour was appropriately coexisting with competition.

Aims

This project aimed to investigate how commissioners in local health systems managed the interplay of competition and cooperation in their local health economies, looking at acute and community health services (CHS). The research questions were:

- 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.

Design and methods

The project consisted of four in depth case studies of four local health economies located in four CCG areas across England. Case study sites comprised a mix of rural and urban settings and were located in the North (two), Midlands and London.

There were two phases of data collection: first in 2013/14 and then follow up in 2015 after the general election in May that year. The main form of data were interviews with senior commissioning staff and 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, as well as their experiences of tendering and bidding for tenders and experiences of collaborative working. Forty two interviews were conducted.

We also analysed local documents to understand local commissioning strategies, and a series of national data sources to find out what competitive commissioning activity there had been in each case study site.

In order to give a context to the understanding and views of local commissioners and providers, as well as their actual behaviour, we compiled 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 October 2015. Sources for this included official guidance and decisions from websites such as Monitor and the Competition Commission, as well as specialist press titles such as *Health Services Journal*, *Health Investor* and *Pulse*.

Results

Understanding of the regulatory framework and attitudes to the use of competition and cooperation

Our findings concerning the understanding of the regulatory context of the NHS market by both commissioners and providers of care indicate that the ‘rules of the game’ are not clear to all ‘players’. The written material issued by the national authorities and the regulators was seen as unclear. 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 in light of them. 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. After the publication of the 5YFV, commissioners reported that there was less emphasis at national level on using competition. It was even less clear what the rules were, but they all seemed inclined to decrease their use of competition as a commissioning mechanism. This increased use of cooperation was thought to be more appropriate when making major service changes locally. But most of the respondents expressed the opinion that it was still necessary for commissioners to be able to use competitive processes at times, when they judged it necessary.

Provider managers shared many concerns that were expressed by commissioners about the rules governing competition with the NHS. Despite being concerned with negative effects of competition within the NHS causing fragmentation of services and increasing costs, many NHS acute providers saw 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. In contrast to the NHS provider managers, the employees of independent providers we interviewed were much more enthusiastic about competition, as this was their route to market entry.

Competitive and cooperative behaviour

There were differences between the four case study sites in terms of the volume and mode of using competition as a commissioning mechanism. CCG2 and CCG4 had more experience in running competitive procurements than CCG1 and CCG3. Furthermore CCG3 had particularly close cooperative relationships with local providers. Such an approach was much rarer in CCG4, which appeared to have the largest degree of enthusiasm for the local use of competition in its CCG board, at least in 2013/14.

Nevertheless, every site (including CCG3, which had claimed in 2013/14 that it had no interest in doing so) had, by 2015, undertaken at least one competitive tendering for the market as a result of a decision taken at the local level. All sites had also undertaken tendering to increase competition in the market as a result of top-down pressure to use competition linked to a particular policy initiative such as any Qualified Provider (AQP). Commissioners saw that competition had its benefits as it is able to stimulate providers to change their behaviour. All the commissioners noted, however, that the procurement process was very resource intensive, as the process was time consuming and cumbersome. Therefore, given current resources available for commissioning, it was not possible to undertake many of these exercises.

By 2014 and 2015 there was a slight decline in the appetite to use competition in some of the sites, especially for large scale service reconfigurations. Commissioners in all case study sites emphasised that competition was not appropriate for implementing large, long-term service transformation programmes. This was because such programmes required full engagement of the providers to succeed. Collaborative planning involving key local providers, creating a sense of shared ownership of problems faced by the local health economy was a preferred way for CCG commissioners to approach large commissioning tasks. Our study has shown that all the sites used cooperative approaches to carry out major service reconfiguration. Moreover, commissioners feared that competitive tendering might financially destabilise local NHS providers if they were to lose income through the process.

There were differences in the way providers experienced competition and cooperation. NHS owned providers were affected by the attitudes and behaviour of their local commissioners, which determined the level of competitive pressures to which they were exposed locally. Also, providers' experiences differed depending on the type of services they delivered. Acute providers were more concerned about competition in the market, as they were able to increase their incomes by treating more patients under the Payment by Results (PbR) cost per case pricing scheme. Commissioners did, however, tender out services which affected outpatient activity, so acute trusts were not entirely immune to competition for the market. As CHS and MH services were not subject to PbR, these providers were not subject to competition in that respect. On the other hand, AQP services were usually delivered out of hospital, so these providers could be subject to competition in the market if they were accredited AQP providers. More importantly for CHS and MH providers, there was a real threat of competition for the market, as it was clear that these services could be subject to tender, and had been in many other areas.

All types of provider were using a blend of competitive and cooperative behavioural strategies in their strategic planning and day to day practices. Providers played a complex game of cooperating with their competitors and competing with their collaborators at times. Apart from cooperation about clinical issues, which was widespread, some providers collaborated by sharing back office functions. Many also collaborated to prepare joint bids to respond to invitations to tender. At the same time, all providers were aware of their competitors and, in some circumstances, engaged directly in competitions against their fellow local providers, as well as possible market entrants from further afield. Independent providers were subject to similar competitive and collaborative pressures as NHS organisations, and responded accordingly. The main difference was that, at times they reported not being treated equally by NHS commissioners and NHS providers, who were sometimes reluctant to share information and other resources with them.

Discussion and conclusions

Our findings concerning the lack of clarity of the regulatory regime for local actors are important. Actors need to understand the rules of the game in order to know how to relate to each other, and these rules are vital in setting the context and limits within which local actors can operate. It remains government policy (as well as being enshrined in the European procurement regulations) 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. In addition to the need for commissioners to treat all providers equally, all actors need to understand the rules governing the market.

It is not surprising that commissioners and providers used a judicious mixture of competition and cooperation in their dealings with each other. This behaviour is common in markets, in order to reduce transaction costs, *inter alia*. In fact, there are certain services whose characteristics indicate that non market institutional structures will be more efficient, due to the transaction costs incurred in operating markets.

Furthermore, the influence of the ‘institutional logics’ are also important to understanding how the NHS operates. The NHS has a long history of hierarchical modes of control which it is difficult to change. Our study indicates that this is substantially true in respect of the NHS quasi market under the HSCA 2012. However, our study also shows that there are signs that competitive forces are gradually taking hold in respect of some more marginal services, and especially in respect of CHS and MH services.

The implications of our study for policy makers are as follows: Local commissioners should be allowed to make their own decisions about which modes of commissioning are most appropriate in their particular circumstances, and in respect of particular services. Setting up nationally imposed rules about what mechanisms must be used is unhelpful (and probably will not be adhered to, in fact). It appears that in most circumstances, the use of cooperative modes of coordination are likely to be more appropriate. Fortunately, the recent policy developments under the 5YFV indicate this is the direction of travel. At the same time, it is important to clarify the rules of the game for local actors. It may be politically unpalatable, but the regulatory framework of the HSCA 2012 needs revisiting.

Glossary

5YFV	Five Year Forward View
AQP	Any Qualified Provider
AWP	Any Willing 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
CQUIN	Commissioning for Quality and Innovation
CSU	Commissioning Support Unit
DH	Department of Health
EAPMC	Equitable Access to Primary Medical Care
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
MSK	Musculoskeletal Services
NHSE	NHS England
OFT	Office of Fair Trading
PbR	Payment by Results
PCT	Primary Care Trust

PFI	Private Finance Initiative
PRCC	Principles and Rules for Cooperation and Competition
QIPP	Quality, Innovation, Productivity and Prevention programme
TDA	Trust Development Authority

Introduction

Policy background

Early history of the NHS quasi market

The NHS was established initially in 1948 as a hierarchical public organisation. However, by the late 1980s a quasi market was seen by the government as the best form of governance structure for the NHS. A quasi market for community, secondary and tertiary health care was introduced by means of a split between the purchasers of care (health authorities and GP fundholders at the time) and its providers. The providers of health care were constituted into 'self governing Trusts' (still publicly owned), who were supposed to compete with each other, thereby enhancing technical efficiency (that is ensuring the greatest output for the least resources used, i.e. 'value for money') (DH, 1989). The system of annual budget allocations was to be replaced with one based on negotiated contracts between purchasers and providers.

The government's reasons for the introduction of the internal market into the NHS were made explicit in *Working for Patients* (DH, 1989). First was the desire to achieve better 'value for money' (Department of Health 1989). Proponents (such as Enthoven, 1985) contended that technical efficiency was more likely to be achieved in a situation of competition between providers than in a structure (such as a hierarchy) which effectively contained monopoly providers. A second reason was that it would stimulate staff and professionals to behave in a more responsive manner in relation to the needs and desires of patients (DH, 1989). A third reason was that patients should be given a greater choice of the services available (DH, 1989).

Despite a softening of the rhetoric about competition and markets, the New Labour government elected in 1997 continued with the purchaser/provider split (Allen, 2002). As Touhy (1999) argues, New Labour 'went with the grain' and retained the quasi market structures. This demonstrated both an ideological change in the Labour party and the extent to which the quasi market had become entrenched as key participants accommodated to and shaped the reforms in the process of their implementation. In place of GP fundholders and the health authorities, smaller locality-based purchasers were created known as primary care trusts (PCTs) (Allen, 2002). After an initial period when the New Labour government emphasised the need for purchasers and providers to co-operate within a re-integrated public service, a series of new policy initiatives was introduced to produce a more overtly marketised system. Attempts to focus on standards and modernisation coupled with the use of centrally defined targets and performance management were tried out, but, especially after the general election in 2001, there was an increased emphasis on markets and choice (Hughes and Vincent-Jones 2007).

The structural reforms in the NHS introduced by New Labour after 2001 can be seen as a response to what was perceived as the failure of the hierarchical model in the early New Labour years, combined with a particular form of learning from the deficiencies of the Conservatives' internal market of the 1990s. The notion of markets as a core mechanism for improving public services, and health services in particular, was not abandoned. Indeed, the objectives of the first Conservative quasi market of the 1990s were re-articulated through a set of more radical restructuring reforms. The government tried to take account of the failures of the quasi market structures, particularly in relation to motivation and incentives on the supply side. The re-emphasis on markets as a motor for improvement was encapsulated in 'four inter-related pillars of reform' which were 'designed to embed incentives for continuous and self sustaining improvement' and produce 'better quality, better patient experience, better value for money and reduced inequality' (DH 2007a). These were: '(i) Demand side reform - more choice and a stronger voice for patients; (ii) Transactional reform - money following patients, rewarding the best and most efficient providers, giving others the incentive to improve; (iii) System management and regulation - a framework of system management, regulation and decision making which guarantees safety and quality, fairness and equity; and (iv) Supply side reform – more diverse providers, with more freedom to innovate and improve services.' (DH 2007b).

As most of these policies were still in effect at the time of the field work for this study it is important to describe them in more detail in order to understand the context for the study.

(i) Demand side reform: Enhanced patient choice was a key feature. NHS patients awaiting referral to hospital could select from a range of providers, one of which had to be an independent provider (DH, 2005b). The role of PCTs was not to direct patients to particular providers, but to offer a choice amongst local NHS hospitals, NHS Foundation Trusts (see below), and independent providers. This later became a policy called 'Any Willing Provider' under which patients could choose *any* hospital provider accredited by the NHS. Patient choice was designed to empower individuals and to act as a mechanism to improve services, as patients were thought likely to avoid under-performing hospitals, and the prospect of losing funding under the cost per case Payment by Results pricing system (see below) would create incentives to improve quality and access times. Choice entailed the growth of a more diverse supply market because, in order for real choice to be available, there would need to be an expansion of provider types and capacity. Later in their term of office, New Labour introduced a policy called 'Any Qualified Provider' which focussed on patient choice of out of hospital services. The policy mandated commissioners to open up a number of CHS chosen from a nationally prepared list to competition through the AQP framework (Jones and Mays, 2013). The aim of the AQP policy initiative was to improve access to CHS and to allow the entry of new providers.

(ii) Transactional reform: A national tariff of fixed prices for procedures, based on health resource groups (HRGs) to pay both public and independent providers was introduced (DH 2007b). This is a cost per case system called ‘payment-by-results’ (PbR), but is actually payment by activity. The idea was to sharpen incentives, as each episode of care reimbursed (or lost to another provider) would be charged at national tariff rates, which were average costs. PbR was initially designed to cover acute hospitals’ work, and it has not been expanded to community health services (CHS) or mental health (MH) services – these services are still paid for on block contracts, which amount to fixed budgets in effect (Allen et al, 2014)

(iii) System management and regulation: In addition to the continuing role of the hierarchical system run from the Department of Health (and since 2013, NHS England), the economic regulation of this system was undertaken by an arms’ length body, the Cooperation and Competition Panel (CCP) which advised the Department of Health in accordance with the *Principles and rules for cooperation and competition* (PRCC) (DH, 2010). This panel had not enforcement powers itself, and its recommendations were not legally binding. 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). (At the same time, aspects of European procurement law applied to the NHS in respect of two main issues – procurement by the NHS had to be transparent and non discriminatory between different types of provider. Some commentators believed that European competition law applied to the NHS during this period, but there were no cases to test this point (Odudu, 2011.)

Regulation of quality of care was carried out by the Care Quality Commission (formerly the Healthcare Commission and before that the Commission for Health Improvement), The quality regulators were responsible for the inspection of both public and independent providers; registration of independent providers and publication of annual performance ratings for all NHS organisations. The other important regulator was (and is- see below for its enhanced powers) the independent regulator of Foundation Trusts (see below) called Monitor. Monitor authorised Foundation Trusts and specified conditions about borrowing limits, permitted income from private treatments, the range of goods and services that could be supplied, and required financial and statistical information (Allen, 2006).

(iv) Supply side reform: The first reform to the supply side under New Labour was the introduction of NHS Foundation Trusts (FTs). While FTs are not independent providers, as they are still owned by the state, they represent a more autonomous organisational form designed to mimic aspects of third sector providers by involving local people in their governance. The aim of the governance regime for FTs (as opposed to ordinary NHS Trusts) was to change the balance between the competing goals of local autonomy and national upwards accountability (DH, 2005a; Davies, 2004) to tip it further in favour of

local autonomy. (For further details of the governance structures of FTs, see Allen et al, 2012). Commissioners were also encouraged to engage with new providers from the ‘third sector’ (social economy) including local voluntary groups, registered charities, foundations, trusts, non-profit social enterprises, and cooperatives (DH, 2006). And finally, for profit providers were also encouraged to enter the NHS quasi market on a larger scale. Initially, this took the form of independent sector treatment centres (ISTCs), which were set up specifically to carry out elective surgery on NHS patients (HCHC, 2006). These ISTCs were initially contracted nationally but the amount of patients treated has declined in recent years (Allen and Jones, 2011).

Recent reforms to the NHS quasi market

A further wide ranging set of reforms was introduced into the NHS under the recent Coalition government. The reforms were designed yet again to increase the market-like behaviour of providers of care (Secretary of State, 2010; Health and Social Care Act, 2012; ‘HSCA 2012’) and they span the Coalition government, and current Conservative regime. The idea behind these recent reforms is the same as that behind previous versions of the NHS quasi market discussed above: that competition between a wider range of providers will produce the desired results of improved quality and greater efficiency.

At the same time, as ever, 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 (Ferlie et al, 2010).

The Coalition Government oversaw the passing of the HSCA 2012, with the majority of its provisions coming into force in April 2013. The HSCA 2012 brought wide ranging changes to the NHS. It made a direct correlation between competitive behaviour in the NHS and competition law (den Exter and Guy, 2014). The National Health Service Procurement, Choice and Competition Regulations No.2 2013 relate to sections 75-77 and 304 (9) and (10) of the HSCA 2012, and include elements of existing guidance that were not previously subject to statutory regulation, including the PRCC and NHS procurement guidelines. These were supplemented by guidance issued by Monitor. Moreover, the Procurement, Choice and Competition Regulations indicate that competitive procurement is to be preferred, although not in all circumstances. Under the HSCA 2012, Monitor (as the new economic regulator for the whole of the NHS, not only FTs) took over some of the functions of the former CCP and, along with the national competition authorities (being, since April 2014 the Competition and Markets Authority (CMA), 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. Monitor has a statutory responsibility to promote competition and is obliged to carry out competition

regulation with the CMA (formerly the OFT) (under the Competition Act 1998 (HSCA s 72). Monitor has concurrent responsibilities with the CMA in relation to anti-competitive agreements and abuse of dominant position (HSCA s 72). Mergers involving one or more FTs are subject to the Enterprise Act 2002 (HSCA s 79) and should be reviewed by the CMA (formerly the OFT) with Monitor taking an advisory role in relation to the benefits of the merger for patients. Monitor on the other hand has sole responsibility for the examination of mergers between NHS Trusts. The Enterprise Act 2002 imposed a duty on the OFT to refer a merger to the CC if it fitted the definition of a ‘relevant merger situation’ and if the OFT believed the merger might result in a significant lessening of competition.

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).

During the course of this study, there was an important policy development, which did not emphasise the use of markets, initiated by NHS England in October 2014. This document, *The Five Year Forward View* (5YFV), did not mention competition between organisations and instead focussed on how organisations in the NHS need to cooperate with each other, and in fact at times merge to form larger organisations. For example, Multispecialty Community Providers could be formed which bring together a range of out of hospital care including GPs and CHS health services. And Primary and Acute Care systems could further integrate inpatient acute care with primary care services. The 5YFV has been seen by commentators (e.g. Ham et al, 2015) as an important indication of the direction of travel for organisational issues in the NHS. Furthermore, in his response to the 5YFV in November 2014, the Secretary of State for Health (Jeremy Hunt) indicated that he did not think that patient choice (i.e. competition) was the best way to improve many services (Hunt, 2014). On the other hand, the director of cooperation and competition at Monitor (Catherine Davies) argued in the same month that competition still had an important role in the NHS, despite the 5YFV (Davies, 2014). And it should be noted that there have been no relevant legislative changes, so the HSCA 2012 remains in force. (The time line in Appendix 1 sets out in detail the regulatory decisions, policy developments and relevant activities in the local NHS during the field work period.)

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.

Extensive research, based on transaction costs theory (Coase, 1937 and Williamson, 1985), demonstrates that markets are not always the most efficient institutional structures compared to more hierarchical forms (e.g. Joskow, 1987), and this research extends to health services (e.g. Croxson, 1999). Indeed, there is some evidence to indicate that the first Conservative quasi market was not entirely successful. As Tuohy (1999) points out, the internal logic of the relevant system will affect the implementation of the policy change. Although state hierarchies can make abrupt strategic changes, they are vulnerable to problems of delay. In the case of the NHS quasi market in the 1990s, the established logic of hierarchical corporatism blunted the effects of the market. Thus, the key to understanding the NHS quasi market was (and is) its institutional context. Analysis of this demonstrates the enduring nature of the hierarchical nature of the NHS during the first Conservative quasi market period, as opposed to any marketised elements (Allen, 2002). Research concerning efficiency in that quasi market does not provide any convincing evidence that efficiency was, in fact, improved by the introduction of the new structures (Le Grand et al, 1998). One of the reasons researchers have identified for this lack of success was that the incentives to behave in market like ways were not strong enough, and the hierarchical elements of the NHS continued to exercise control (Enthoven, 1999; Touhy, 1999; Allen, 2002).

Furthermore research studies about the New Labour and current incarnations of the NHS quasi market demonstrate that it continues to contain very strong hierarchical elements, despite the increasing series of pro market reforms over since 2001 (Mays et al, 2011; Allen et al, 2014). It should be noted that there is recent empirical research about the effects of competition in the NHS reforms introduced by New Labour (e.g. Cooper et al, 2010; Gaynor et al, 2011), which finds in favour of competition on efficiency and quality grounds.

There was a need to investigate the way in which local health systems were managed to ensure that cooperative behaviour was appropriately coexisting with competition. An important aspect of understanding how competition and cooperation operate together is to investigate the rules which govern these interactions between people and organisations (Ostrom, 2005). In the case of the English NHS these rules consist of both legislation (primary i.e. acts of parliament; and secondary i.e. statutory instruments) and policies issued by the Department of Health and NHS England. 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 were being managed to balance competition and cooperation under the current Coalition and Conservative governments' reforms has been investigated.

Study of commissioning through competition and cooperation

For this reason, PRUComm has undertaken 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 CHS 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.

Study design and methods

The study consisted of a series of four in-depth case studies to investigate how commissioners approach their roles as shapers of the local health system in respect of competition and cooperation issues. The use of case studies was thought to be the most appropriate research design as case study interviews and documentary analysis were informed by the contextual information we were able to gather by concentrating on four specific CCGs across the country. We were able to pursue our research questions in depth, informed by two sets of in-depth interviews and examination of local documents (including CCG commissioning strategies and board minutes).

Ethical approval for the study was granted by the London School of Hygiene and Tropical Medicine internal ethics committee on 23rd June 2013 (approval number 6439). The NHS ethics service (NRES, at the time) confirmed that NHS ethical approval was not required as only NHS staff were being interviewed.

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 comprised a mix of rural and urban settings and were located in the North, North West, Midlands and London (see Tables 1 and 2).

The original purpose of the follow up interviews in 2015 was to find out whether local actors had changed their views on and understanding of the regulatory regime introduced by the HSCA 2012, and the extent to which the use of competition had changed over the passage of time since the first fieldwork phase. After the first phase of field work, the 5YFV was issued in October 2014. It was clear that this had the potential to constitute an important policy change, so we took specific note of respondents'

views of its potential and actual effects in the follow up interviews. (We waited until after the general election in May 2015 to carry out the follow up interviews in order to see if there was a change of government which might have significantly affected competition policy in the NHS. The election of a Conservative government did not indicate there would be.)

In the second phase of data collection, between July and October 2015, we carried out 9 follow up interviews with commissioners (8) and one provider to gauge any changes in the views and experiences. We attempted to interview providers from the first phase of the fieldwork, but it proved impossible to induce them to participate in the study again. (This may have been due to the deteriorating financial position of most providers by 2015, dealing with which was proving very time consuming for managers.) In total we conducted 42 interviews.

Table 1. Interviews by case study sites and phase

Case study site	Location of CCG	No. of first phase interviews	No. of follow up interviews	Total
CCG1	Rural, North	10	2	12
CCG2	Urban, Midlands	9	2	11
CCG3	Mixed, North	7	2	9
CCG4	London	7	3	10

Table 2. Interviews by case study site and type of service and provider

			CCG1	CCG2	CCG3	CCG4
Commissioners			8	5	3	5
Providers	NHS	Acute	2	1	2	2
		Community	1	2	3	2
		Mental health	0	1	0	0
	Independent	Acute	0	0	0	0
		Community	1	2	1	1
		Mental health	0	0	0	0

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 the first part of this 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, incentives to cooperate and compete, impact of HSCA 2012 and 5YFV. In the second part we explore commissioners' actual use of competition and cooperation; and providers' experiences of competition and co-operation..

Data analysis was conducted with the help of the qualitative research software NVivo. DO, ES and PA agreed the main themes derived from the research questions, the literature on competition and cooperation, and additional themes suggested by the data. These themes were subsequently uploaded in NVivo.

We wanted to obtain comprehensive data on services which had been competitively tendered in the four case study sites. Ideally we wanted to find out the type of service tendered, date when it was tendered, the value of the contract, length of the contract and who was the commissioning authority (as some tenders were conducted jointly by several CCGs and others were conducted on behalf of the CCGs on a regional or national basis). Surprisingly, collating even such basic information about tenders in four case study sites was very difficult. There was no single source of data containing such information. This is an interesting finding, as it indicates that there has been no national oversight of the extent of contracting out of services for NHS patients.

In order to obtain this data we consulted a number of data sources – interviews, documents, public procurement databases, and email correspondence with commissioners. The main barriers which we came across whilst trying to compile this data were the incomplete information on procurement database websites (two of which have been archived during the lifetime of this project), poor or non-existent search function on archived websites, lack of information about the outcome of the tender, loss of organisational memory due to staff turnover in the commissioning organisations, structural change in the commissioning organisations resulting in difficulties of tracing who was the commissioning body.

Among other things we searched the Supply2Health website just before it was decommissioned in March 2014, the archived version of the Contracts Finder website which replaced the Supply2Health website (containing contracts advertised between 11th of February 2011 and 25th of February 2015) and 'live' Contracts Finder website. Through triangulation of different data sources we were able to build

an indicative list of services which were put out to tender by the CCGs or their immediate predecessors, which is contained in Table 3 in the relevant section of the results. This list needs to be treated with caution as there may be some services that were put out to tender which we have not been able to find. Equally, we could not ascertain in all cases whether these procurements were concluded or abandoned and who won the tender. As a result, assembling the information on the number of competitive tenders for clinical services issued by local NHS commissioners in the four sites was a piecemeal, time consuming task offering only a partial understanding of the issue.

In order to give a context to the understanding and views of local commissioners and providers, as well as their actual behaviour, 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 October 2015 (see Appendix). The timeline was 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 findings we provide a brief sketch of local health economies in the four case study sites.

Case study sites

CCG1

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

The CCG1 area crossed 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 was one main acute provider which was an NHS Foundation Trust (FT). It provided services from its main hospital site as well as CHS from health centres and general practices in the community.

There were two main CHS providers one of which was the main acute provider and the other – an NHS trust dedicated to CHS. One trust provided CHS to one district of CCG1 and the other provided it to the other two districts. The rationale for the configuration of these two providers was historical from the PCT. The CCG has carried out a CHS review and was considering the need to re-procure the community nursing service. The CCG considered a possibility of putting CHS to open tender but eventually opted for a collaborative service redesign with existing providers working towards an outcome based contract.

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 was meant to 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 focused on transforming planned care, MH services and urgent care.

CCG2

CCG2 was located in the middle of England and crossed 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 were relatively poor, with high levels of deprivation, health inequalities and reduced life expectancy compared with the England average. There were significant numbers of minority ethnic groups within this population who experienced higher health needs.

The governing body papers indicated that the CCG2 was in financial balance. The major health issue for the CCG was transferring care from hospital to the community. A local programme has been running in the CCG's area for some years. This was a collaboration between the local authorities and CCG, acute hospitals, mental health and CHS trusts.

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

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

The main challenge for commissioners in CCG2 at the time of this study was 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 were obliged to contract with large acute providers with considerable market power.

CCG3

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

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

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

The CCG had 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 included outcomes to support the overarching local commissioning strategy. The CCG's ambition was to incentivise collaboration across care settings to achieve its plans.

CCG4

CCG4 was coterminous with a London borough. Its population was generally wealthy and it boasted good health outcomes. The population was served predominantly by the two acute trusts 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 utilised other London hospitals to a smaller extent. The two main acute care providers serving the population of CCG4 have been part of hospital reconfiguration programmes aiming to concentrate services onto fewer sites.

There was one main NHS CHS provider. The CCG was undertaking an evaluation of this provider with a view to re-commission the CHS utilising outcome based commissioning approach.

CCG4 had two MH service providers. The primary care MH services were tendered several years ago. A new provider won the tender and took some of the activity away from an incumbent one. At the time of the fieldwork two providers delivered different types of MH services for the population of CCG4.

The commissioners had 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. The work on BCF services ran 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. Commissioners invited two acute trusts, community care trust and a GP federation to work collaboratively on a proposal for a redesigned outcome based community services.

Commissioners' attitudes towards competition and cooperation

We begin by reporting the views of commissioners concerning the current regulatory structures. The bulk of the data were collected during the first field work period between August 2013 and June 2014. Later in this section we report on commissioners' views since the 5YFV was issued in October 2014.

Commissioners' understanding of current policy in 2013/14

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 CHS. 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 CHS 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.

Commissioners’ views on the 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 accredited 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, 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)

Commissioners noted the lack of clear guidance with regards to whether LES ought to be put out to competition or were exempt from it.

We’ve got three and a half million pounds worth of LESs(...). 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, Aug 2013)

One respondent 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. CCG4 commissioners appeared to be most at ease about using competitive tendering out of all case study sites.

Summary of commissioners' understandings of the rules in 2013/14

Overall, the commissioners agreed that there was 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, given that it is also in a large conurbation.

Commissioners' 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), the Competition and Markets Authority (CMA), the Trust Development Authority (TDA) and the 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), 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)

One commissioner from CCG3 was concerned that Monitor might intervene and put a stop to the “controlled market approach” which 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 CHS. 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 “*what trumps what?*” – greater opening to competition or move to integration of services, both of which seemed to be pursued concurrently as government policies.

Summary of commissioners’ views of regulators

Overall, commissioners in different case study sites differed in the 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. One could discern certain wariness of sector regulators on the 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 national policy and decisions having

unintended consequences and conflicts of interest at local level. They tried to make sense of this situation in their daily practice, but they feared losing control locally.

Commissioners' views on the impact of HSCA 2012

Given that some 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. (The abolition of PCTs and introduction of CCGs and giving considerable commissioning responsibilities to new body NHS England and some to new body Public Health England, as well as some to local authorities, were the main structural changes.) 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 England; 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 CHS 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.

Summary of commissioners’ views on the impact of HSCA 2012

There was little difference between the views in each CCG – they all found the restructuring of commissioning bodies had made commissioning more difficult and fragmented. They were not so sure that the competition provisions of the Act had made a large difference to their day to day commissioning processes.

Commissioners’ views on incentives to cooperate and compete

As the study aimed to find out how commissioners were 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 respectively.

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, understandably, insufficient funding 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)

Summary of commissioners' incentives to compete and cooperate

From the point of view of the commissioners, in times of financial stringency in particular, the incentives on them were in favour of acting collaboratively with their local providers, and they hoped that providers would see the logic in doing so, in order to benefit patients. On the other hand, the lack of money in the system might have the effect of encouraging providers to compete for a larger proportion of the diminishing local resources.

Commissioners' general views on competition and cooperation in 2013/14

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 and inconsistent. 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 competitively to 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 planning¹ 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)

¹ 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>

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)

The other side of the coin was that some commissioners saw the HSCA 2012 rules governing the commissioning system, in particular those which stipulated the use of competitive tendering for procurement of clinical services, as unhelpful and impeding the necessary radical service transformations.

We have a vision, we’re developing our five year strategy with the local health economy, if we are not given the levers to deliver that strategy, the system will fail, it will not realise the savings that have to be made. Too much regulation, too many targets, too much fragmentation, I can only describe the system currently as chaos, chaos. (...) Through the Call to Action², we are going to be responding to say that the regulation has to change, the competition rules have to change and we have got to mega think out of the box (...). At the moment, if nothing changes, we’re set up to fail. (Commissioner 6, CCG1, November 2013)

Summary of commissioners’ general views on competition and cooperation

² Respondent is referring to the NHS England publication “The NHS belongs to the people. A call to action” and associated consultation on the future of the NHS launched in July 2013.

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. Nevertheless, it is notable that the commissioners in one case study site (CCG4) expressed greater enthusiasm for the use of competitive mechanisms than the other three. This site was in the London area, and therefore had access to a larger range of providers. However, it is not clear that the market structure was the cause of the attitudes, as after all, CCG2 was also in a large conurbation.

Commissioners' attitudes in 2015 following the Five Year Forward View (5YFV)

When we returned to interview commissioners in the case study sites in 2015, they had had a chance to consider the early effects of new policies, in particular the 5YFV.

Commissioners noted that the regulatory framework, which had not changed, was inconsistent with the ideas expressed in 5YFV.

We work with Monitor and we work with TDA and everything, but whilst the Five Year [Forward] View says it wants to be like that, but I don't think the rules and regulations that are in place at the moment match that. (Commissioner 1, CCG1, Aug 2015)

This commissioner noted a move away from the choice and competition principles in commissioning. In their opinion, such a turn had not been codified anywhere but rather could be deduced from 'subtle' noises from above, "general word on the street" (Commissioner 1, CCG1, Aug 2015).

From what I hear from what's coming from above, they realise that choice isn't as key anymore (...) It can't be provider driven, because choice and competition is provider driven. And whilst we all want a choice, we all want to go to the best hospital, et cetera, with the lowest waiting times, we can't always afford that as well. I mean, [local independent provider], that's one of our independent sectors, they can churn through activity much quicker than what we can afford to pay. But that's a choice, and we can't stop that because of the choice, and we would never slow down activity, and that's not what I'm saying. It's just there's so many perverse incentives because of the choice and competition and the rules and policies and the regulations that sometimes you can't break and do something different. But I think from what I hear and just general word on the street I think we're moving away from choice and competition. (Commissioner 1, CCG1, Aug 2015)

This was echoed by another senior commissioner re-interviewed in July 2015 who remarked that although the general regulatory framework had not changed since the publication of 5YFV, there had been a subtle change in policy rhetoric which accorded a sense of legitimacy and supremacy to cooperative approaches to commissioning.

I think the big difference, I mean the really big difference, having said all of that, is that there's a very different mood music there. So, um, the headlines aren't different, but, but the kind of background noise is very different. (Commissioner 1, CCG2, July 2015)

In particular in this commissioner's opinion, the 5YFV had created a sense of urgency for the new ways of commissioning which freed the local commissioners from the constraints of the rules on competition.

[5YFV] has created a very strong sense that collaboration is actually much more important than competition. There's lots and lots of rhetorical noise about not allowing competition rules, PBR, the tariff, all those kinds of things, to get in the way of doing the right thing. So we're getting lots and lots of kind of top-down permission to break all the rules if we need to. And whether that's actually true is another matter, but it's indicative of, of the determination, I think, that the centre has for those of us working here not to use the system as an excuse for not getting on and getting stuck into change (Commissioner 1, CCG2, July 2015)

He thought it was possible to work out what was now permissible.

The lines are largely invisible in the sense that they're unspoken, but I have a sense of where they lie. (Commissioner 1, CCG2, July 2015)

On the other hand, the commissioner in CCG1 reported that they were receiving contradictory messages from the regulators. Monitor and the TDA were still advocating competition and income growth for individual providers. NHS England appeared to be more interested in cooperative approaches (as reflected in the 5YFV).

Monitor really push for competition, don't they, so do TDA. They've got quite a loud voice in the system. (...)Monitor is telling us to do this. Well, NHS England are telling us to do this. I said at the last meeting I went to, Monitor and NHS England were there, I said, you two need to talk to each other, because you're saying one thing, you're saying another, and we're in the middle, but then when you come and talk to us as a group you're saying oh, well, we're working together. Well, you're not. (Commissioner 1, CCG1, Aug 2015)

A commissioner from CCG3 also noted a relaxing of the rules about competitive procurement since the first phase of the fieldwork, but did not tie this explicitly to the impact of the 5YFV, and seemed to think the relaxation had started prior to the 5YFV.

I think over the last 12 months, it's almost as an unwritten rule there does seem to be a relaxing of the rules around the need to go to full procurement. If you can demonstrate it's in the best interests of the patient, you can stick with your local patch and it is seen to be almost an unwritten rule, and if you ask me to go and find a document that says this is how you should do, I'd struggle, but it's how everyone seems to be operating now. (Commissioner 1, CCG3, July 2015)

A commissioner praised a new “methodology” of change in the 5YFV permitting the emergence of locally generated service change ideas which could subsequently be translated into a series of “*controlled experiments*” in the ‘Vanguards’ programme (i.e. new organisational configurations under the auspices of the 5YFV) (Commissioner 1, CCG2, July 2015). This was contrasted with the top-down change enforced on commissioners by the HSCA 2012. In the opinion of this interviewee, senior local commissioners were increasingly permitted to use their judgement and “largesse” as to which commissioning mechanisms to adopt. He had to use his “intuition” to work out when it would be permissible to commission services without a formal procurement process. According to him, services falling under the ‘vanguard’ new models of care programme launched by the 5YFV did not need to be competitively procured. Similarly he took the view that service changes under the auspices of the BCF were exempt from competitive procurement.

A commissioner from CCG4 noted that the 5YFV was consistent with the work which was being undertaken locally on outcome based commissioning but that the latter predated the 5YFV (Commissioner 5, CCG4, Sep 2015).

However at the same time there were some limitations on how relaxed one could be about the competition rules. One commissioner (Commissioner 1, CCG2) took the view that the translation of rules and the interpretation of national rhetoric into local circumstances made the job of senior CCG commissioners both tricky and rewarding at the same time. It required astute skills, experience and deep knowledge of the NHS bureaucracy.

Although the CCG2 commissioner welcomed the turn towards collaboration in policy rhetoric and talked about cooperation with providers being a default position in their local commissioning practice for a long time, at the same the participant expressed his concern about doing away with competition and purchaser provider split altogether.

I think there's a massive question mark about the validity of the internal market for health, um, in England. (...) I slightly fear is that we will simply throw it all out. (...) Commissioning is important. And I suspect that people get confused between, you know, no internal market, no need for commissioning. Well, that's wrong, in my opinion. You know, planning, procuring, and performance-managing healthcare is important. And being able to use a range of techniques, including, on occasion, procurement, is helpful. Having a policy that says everything must be procured at all time is unhelpful. And I, I have a slight nervousness that we're gonna go from the kind of pendulum of procure everything to nothing can be procured and we're gonna get rid of commissioning completely. Which is, you know, which would be just as rubbish the other way 'round... (...) there is a tendency for the political process to swing from one extreme to another. So, uh, I, I'll, I'd lived through the one end of it. I suspect I might get the kind of joy of whizzing back along that trajectory and ending up at the other, where no one's allowed to plan anything and you just give all the money to providers and that's the end of it (Commissioner 1, CCG2, July 2015)

And one commissioner actually expressed a personal view in favour of keeping competition as a mechanism of commissioning NHS services.

You've got to have organisations who perhaps wouldn't ordinarily be involved in the delivery of health care or wouldn't be involved in the delivery of health care on that scale, coming into the market and challenging the old guard, if you like, and say, you know what, we can do that better. I come from the private sector, so it's no different to me. It's kind of, you know, what you want is the best organisation delivering the best services, providing you with the best value for money. And that can only happen with an increased level of competition. (Commissioner 2, CCG2, July 2015)

In the opinion of this commissioner the 5YFV was not incompatible with competition as once the successful new models of care emerged in the Vanguard programmes, they could then be rolled out and procured on a competitive basis (Commissioner 2, CCG2, July 2015). Furthermore, the participant advocated that commissioners put more effort into market

development by engaging with potential providers and getting them to a point where “*they would be able to bid*” (Commissioner 2, CCG2, July 2015).

Furthermore a commissioner thought competition would have to be used as a mechanism to move some acute activity into community and to tackle hospital reconfiguration programme because, if it were not, FTs would use the competition rules to challenge commissioners’ decisions.

Unless someone’s going to start giving us ten per cent growth, hospital reconfiguration is going to have to be tackled at some point and that has to be done through some sort of procurement process because (...) they’re such independent organisations, the FTs now, they are going to challenge any sort of decision. (Commissioner 1, CCG3, July 2015).

Another commissioner also saw a future for competition in commissioning clinical services, as none of the aspects of the regulatory structure had been changed. One of the benefits of using competitive approaches was that it forced a better understanding of provider’s activity and costs.

Unless the government changes legislation and unless the European Union changes legislation, I can only see it being competitive. I think actually, if you think about things, you know, the old fashioned traditional block contract, God knows what went into it, a multitude of many things, I am quite a simple creature, I like to see evidence and activity which then translates into monetary value. I think competitive tendering focuses people to actually know what their business is, to know what their business model is, to know what the unit cost is, and how much it’s going to cost, and what they’re going to be delivering over whatever period of time. (Commissioner 2, CCG3, Oct 2015)

In contrast to commissioners from the other sites, one CCG4 commissioner was more inclined to see cooperation as the main mechanism of NHS commissioning for the future. He saw improvements in value for money of NHS services being driven through hierarchical measures (such as the QIPP programme) rather as a result of competitive pressures. Furthermore this commissioner thought that the place for competition in the NHS was limited.

My personal view is that I think there’s much more potential for a cooperative method than a competitive method. I think we have to, having said that, we have to be mindful

of the procurement rules and, you know, legislation. But I do think that, you know, the organizational ethos of the NHS is very much to do the right thing for the patient and if we can engender that within a cooperative model rather than a competitive model, because even when you've gone out on competition and you've procured something, they still have to work with other parts of system. (Commissioner 4, CCG4, Aug 2015).

Summary of commissioners' views on competition after the Five Year Forward View

Commissioners in all case study sites who were re-interviewed in 2015 noted a change in tone of national policy messages towards greater promotion of collaboration in commissioning. This was partly an impact of the 5YFV which legitimised local cooperative initiatives aiming to transform services. It allowed them greater latitude in deciding whether to tender out services or not. However at the same time commissioners pointed out that none of the underlying rules guiding procurement of clinical services had changed as a result of the 5YFV and warned that the rules could not be disregarded completely. Conflicting messages were being sent by the different national bodies, some in favour of cooperation (NHS England) and some still promoting the use of competition (Monitor and the TDA). Most of the re-interviewed commissioners saw a need for competition to remain available to them as a commissioning tool to use at their discretion.

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 in light of them. 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 clear guidance about which aspect was more important. The national regulators were not able to help. 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. However, after the publication of the 5YFV, all the commissioners reported that there was less emphasis at national level on using competition, although the formal regulatory structures had not been changed. It was even less clear what the rules were, but they all seemed inclined to decrease their use of competition as a commissioning mechanism. This increased use of cooperation was thought to be more appropriate when making major service changes locally. But most of the respondents expressed the opinion that it was

still necessary for commissioners to be able to use competitive processes at times, when they judged it necessary.

Although all sites preferred to use collaborative approaches to achieve transformation of services, we found that during the first field work period, 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 a greater number of potential providers (being in London) or due to the personal preferences, experiences and convictions of senior managers and leading GPs. By the time of the second phase of field work, the commissioning personnel at CCG4 had changed. The new staff appeared to be much less enthusiastic about competition, and were advocating the use of cooperative methods to reconfigure local CHS services.

Providers' attitudes towards competition and cooperation

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' understandings of the regulatory landscape surrounding competition and cooperation, and their views about these issues. The bulk of the section deals with the first field work period between August 2013 and June 2014 when most interviews were conducted.

Providers' understanding of current policy in 2013/14

It was important to find out about provider managers' understanding of current competition and other policies, as this would clearly affect their actual behaviour in relation to these issues. 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 confident 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 to do so, 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 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 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 (five) of independent CHS providers. One independent provider manager 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 (despite the fact that he was keen to enter the NHS quasi market).

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)

Many CHS and MH providers reported that there was widespread confusion among commissioners about whether they were obliged to tender all services. One provider manager 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 that their CCGs had informed them that they were obliged to tender out all services.

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 OJEU³ 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, CHS and MH, 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)

A provider manager in CCG4 thought that the policy of 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 mental health CCG4, January 2014)

Summary of providers' understanding of current regulations

Provider managers 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 echoed commissioners' concerns about the vagueness and complexity of the 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,

³ The Official Journal of the European Union.

although one commented that he thought that commissioners had misunderstood the role of the competitive market.

Providers' views on the 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 were also 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 were differing levels of involvement of NHS England Area Teams (ATs) in commissioning in different areas; and there had been a reduction in local discretion over the last five years, with a move towards a more centralist approach.

It was noted that there was variation between commissioners.

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, independent, 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)

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)

The role of the NHS England ATs was reported as being more open to local interpretation, because there was no framework for their 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.

Some provider managers took the view that 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 held 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, independent, community and/or mental health, CCG2, May 2014)

Summary of providers' views on local discretion

Local discretion was seen by several provider managers varying between areas, and some also reported that it had been reduced in recent years, not only as a result of the HSCA 2012, but also by the effects

of growing financial stringency. The approach of ATs to their involvement in commissioning by CCGs also affected local discretion.

Providers' 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:: Monitor; CQC; NHSE through the agency of ATs; the OFT (replaced by the CMA); the TDA; the Prime Minister; and the 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 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 mental health, CCG3, November 2013)

The interaction of different organisations involved in regulation had a damaging impact on the day to day work of 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 CCG2, CCG3 and CCG4 commented on service reconfiguration being held up by disagreements between regulatory bodies. One provider in CCG3 reported that the granting of Foundation Trust status was being delayed because Monitor and the 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:

The Office of Fair Trading 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 CHS 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*”.

Summary of providers’ views of regulators

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.

Providers’ views of the impact of HSCA 2012

The changes to the English NHS in general, including the HSCA 2012, had 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 mechanisms of acute trusts by a form of cost per case payment (i.e. PbR), 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 (although not in fact necessitated by it).

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. Benefits of the HSCA 2012 were seen as being that it created a legal requirement to deliver contracts. 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.

Providers' views on 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.

A provider manager suggested 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 was 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)

Since 2013/14, 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 in order to optimise efficiencies. A number of other factors militated against competitive behaviour in some circumstances: for example, where there were no alternative providers in some areas; and when services were viewed as unprofitable, and therefore not worth bidding for.

On the other hand, the incentives to compete were introduced by cost per case (including PbR) payment mechanisms, coupled with the patient choice agenda which incentivised acute providers (and those in the AQP scheme) to compete for patients in the market. Opening up some services to tender and the transfer of some services from acute to community settings incentivised providers to compete for the market.. 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.

Summary of providers' views on incentives to cooperate and compete

Provider managers could see that there were incentives to cooperate at some times, and to compete at others. The diminishing amount of money available in local health economies both incentivised

cooperation to use local resources in the best way possible for the benefit of patients, and also made providers aware that they needed to ensure their organisations did not lose out.

Providers' general views on competition and cooperation

Provider managers gave us their general views on competition and cooperation in shaping services and the 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 cost per case tariffs in community settings making competition difficult; and the destabilising effect on existing service providers of tendering more profitable services.

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 clearly different ideological preferences for or against market principles by different governments 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 remarked that the balance between competition and cooperation was hard to undertake satisfactorily following the decision of the Competition Commission on Bournemouth and Poole Hospitals proposed merger in favour of competition, rather than merger. 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.

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.

Several provider managers were critical of increasing competition in the NHS for a variety of reasons. One acute provider manager was concerned that tendering out profitable services had adverse effects on other services and that commissioners did not appreciate fully the interdependencies of different services based in a hospital. There could be unintended consequences. One example was given of

contracting a 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)

A CHS provider manager echoed the point 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 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)

As one respondent explained, patient choice was hard to object to, but it could have negative consequences.

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)

A respondent pointed out that increasing competition in the NHS quasi 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 agreed that tendering was not compatible with the 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 CHS provider in the same case study area saw a place for competition in the NHS

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)

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.

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 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. It is unsurprising that independent providers had a more positive attitude to competition than those in the NHS – competition was the main method by which they could enter the NHS quasi market.

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)

Summary of providers' views on competition and cooperation

The findings show that provider managers held a wide range of views on the place of competition within the NHS from highly critical due to the danger of destabilising incumbents 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.

Providers' attitudes following the Five Year Forward View (5YFV)

As explained in the methods section, it proved impossible to re-engage most provider respondents in the second round of field work in 2015. The follow up interview we conducted with one of the providers in 2015 highlighted many important changes in the way providers perceived the rules in respect of competition and cooperation in commissioning of the NHS services at the end of 2015 compared to the earlier period. The interview was conducted with the senior manager at the community trust in CCG4 which was in the middle of collaborative work with other local providers on an outcome based contract to implement CHS redesign.

The interviewee noted that the publication of the 5YFV did not change his understanding of the policies and rules about the use of competition in commissioning. However 5YFV had encouraged and to an extent legitimised innovative, collaborative ways of working. Different providers, and CCG4 CHS trust in

particular, have been increasingly engaging in testing the rules by getting together and working more collaboratively, pushing “*the art of the possible*” (Provider 5, NHS, community and MH, CCG 4 Oct 2015). Such grassroots local developments driven by the genuine pressing concerns over costs and quality of services tended to override strict interpretations of the legal framework that so far remained unchanged.

I think my understanding and the approach I've taken and the legal advice I've taken is that the key thing here is to understand what are we trying to achieve, and we're trying to achieve best value for money and best possible outcomes for patients. So, the best use of taxpayers' money and best possible outcomes for the patients. Therefore, at a simple level what you need to be doing as a commissioner, is to work with your existing providers to deliver that. If you can do that, if you can undertake something which is in the best interests of the patients, and is also in the best interests of the taxpayer, then actually, the boundaries which are, you must go to the market after three years, I think, can be tested and pushed. I think some of that is currently being tested and pushed, (...). My view is I will always justify what we're doing if it's in the best interests of the patients, because going to the market is time consuming, it's complicated, and by and large if you put together a specification and go to the market, you will get a provider that does what you've asked; that might not be what you actually need. And so therefore, for me, it's much better to work in a much more collaborative way with providers to get what is needed rather than what is asked for. (Provider 5, NHS, community and MH, CCG 4 Oct 2015)

I think what [5YFV] has started to do is , actually the art of the possible, is something which should be looked at and this concept of providers coming together to work in different ways, in a much more collaborative way, if it's in the best interests of the patients, then that's being pushed quite heavily. And almost there's a, you know what, that overrides the strict legal framework that we've been trying to work in, because in part the NHS marketplace is like no other marketplace. So, I'm happy, I'd be happy to take a legal challenge on the basis of what we're doing, because I think we're doing it in the best interests of the patients. And I don't want to waste money, going down a contract route or a procurement route when actually I have to spend that money improving healthcare. (Provider 5, NHS, community and MH, CCG 4 Oct 2015)

The interviewee also noted an important role that the CQC and other regulators had played in forcing providers to look inwardly and focus on improving the quality of services they provided. This brought providers' attention back to their core mission rather than being distracted by external circumstances, such participating in the market. The participant concluded that in his personal opinion “*competition will increasingly become the last place we go*” and it will be replaced by working in partnerships. He reiterated the frustration expressed by some other providers in this study about unwritten rules and lack of a level playing field that permeate the NHS quasi-market; and about exemptions from competition that apply to some providers but not the others.

The NHS has a marketplace which has fixed prices and all sorts of nonsensical interventions from politicians and what-have-you. So it's not a market, it's not even a managed market, it's a nonsense. I think that's probably the economic word for it. So, we pick and choose bits of what we say are market, or what is competition, so I think there's going to have to be a major re-think on that. Because if you're going to have a market, then allow the market, within a framework and be very clear of the framework (...). Don't pick and choose bits. If you're not going to do that, then be very clear that it's not a market, it's a centrally managed environment which we are trying to work in a collaborative way or whatever. (Provider 5, NHS, CHS and MH, CCG 4 Oct 2015)

At the same time the interviewee cautioned against falling into another extreme of creating “monster-big”, merged provider organisations which might become complacent monopolists. Instead the interviewee advocated multiple partnerships and network approaches.

I can see no benefit in this drive to, let's merge everything together, you know, greed is good, big is beautiful. I think the partnership approach and working as partners around areas, I think is a much more, I think there's much more fertile ground there. So I can be a partner in [one area of London], and I can be a partner in [another area of London] and that partnership can be completely different. But the partnership approach, I think, gives us a bit more opportunity to be creative. And ultimately if I don't deliver, then my partners will sack me. And that, I think that, you know, that for me is a better way of doing it because that requires seriously mature organisations and seriously good leaders to do that. (Provider 5, NHS, CHS and MH, CCG 4 Oct 2015)

Summary of providers' views

Provider managers 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 NHS 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 provider managers such changes could not be delivered through greater use of competition due to additional costs that accompanied 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. In contrast to the NHS provider

managers, the employees of independent providers we interviewed were much more enthusiastic about competition, as this was their route to market entry.

The NHS provider manager respondent in the follow up interview in 2015 thought that the push to use competition was waning, following the publication of the 5YFV, despite no changes having been made to the regulatory framework. He welcomed the greater opportunities to use cooperative methods to reconfigure services.

Commissioners' experiences of competition and cooperation

As well as gauging commissioners' and providers' understanding and views on competition and cooperation in the NHS quasi market, we investigated what they actually did. This section will report our findings on commissioners' experiences of implementing competitive and cooperative approaches in commissioning. This addresses the research question about how commissioners utilise competition and cooperation in shaping local provision of services and maintaining relationships with providers.

Service reconfiguration challenges

Before discussing how commissioners used the available mechanisms of competition and cooperation locally, it is necessary to understand the main challenges each CCF faced in respect of its local health economy. Then we will report *how* the CCGs approached these challenges.

The four CCGs in our study faced similar service delivery challenges focussed on, on the one hand, ensuring the viability of local acute providers and, on the other hand, on attempts to redesign and increase the provision of health services out of hospital. Responding to a national policy priority, each of the four case study sites had a locally adapted, long-term commissioning strategy of moving services out of hospital into community settings. The strategies envisaged a move away from secondary care centred system to one focused on health care in the community with easy access to primary care; prevention of unplanned hospital admissions, re-admissions and A&E attendances; and facilitation of discharges from hospital into the community.. In some cases this also included moving some acute outpatient activity into the community and closing some outpatient and inpatient services.

The commissioners' overarching strategies also set a goal of achieving greater integration between health and social care services. The latter goal had gained some prominence as a result of the national Better Care Fund (BCF) (initially named 'The integration transformation fund') policy initiative launched at the time of the first phase of the fieldwork in 2013/14 This was defined as "a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities" (LGA and NHSE, 2013). (See the section below for further details of the BCF.) Notwithstanding the continuing salience of integrating health and social care services, the BCF as a policy initiative aiming to address this issue had waned in importance towards the end of our fieldwork, arguably due to the change of focus to the 5YFV from the end of 2014 onwards, and the deteriorating state of NHS finances (HSJ 2015) .

Turning to each CCG, we set out how these issues manifested themselves locally. The commissioners in CCG1 were particularly concerned about the financial sustainability of the main acute provider which was a small foundation trust hospital. There were two historical CHS providers – a combined acute trust and a CHS trust, which were both keen to consolidate provision under one provider. At the time of the

first phase of the fieldwork the commissioners in CCG1 were considering some radical proposals to redesign the CHS, including a move to a prime provider model (under which one provider would hold a contract with the CCG and then subcontract to other providers as needed). This potentially would have included primary care, with all GPs moving to salaried employment (Commissioner 6, CCG1, November 2013). CCG1 was also considering putting all CHS out to competitive tender. CCG1 itself faced a tight financial position.

Local providers, [acute trust], financially on the cusp; I always worry, and I've flagged this up for years, that if something specific happens and they haven't got the capacity to react to it, it's always, oh my God, we need more money; and they're very, very lean. (Commissioner 1, CCG1, May 2014)

There were three core elements to the CCG2 commissioners' long-term strategy – investment in CHS infrastructure, investment in primary care, and reduction of acute hospital sites from two to one new build, and associated reduction of hospital activity. They were pursuing a number of service reconfiguration projects within the remit of their out of hospital services strategy. CCG2 achieved a transfer and split of their CHS into two different organisations – combined acute and community trusts. As part of the BCF, they targeted emergency activity and services offering intermediate care, community nursing and discharge planning all of which relied on close working between health and social care professionals. They also completed a number of closures of specific hospital service departments in anticipation of the move to a new hospital site.

The commissioners in CCG3 focused on integrated care in the community as part of their out of hospital care strategy, in particular strengthening primary care and maternity services. The financial situation of the main acute provider was tight and achieving financial balance would require closing some of the inpatient services.

The [acute trust's] position is tight. That's an inevitable consequence of the tariff deflator and the way the prices have been set over the last two or three years. I think it's just now starting to really pinch providers (...) the [acute trust] can't afford to keep these wards open. They've got to save 40 million pounds over the next three, four years because of the squeeze on the NHS funding, and they know the only way they can do that is shut a ward. (Commissioner 1, CCG3, Aug 2013)

Similarly, the commissioners in the London based CCG4 were preoccupied with efforts to reconfigure the local CHS due to the lack of satisfaction with the main provider, an NHS CHS trust. Two main acute trusts serving the population of CCG4 were part of two different hospital reconfiguration programmes managed at a higher level of NHS hierarchy covering a number of neighbouring CCGs in the London area. The long-term commissioning strategy implied moving some outpatient hospital services into the community and investing in community infrastructure. As part of the BCF, CCG4

focused on the integration of services serving the frail elderly population by working on admission avoidance and early discharge facilitation.

Commissioning mechanisms used to implement service reconfiguration

Commissioning Better Care Fund services

Originally we planned to examine the commissioning of services falling under the auspices of the BCF as a way of understanding how CCGs used competition and cooperation. The BCF was announced in the 2013 Comprehensive Spending Review and aimed to facilitate integration of health and social care services. There was no new funding associated with this policy. Instead, the CCGs and LAs were asked to pool part of the local health and social care budgets and commission services on a joint basis. The CCGs were allowed to choose a focus for the BCF services as long as it stayed within the general aim of improving out of hospital services for people who were the clients of social care and heavy users of the NHS. The CCGs were going to be judged on implementation of BCF by a range of metrics such as reduction of emergency admissions, and reduction of admissions to residential and care homes. Commissioners also had flexibility in deciding how to commission such services, i.e. whether to go down competitive tendering route or not, making it a potentially interesting issue to study for this research project. However, by the end of the second tranche of fieldwork in autumn 2015, it was clear that the importance of the BCF as a policy tool had waned. Recently in autumn 2015, it was announced that the amount of cash that could be pooled as part of the BCF in 2016/17 was to be frozen and the BCF was to remain only one, 'minimum' option amongst others available to commissioners to tackle integration of health and social care (HSJ, 2015).

During the fieldwork we have discovered that in our case study sites hardly any new services were commissioned as a result of the BCF and the exercise mostly consisted of moving budgets for existing services, generating some concerns among NHS commissioners about using health budgets to prop up dwindling LA spending. Furthermore, policy makers' and commissioners' attention turned to implementation of the new care models 'vanguards' programme launched under the 5YFV.

We did find that the four CCGs in the study did not use competitive tendering to commission services under the BCF. Often existing services were simply "*rebadged*" (Commissioner 1, CCG1, May 2014) under the BCF banner. Commissioners were preoccupied with dispelling confusion on part of some providers who assumed that there was a separate budget for BCF services, whereas in fact it constituted a transfer and/or pooling of existing budgets with LAs. Some commissioners were also concerned that health budgets transferred to LAs as part of the BCF were in danger of being used entirely by the LAs to balance their books, as they had suffered very substantial cuts to their funding.

It's existing funding. So [the government] can go on and use it all they like and say this is new funding, it's not, it's just a new way of showing it in your books. (Commissioner 2, CCG1, March 2014)

But what worries me is the expectation of the local authority as well is that they'll just get that [BCF] money and it will just go into their bottom line; and I'm not always convinced that it will and I don't know how it will get shared out: no idea. It's an unknown. (Commissioner 1, CCG1, May 2014)

The transfer and pooling of budgets for the BCF highlighted an issue in some CCGs: namely providers being accustomed to treating certain budget allocations as “theirs” by default.

I think that's the difficulty is that providers think the funding that we get is all theirs, the large providers, and it's not, it's for us as a CCG to commission whatever service is required. (Commissioner 2, CCG1, March 2014)

According to one of the CCG1 commissioners we interviewed, the BCF policy was a lost opportunity to take stock and do things differently. This was because instead of allowing local partners to come up with local solutions, it was seen as heavily top down policy which was also misleadingly communicated. It failed to break the barriers between different provider organisations who continued to fight for “their” chunks of the budget rather than rethink the service delivery system as a whole.

[BCF is] a great idea, poorly implemented. There has to be integration of health and social care at some point, because it is so interlinked. You know, particularly with elderly, it's so interlinked. And, you know, it's an opportunity, it's turning into being a millstone, but it was set up as an opportunity to radically do things different. But I think it's been so poorly communicated nationally to the health and the social care partners, that everyone seems to think it's a...oh, I want a bit of that, and everyone's, oh, that's the only money that's available, I want it. And it's done more harm than it should have good. It should have been an opportunity for us to sit down with councils and say, look, how are we going to do things differently? You've got no money, social care costs are going through the roof, let's understand your system, let's stop this cost shunting around the system. You know, you haven't got any care beds, so they stay in hospital for ages. You know, break those sort of myths, and it just hasn't worked out like that. It's just turned into, oh, I want this, I want that money, I need that money. You know, organisation sovereignty again. (Commissioner 3, CCG1, April 2014)

For CCG2, the additional challenge in implementing the BCF was the fact that the CCG itself spanned two different LAs and each of their BCFs focussed on a slightly different set of priorities – one focusing on admission avoidance services, whilst the other on services for the frail elderly. These created gaps and unequal provision for the population of CCG2 depending on the LA of their residence.

CCG4 followed a cooperative approach in commissioning the BCF services by setting up a special advisory forum for local stakeholders to discuss the BCF implementation issues. Although in theory no commissioning mechanisms were excluded from the outset, in practice no competitive tendering was undertaken to procure BCF services. Instead the commissioners followed a path of cooperative service development with existing providers.

In the interviews, the BCF was viewed as a clearly delineated, ‘stand-alone’ commissioning tasks. However, often it was not clear how this policy initiative fitted with the long-term, overarching local commissioning strategies in each case study site of transforming CHS in health and social care.

Solving local service challenges

More fundamentally than the waning interest in the BCF, the CCGs in each of the case study sites faced a series of local service challenges which have been set out above. In order to tackle these big service reconfiguration challenges the four CCGs were exploring mainly collaborative approaches. Among other things they looked at options to introduce outcome based contracts and replace multiple contracts with one contract under prime or lead provider model. Although such approaches did not exclude the use of competitive processes, in practice the commissioners in the case study sites opted for collaborative service redesign programmes involving all stakeholders. Thus commissioning work on strategic reconfiguration was carried out mostly by commissioners coordinating cooperation between themselves and providers.

Commissioners in all sites were exploring the option of using outcome based commissioning approaches as well as lead provider models for a range of different services. In two sites – CCG4 and CCG1 – the outcome based commissioning approach was used to redesign the provision of CHS. Commissioners hoped that prime provider models and outcome based contracts would remove cost pressures associated with the “*open chequebook*” (Commissioner 3, CCG1, April 2014) pricing structure of AQP and Payment by Results (both of which are forms of cost per case pricing), by moving to capitated budgets. These new organisational models were likely to reduce the amount of local choice available to patients by the formation of larger organisations and the reduction in the number of possible organisations to choose from. (But some commissioners noted that reaching an agreement with providers about a shared outcomes based framework might prove difficult given the difficulty they had already experienced in agreeing CQUINs (i.e. local quality related targets) and other targets (Commissioner 3, CCG1, April 2014).) Although these approaches (outcome based commissioning and lead providers) could have involved competitive tendering, they did not do so in our case study sites.

Instead, providers were encouraged to stop treating themselves as “*little entities*” in a competitive game looking after their own interests and to start to acknowledge that lack of money in the local health system required a change of mentality (as well as more efficient processes).

With the advent of the outcomes based approach to commissioning in some areas, commissioners were also trying to move away from actually designing services and patient pathways, leaving this for providers to sort out amongst themselves. The view was that the primary role of commissioners was agreeing desirable outcomes, taking care of the budgets and monitoring service delivery. It was up to providers to propose exact service delivery solutions using the money that was available. This approach was taken by CCG4.

The urgent need to find savings had been made clear by NHS England in July 2013.

The game-changer is going to be the Call to Action, 30 billion [funding gap]. There's got to be major strategic change of hospital services and delivering care in the community, sustaining people and people sustaining themselves through self-care. We just haven't got the money and we're not going to. (Commissioner 1, CCG4, November 2013)

The way our case study sites went about tackling such challenges was by collaboratively talking with existing providers, gathering intelligence and data needed for service reviews, assessing the performance of services and areas that required change and finally looking for contractual levers to use to deliver the change. Going to an open market was seen as an option of last resort when it came to big service delivery transformations.

We will now explore in more detail how each case study site's commissioners went about major service reconfigurations, showing the large extent to which this was achieved in each area by the use of coordination and cooperation on their part. (However, as we will show in later sections, this does not mean that the commissioners did not use competitive mechanisms at all. But the latter were not used for major service reconfigurations.) Commissioners in CCG1 noted that competitive procurement was not consistent with long-term, whole system thinking. Their priority was to ensure the sustainability of existing providers, whilst at the same time realising that on occasion it was useful to have an option of using competition as a stimulus for the providers to change their practices.

All the new guidance that comes out is you have to take that whole system view as to, if you're taking it off a provider, what would that do to the stability of stuff. But we've never really tested big stuff, we've always done...you know, when was the last time someone really ever tendered something big, a big service? We've always said, that's part B. (...) It's always been work with your local provider, make sure they're sustainable and, you know, the ethos was to look after them. (...) Well, talk to me on another day and I'll say, I'm quite happy to destabilise a provider if that forces the system to do something differently. And actually, is that what may need to happen? Do you need the burning platform...do you need to destabilise an organisation? Do you need to put them in special measures? Do you need to get them to breakpoint that then makes you have the proper conversations about doing things differently? (Commissioner 3, CCG1, April 2014)

Commissioners from CCG1 noted that providers' plans were made on an assumption of continuous income growth which was in fact unsustainable. Providers were urged to begin to reduce costs as income was flat lining. As a result, commissioners were predicting tough years ahead with the CCG facing a potential deficit. Some also saw lack of money as an opportunity to start a real savings programme and system transformation. CCG1 organised a meeting inviting all stakeholders to explain the financial challenges faced by the local health economy. This was an example of establishing a dialogue and attempt to bring all parties on board in a collaborative search for solutions. Commissioners were trying to create a sense of common ownership of the problems faced by CCG1.

Come 2015, things will be very tight, we've been doing our forward planning to 2015, when it's really going to hit, because there's actually going to be no real growth in our finances. We will still be okay, but it will be tight, but that's against a background of a financially unstable main provider. We are very, very lucky in that we have a very, very solid close working relationship with our main provider clinically and managerially and only on Tuesday night, we had a joint event with all our practices, we got 60 GPs there, plus clinicians from [local] Hospital, their chief executive and we went through what their financial position was and what we might have to do in terms of transforming our economy (Commissioner 6, CCG1, November 2013)

CCG1 commissioners were also considering suspending the cost per case PbR pricing framework, as it did not lend itself to service integration and transformation. Commissioners advocated putting all the money into one pot, instead of different providers fighting for ever bigger slice of the budget (Commissioner 6, CCG1, November 2013).

CCG1 approached service change by conducting reviews of services as their contracts came close to expiry. Some services, for instance those provided by some GPs, were formalised into contracts for the first time. During such service reviews an option of putting a particular service to open tender was considered. CCG1 also reviewed the performance of their CHS in a similar manner. Following review and despite some early indications of possible competitive tendering route CCG1 decided not to go out to tender on the CHS contract. In an email to the research team CCG1 sent in September 2015 a commissioner explained that such a decision was reached because *"the two existing providers agreed to work together to implement an outcome based integrated community service covering community nursing, intermediate care, community therapies and palliative care, all services which they were already contracted to provide. Efficiencies realised through joint working have enabled an extension to core hours, inreach into care homes and resilience to out of hours service provision."*

CCG2 commissioners argued that competitive procurement (although part of a commissioners' toolbox) was not suitable for reorganisation of extensive, complex services or long-term service transformation programmes such as reducing two hospital sites to one.

A strategic shift of resources from secondary care to primary care is part of a managed change process over a generation, really. Competitive procurement isn't terrible helpful in that context (Commissioner 1, CCG2, November 2013)

Our strategic direction is defined for us by our partnership approach to [local out of hospital care strategy], so 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)

In the case of politically sensitive decisions about closing major services on one hospital site, CCG2 considered the open procurement route but deemed it unviable and likely to create more chaos rather than offer long-term solutions. They thought it would have the potential to destabilise the existing acute provider, worsening relationships between providers in the area and igniting public opposition.

We've already closed one [XX] department, transferred tens of thousands of procedures into the community; closed 200 beds. We'll close another 200, so 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)

It wouldn't have been appropriate, in my opinion, to have used competitive procurement for individual services lines, or even whole service transformation in place of the partnership arrangements, we wouldn't have got the progress and buy-in, the commitment that we've got. And we wouldn't have got – particularly have got the public engagement, I think (Commissioner 1, CCG2, November 2013)

Had we, for example, in that instance said, "We want to put a tender for a single [XX] service" first of – which is what we wanted, we could've written a specification for it. First of all, if the local hospital hadn't have won it, who would've and how would they have run an [XX] Service in the heart of another hospital? Secondly, it would've pitched several providers into a debate about, you know, what if it had been a private sector partner, could we have carried the public with us on that issue? I doubt it. I guarantee you that issue would've ended up on the Secretary of State's desk, with public outrage and complete confusion. And much worse, we still wouldn't have got the changes we needed for [patients]. (Commissioner 1, CCG2, November 2013)

Despite acknowledging the inappropriateness of open procurement in major transformations, CCG2 successfully used a threat of putting the CHS contract out to tender to push through a service change that they wanted on existing providers. GPs wanted to reorganise community nursing around smaller communities with a named District Nurse serving a small population focused around a GP practice.

Initially providers were not keen on that change as their processes were built around serving much larger areas, but a threat of open procurement from the CCG resulted in the provider accommodating the changes requested by the commissioners.

Once they realised that we were serious about going out to procurement – and this would have been a procurement, you know, that’s potentially a, sort of, £10 million contract over three years, yeah, probably more, actually. So that would have been a big (...) procurement, and the thought of them losing that level of activity and income was sufficient enough for them to come to work with us round the table. And it’s worked out really well (Commissioner 2, CCG2, Feb 2014)

CCG2 has also used decommissioning services as another lever in relationships with providers. This was used mainly for minor services or small providers such as minor surgery in a GP practice or certain nursing homes, except in the case of a large inpatient department which was closed in partnership with acute provider. CCG2 also experimented with suspending PbR rules in order to shrink acute activity and arranged transitional funding to support the decrease of hospital activity. In line with other CCGs in the study, CCG2 commissioners held the view that PbR rules stood in the way of local service transformations.

Overall, CCG2 commissioners cautioned against jeopardising long-term relationships for short-term gains. In one CCG2 commissioner’s opinion, the commissioning mechanism had to be appropriately tailored to a specific task in a “*horses for courses*” manner (Commissioner 1, CCG2, November 2013).

Be very careful about, first of all, about how you commission the service. What things are you prepared to procure and what things do you need to plan? What things need to be delivered in partnership? And so, I think manage the supply chain, think about the long-term relationships, you know, is it more important to save 50 grand this year by getting Virgin to deliver District Nursing Services, or is it better to lose that 50 grand but keep the continuity of nursing in the context of all the other services the local providers deliver, which could give us, you know, millions of pounds worth of QIPP achievement by rationalising the hospital service. (Commissioner 1, CCG2, November 2013)

Similarly the CCG3 commissioners preferred to implement major service changes through cooperative partnerships between commissioners and key local providers. Commissioners were engaged in talks with the main acute provider to agree on a shared understanding of the situation and to instigate change of behaviour.

Unless you take the capacity out you’ve just created extra capacity in the system, and the [local acute trust] know that now. They didn’t before, but they recognise that now. But they’re saying we can’t take that capacity out here unless we’ve got control of the alternative, because the alternatives are the community. The message to the [acute trust] is we need to move ourselves out into the community and stop being this (...) castle with a big wall round the outside. That’s

the behaviour change that we're seeing. (Commissioner 1, CCG3, Aug 2013)

CCG3 opted for a collaborative approach to change their CHS by talking to the main combined acute and CHS providers and asking them to rationalise their CHS provision and reduce duplication, instead of going out to tender.

If you take the [acute trust] and the [community trust] as an example, they both have therapy services, and that's just a ridiculous situation, so what we're saying is look, you should be looking to combine your therapy services into one team. And there are some things that [community trust] provide which the [acute trust] are saying we would be better at providing that and it would allow us to drive through the efficiencies because we'd have control of our destiny, and the negotiations are being held, so we're going to be starting switching between organisations. That's what we're trying to encourage. For us it's a much easier thing to do than do it through a tender, which takes 18 months to get to the same point. (Commissioner 1, CCG3, Aug 2013)

The commissioners in CCG4 relied heavily on planning and collaborative engagement with the stakeholders for the redesign of its CHS. Commissioners stressed the importance of understanding the rationale for changes and only then looking for appropriate commissioning tools to deliver such a change. They had made two attempts at transforming local CHS. Initially commissioners tried to reorganise the CHS trust into the Integrated Care Organisation combining health and social care services. This attempt did not gather sufficient local support and was blocked by the GPs. Following this failure the commissioners instigated a lengthy process of consultation and redesign of CHS aiming for an outcome based contractual model. Commissioners were supported by the external consultants in carrying out this review process. Commissioners invited stakeholders to the process of comprehensive assessment of CHS and appraisal of required changes. After some initial options appraisal, commissioners eventually decided in 2015 that the preferred option was not to put the service out to tender but to invite local GPs, two main acute trusts and the existing CHS provider to form an alliance and to propose a service model. This was not a competitive process but commissioners retained an option of going to an open market in case the chosen providers failed to deliver required changes. At the time of the field work in 2015, the alliance of providers was about to submit a joint proposal containing the service delivery and organisational models for CHS.

As was discussed earlier in this report, commissioners in CCG4 had little sole oversight over hospital reconfiguration programmes that affected its two main acute providers, as these were steered by pan-CCG bodies in London. Two main acute providers participated in the two different acute reconfiguration programmes. Both hospitals, as in other case study sites, faced financial challenges.

The predecessor PCT to CCG4 had instigated and carried out a competitive tender for primary care mental health service. The bulk of work on this tender was carried out prior to the establishment of the

CCG in April 2013. According to commissioners, this led to considerable improvements in the primary mental health service provision. However the follow up interviews conducted in 2015 indicated that CCG4 had scaled back the use of tendering for procuring services to focus resources on the outcome based commissioning (OBC) project in respect of CHS. Following service reviews, most of the small contracts in respect of various aspects of out of hospital services were rolled over with a view to bringing the services they covered within the remit of the OBC at a later date, rather than opening up the services to tender. This also included the contract for the primary mental health service. The CCG decided to roll the contract over with a view to bringing mental health within the scope of the OBC arrangement at a later date.

Fragmentation of commissioning remits

Despite the fact that all of the four CCGs in the study mainly used planning and collaborative approaches to make major service changes, commissioners faced some obstacles in doing so.. The main obstacle mentioned by commissioners was the fragmentation of commissioning remits introduced by the HSCA 2012 which made strategic and operational planning more challenging. CCGs retained overall responsibility for health outcomes of their local population despite losing control over commissioning some public health and other services impacting such outcomes. Following the HSCA 2012 commissioning responsibilities for some services in areas of sexual health, obesity, drug and alcohol or smoking cessation have been handed over to LAs, whilst those for specialist services and primary care were now the responsibility of NHS England. In some cases such fragmentation jeopardised service provision as it created gaps in local services, such as specialist obesity services and sexual health services. Furthermore, allocation of commissioning of GP-led urgent care centres (so called ‘Darzi centres’) to NHS England had an adverse effect on the ability of CCGs to plan their urgent care strategies.

Factors identified by commissioners against using competitive tendering

Despite some challenges associated with cooperative approaches, the general preference for commissioning mechanisms amongst the commissioners in our study was not to tender services if possible. We asked commissioners why they tended not to use competitive tendering as a method of improving services.

Commissioners reported avoiding tendering because of its high costs, including any costs of potential litigation, fear of damaging relationships with local providers, and potential adverse effects on interdependent services.

Firstly, competitive procurement is an expensive thing to do, so there’s a proportionality and the costs associated with competitive procurement can outweigh its benefits if you’re not

careful. It's – and it's also now increasingly subject to litigation, I think, so it can be a very cumbersome time consuming process. Secondly, it can damage longitudinal relationships and my fundamental belief is that healthcare is about people. It's about the interpersonal relationships between organisations, and it strikes me as interesting that the NHS has really embraced competitive procurement at a time when many other industries, particularly those under pressure, are looking towards long-term supplier chain relationships, which competitive procurement doesn't always kind of support. And then, thirdly, I think, it can be inefficient because of interdependencies. So there are some services you can kind of competitively procure as cameos, but there are others where interdependencies with other service provisions, mean that effectively the procurement is either inappropriate or potentially disruptive to other service delivery. And that most of the agenda that I face and that we continue to face is about affecting transformational change and competitive procurement is not a great way, I don't believe, of achieving transformational change. (Commissioner 1, CCG2, November 2013)

Some commissioners assessed the potential impact of tendering a service on the local health economy as a whole and were concerned that tendering might destabilise one of their local providers. (Commissioner 3, CCG1, April 2014).

I suppose the big killer in all the new guidance that comes out is you have to take that whole system view as to, if you're taking it off a provider, what would that do to the stability of stuff. But we've never really tested big stuff, we've always done...you know, when was the last time someone really ever tendered something big, a big service? We've always said, that's part B. (Commissioner 3, CCG1, April 2014)

Furthermore many commissioners noted tendering was a lengthy process and often commissioners could not afford to wait that long to settle urgent issues.

18 months tendering process would just cause chaos in some places, and it might be too late, because the overspends will be racking up. (Commissioner 1, CCG3, Aug 2013)

In addition, some commissioners listed practical reasons preventing the use of tendering. In particular, commissioners from CCG2 noted in order to put a service to tender one needed to understand the costs of that service which were often not easy to ascertain. If the costs of the service were not well understood, then commissioners were unable to make a decision about affordability and effectiveness of competitive procurement route (Commissioner 2, CCG2, December 2013). The lack of clear costings also impacted on providers' ability to judge whether a particular tender was worth bidding for.

Commissioners in CCG3 also pointed out that one of the reasons for not undertaking competitive tendering more frequently was lack of in-house procurement expertise.

The PCT never had the in house procurement expertise, and it never had the access to the CSU type external. It's a bit like the third lane of a motorway, if it's not there you don't use it. I think because we didn't have the in house expertise we never got that far. (Commissioner 1, CCG3, Aug 2013)

Commissioners' reasons for undertaking competitive tendering

Despite many reservations towards tendering, commissioners told us that some circumstances warranted seeking a provider in the open market. Commissioners paid attention to two main criteria when deciding to go out to tender – quality and costs of the services.

As a commissioner respondent pointed out, there was a place for competitive procurement at times.

It's one of the levers to make qualitative improvements, financial improvements and best value decisions for how you have services arranged for patients. And therefore, I'd be an idiot if I did not have procurement or competition as part of the armoury to achieve that. (Commissioner 1, CCG4, Nov 2013)

Quality of care was a crucial factor. CCG2 went out to tender in respect of some services because the service were failing to deliver required outcomes and providers were unresponsive to commissioners' calls for improvements.

We'd worked with the existing provider [of XX Services] to try and improve those services and in the end they wouldn't, actually. Couldn't, wouldn't, I'm not quite sure which still, so we went out to competitive procurement and bought a new service. And that worked reasonably effectively, but in a sense the disconnect with services was already there, so there was nothing much to lose and we got other service benefits that made it worthwhile. (Commissioner 1, CCG2, Nov 2013)

We used competitive procurement for commissioning some [YYY]services, largely because our partnership approach failed to deliver the benefits we wanted and we went out to competitive procurement as a consequence. (Commissioner 1, CCG2, Nov 2013)

But tendering was considered a measure of last resort by commissioners, who used it only if their calls to improve the quality or change the service remained unanswered. Thus a poor quality service did not automatically mean the service would be subject to open procurement, but instead opened the space for a discussion between commissioners and providers.

Sometimes concerns over quality overrode the issue of financial savings. For instance, commissioners from CCG3 chose to use competitive procurement to improve the quality of their one of their CHS despite predicting that it will not deliver savings.

The [XX service] one, which is the one tender/AQP that we are about to kick off, I don't think it will save any significant financial savings. I think it's more of a quality and a pathway issue. So it can be either. Obviously the first priority is savings, but if there's something that was a significant quality issue we would still do that. You've just got to balance your resources in terms of people to do the work. But we're not exclusively driven by savings only. I'd say the weighting was more heavily towards that. (Commissioner 1, CCG3, Aug 2013)

Financial savings were also an important reason for tendering out services, sometimes to reduce the number of places in which they were provided.

I think what happened with the [clinical support service] tender, and I don't know if this has been reflected by other people, is that by, you know, by, sort of, going out to tender on that scale, if you like, is really – was really about saving money more than anything else, you know. It didn't make sense to have a large number [clinical support services] sitting – you know, for Commissioners, across the geographical location all doing the same thing, when the reality is, you could probably do – you could do the same amount of work with two or three [clinical support services] across the patch, and for a, kind of, cost-saving to Commissioners. (Commissioner 2, CCG2, Feb 2014)

Another way of achieving savings was by reducing the budget for the service. For instance, CCG4 wanted to provide a local service from a community hospital site and at the same time achieve a lower out of hospital tariff. It commissioned the relevant service via competitive tendering. The contract was awarded to a specialist acute trust who agreed to provide the service in the community at a lower tariff. CCG4 commissioners were exploring competitive tendering for other out of hospital services if they thought they could achieve better value for money.

In case of services which were very fragmented, tendering them competitively offered an opportunity to make them more coherent, to “tidy up a little” (Commissioner 2, CCG2, Feb 2014). This was the case in respect of two services in CCG2. Due to the legacy of restructuring of commissioning organisations and different organisational boundaries in CCG2, there were three different providers of these services which were working to three slightly different service specifications.

Well, basically, we've got a bit of a fragmented service in the first instance, 'cause we had two providers providing different types of services, and actually though, you know – well, it's three, if you included the [YY] bit, but – so we had three providers doing three different types of service. Whereas if you look at [XX services] across other Commissioners, they would – would happen with one provider. So we went out tender. (Commissioner 2, CCG2, Dec 2013)

In practice there might be multiple reasons for tendering a particular service. CCG4 issued a tender for a primary care mental health service. This was in order to correct some mistakes made by commissioners during the first tendering for this services which resulted in a choice of an unsatisfactory

provider. The second tendering, apart from the need to correct such mistakes, provided opportunity for slight redesign of the service.

Because the previous service which had been won, which was for kind of IAPT Plus services, which had been won by [a private provider], [provider] had decided to leave the market and was not sufficiently responsive or resilient to the requirements locally (...) for example, they'd won the tender without having any strategy for estate, they had nowhere to provide the services. You know, (...), it was (...) a steep learning curve for all of us. And in hindsight we should've challenged that, but we just assumed that they'd got that in their baseline somewhere (...) despite working with the provider it was not possible to turn it round despite the best attempts. And so what happened was (...) that was to be wound up and the staff were to be TUPE'd into the whoever won the new tender. But the new tender took the opportunity to decommission elements of the [community] mental health contract as well. (Commissioner 1, CCG4, Nov 2013)

Some CCGs carried out competitive tendering jointly with other commissioners in order to realise economies of scale. In particular CCG2 was undertaking many of its competitive tenders on a joint basis with other CCGs. For example CCG2 conducted a joint tendering processes with other CCGs in the region for a range of services.

You scale up where there are clear benefits in doing so, so for example, [XX Services], we procured that on behalf of the whole of the [region] against the national framework. So that was, you know, that was a great scale to do it, but it made sense because this is a national market, you know, it's – these organisations, actually some of them are global. You don't really need to reinvent the [XX service] specification, you know, ten times over, even for ten strategic health authorities; one for England is plenty. Actually, Wales joined in as well. The call down framework identified five suitable providers, so it saved an absolute mountain of work around trying to work out who was and wasn't a credible provider and then we went to a procurement against those five providers for a slightly locally amended specification, at the scale of the [region] where, you know, that's the kind of minimum scale at which you get cost effective benefit. So that's absolutely the right thing to do. It worked very well, made a lot of sense. (Commissioner 1, CCG2, November 2013)

One of the costs which could be reduced by joint tendering with other organisations were the costs of involving the relevant commissioning support unit (CSU),

We work our procurement process with the CSU on a token basis, so while there are a few choices, you're usually using two or three tokens for one procurement. That might cost us, you know, sort of, six between us, if you like, or rather – or four between us, so we share that

procurement. So, you know, it's still one procurement (...) and it's on a bigger scale, there's a bigger evaluation to be done. (Commissioner 2, CCG2, Feb 2014)

Not all decisions to go out to tender were taken by local commissioners themselves. In a number of cases such as AQP, and Equitable Access to Primary Medical Care (EAPMC) services procurements commissioners reported that a requirement to procure certain services competitively was enforced top down. For instance, the CCG1 commissioner spoke about 'inheriting' EAPMC procurement from the PCT who instigated it. The CCG1 commissioner noted that in the case of EAPMC the national specification was skewed towards benefiting providers.

I suppose the biggest one was good old Equitable Access. So that was looking at commissioning new primary care services in [locality]. Nationally driven scheme. Bollocks, if you ask me. Inherited a scheme, or inherited a procurement that had been completed that fell over And then looking at the national contract that was provided, there was stuff in there that was so written towards the provider and not the commissioner, it's like, well, why...who are you providing these for? Are you providing this for the private sector to come in and make a nice juicy bit of public sector money, or are you writing it actually to provide a service for the patient and for commissioners? The unfortunate thing of that was, you know, taking some of those juicy things out, commercial providers weren't interested. (Commissioner 3, CCG1, April 2014)

Summary of commissioners' reasons for tendering out services

The reasons commissioners gave for tendering out services were in order to improve quality and/ or value for money of those services. They only used this route when other methods of improvement had not worked. On some occasions, they were forced to do so by other parts of the NHS.

Commissioning services via the Any Qualified Provider (AQP) framework

In some cases local commissioners had little discretion over deciding whether to use competition as a mechanism to commission services. One such case was the implementation of AQP policy which, as explained earlier, mandated commissioners to open up a number of CHS to competition. . It was an example of competition 'in' rather than 'for' the market as once AQP providers were licensed by the local CCG, patients could choose which provider to use. As this was a form of competition in the local market which was mandated, and thus different from discretionary areas where commissioners could decide whether or not to put services out to tender, we investigated commissioners' experiences of the process and results.

There was some variation in the way AQP policy was implemented in the case study sites, and also variation in the extent to which commissioners found this route for procuring services useful... Patients

varied as to the extent they chose independent AQP providers over NHS ones. All the commissioners reported that expenditure on services subject to AQP had increased once AQP was in place.

The services subjected to AQP across the four case study sites were podiatry (in three sites), audiology, and muscular skeletal services (MSK), mainly physiotherapy. The commissioners in CC1 decided to procure of AQP podiatry services because there was insufficient capacity in the incumbent NHS provider. Four providers were accredited: two NHS providers – local community and acute trusts and two independent providers – a social enterprise and a very small scale for profit provider. In the financial year 2014/2015 the CCG spent approximately £230,000 on AQP podiatry. The bulk of this money (about 95%) went to the local NHS CHS trust and about 5% to the NHS acute trust which served a particular geographical section of the CCG's population. The social enterprise registered negligible activity and decided to give notice on provision of the AQP podiatry from 2015/16. At the time of writing, the small for profit provider remained registered as a qualified provider but had not undertaken any NHS funded activity.

The CCG1 commissioners found the process of preparing and assessing AQP podiatry tender overly bureaucratic and time consuming. According to one commissioner the whole process from developing the specification to selecting the providers took about six months. Furthermore the incumbent NHS trust remained by far the biggest AQP podiatry service provider, and there had been no improvement in the service.

The process was unbelievably bureaucratic, the number of people that you had to evaluate against the criteria that was overwhelming really, it was overwhelming and I don't even think...we've got about three providers that met the criteria, but I don't think it's improved, I don't think it's improved the service in any shape or form by doing that and we still don't have a provider that wanted to operate in [a particular locality] and it's all with the politicians and...so it hasn't been helpful, quite frankly, it's too bureaucratic. (Commissioner 6, CCG1, Nov 2013)

Furthermore, the CCG1 commissioners had concerns about the “open chequebook” premise of AQP contracts creating a supply driven demand which made it hardr for commissioners to control costs (Commissioner 3, CCG1, April 2014).

In CCG2 AQP was used to commission services in audiology and podiatry. CCG2 accredited 25 providers for hearing aid services, out of which 17 were NHS organisations. The data provided to us by CCG2 showed that commissioners spent approximately £325,000 on AQP audiology in 2013/14 and this had risen to £410,000 in 2014/15. About 80% of the total spend on AQP audiology went to four independent providers, the bulk of it to two for profit high street chains. The local acute trust was the largest NHS provider of audiology services accounting for about 18% of the total spend. 23 providers for podiatry were also accredited, 14 of which were NHS organisations. In contrast to audiology, the

spend on AQP podiatry was much smaller and oscillated around £50,000 per annum, all of which went to the NHS providers, mostly the local acute trust.

CCG2 commissioners told us that they had reservations about the AQP policy because it was mandated as a prescriptive policy rather than a tool for commissioners to decide to use when they saw fit.

I think it's a mistake to prescribe an approach to commissioning. It's a bit like telling a carpenter you've got to build a house with a hammer and you're not allowed to use a saw, you know, it doesn't make any sense, really. So it's just dogmatic and it's wrong. The fundamental problem with requiring AQP to be used for certain services is that it doesn't always accord with local commissioning strategy and it also creates a demand led approach to commissioning when we're trying to control costs in commissioning (Commissioner 1, CCG2, Nov 2013)

The list of mandated AQP services was described by this commissioner as “*the eclectic mix of kind of things that weren't perceived to really matter*” (Commissioner 1, CCG2, November 2013). Commissioners also had reservations about their inability to control costs of AQP and the creation of “*a non-cash limited priority area*” (Commissioner 1, CCG2, Nov 2013) in respect services that were not a priority.

At the same time CCG2 commissioners argued that AQP might be useful in some cases but the decision ought to be left to local commissioners. In one instance CCG2 decided to adopt the AQP approach because they saw it as the most appropriate commissioning mechanism. Commissioners deemed that a specific health promotion service commissioned on an AQP basis would reach different hard to reach groups and offer a more targeted service. According to commissioners the outcomes of the service improved considerably. However after the transfer of this service to the LA, it was decommissioned as the LA commissioners did not want to continue with “*a non-cash limited contract*” (Commissioner 1, CCG2, November 2013).

We ended up with about 15, 16 suppliers, some of them targeting particular niche groups, like young people in colleges or particular segments of the community from an ethnicity point of view. And we managed for a couple of years consecutively to achieve [the service related] target we'd never got near before, and it saved lives, you know. So, you know, it shows that AQP as a technique can be extremely effective. (Commissioner 1, CCG2, Nov 2013)

Overall, CCG2 commissioners reiterated the importance of a tailored approach to selecting the appropriate commissioning tool for a particular problem.

It's not about saying, “Well, you know, so AQP is better than tendering.” Well, it was in that instance, but for the next thing, it might be exactly the wrong thing to do. You've got to match the commissioning approach to the challenge and the agenda you're trying to achieve and accept that, you know, AQP worked brilliantly for [the specific health promotion service], but

it would be the wrong thing to do for something else, just as tendering worked brilliantly on drugs and alcohol in the end, but, you know, wouldn't have worked so well on some of the other things we've done (Commissioner 1, CCG2, Nov 2013)

The situation of CCG3 differed from other sites as it had decided not to implement the mandated AQP framework for CHS. However, the overall AQP landscape locally was more complex as CCG3 had some experience of using the Any Willing Provider framework, the predecessor of AQP. When some prior contracts had expired (before CCG3 came into being), they were bundled together and re-procured as a single AWP contract on the commissioners' initiative. The procurement process was carried out on a much wider collaborative footprint than CCG3 alone. The end result was that providers that were awarded contracts were allocated to a specific PCT (latterly CCG) to host their contracts on a geographical basis, on behalf of several organisations. At the time of the research CCG3 held the contract for one of the providers and the second contract was held by another CCG (with CCG3 being an associate to the contract).

Although not following a top down mandate of opening up some services to AQP might have been seen as a substantial transgression against national policy at the time, CCG3 commissioners reflected on the demise of this policy:

And [AQP] sort of collapsed and has now disappeared. I was talking about this about two weeks ago, and we all reflected on the fact that it disappeared. It became a bit of a game, because you had to put the three out, and there was a... is it three per PCT or is it three per cluster. We all went ah. Because [neighbouring CCG] have done loads of these AQPs, so we said okay, we've done our three as [neighbouring CCG] have done them. (Commissioner 1, CCG3, Aug 2013)

Finally, CCG4 operated two CHS – Muscular skeletal services (MSK) and podiatry – under the AQP scheme. These services were chosen for AQP procurement from the list of eight priority service lines compiled by the Department of Health because of poor local performance. The CCG also participated in a third AQP service procurement – Continuing Healthcare in Care Homes with Nursing – which was tendered on a pan-London basis.

CCG4 commissioners chose podiatry and MSK for AQP procurement because of poor quality and long waiting times associated with services provided by the incumbent provider – the local CHS trust. According to data provided by the CCG4 there were nine qualified MSK providers and four podiatry providers which registered activity. The local CHS trust and an acute trust were the only NHS providers featuring in the data. The rest were independent sector providers. The local NHS CHS trust was the top provider by volume for both services, but it was followed closely by a number of independent sector competitors. CCG4 was spending around £500,000 per annum on AQP MSK. In 2013/14 about 45% of the money went to the NHS providers (mainly community trust) and 55% to the remaining seven

accredited independent providers. In 2014/15 the share of AQP MSK spend on the NHS providers increased to 50%. The total spend on AQP podiatry was around £480,000 in 2013/14 and £340,000 in 2014/15. The two NHS providers received over 80% of this money in 2013/14 and over 70% in 2014/15.

There was a significant increase in spending on MSK and podiatry services following introduction of AQP for these services compared with previous budgets for those services (overspend of about 60% for MSK and 40% for podiatry). Commissioners underestimated the amount of additional demand the AQP services created.

People can choose, choice, but the control on the volume is impossible, and so therefore I've overspent almost half a million pounds on [MSK and podiatry], compared to what I have previously. (...) We can specify the service we want, but by specifying the gateway or access points to the service, we're not sophisticated enough to know, right, if we allow access at this pain threshold to physio, it will mean total volume for our patient and our population of patients will equal this cost in the year. We've probably set our thresholds so low – oh, and it's virtually open access physio, but our cost is 300 grand – £300,000 over the previous budget and expenditure. So, can I actually financially support choice? (Commissioner 1, CCG4, Nov 2013)

At the time of writing CCG4 commissioners had extended the contracts with all AQP providers. One of the independent providers of the MSK service gave notice due to very low volumes of activity. The commissioners had not yet decided how to align CHS commissioned on the AQP basis with the outcome based contract for CHS that CCG4 was working towards.

Summary of commissioners' experience using AQP

AQP was perceived by many interviewees as a top down, prescribed competition which had to be implemented regardless of local circumstances. However even in the case of mandated AQP policy we found some variation in the way this policy was implemented. Although the AQP policy stipulated subjecting three CHS to AQP procurement in all PCTs (and later CCGs), the implementation of the AQP mandate varied substantially between our four case study sites both in terms of the number and type of services subject to AQP. Some commissioners did find the AQP route useful for specific services where greater flexibility of provision was required. Moreover, the extent to which AQP independent providers were actually used by NHS patients varied between case study sites, and between services. In one site, most of the activity was still provided by the NHS, but this was not the case the others. All the commissioners noted that using AQP increased spending on the services which were included, and that they were not able to control demand, due to the way in which AQP was structured round patient choice.

Services commissioned via competitive tendering

Having discussed the use of procurement to produce competition in the market in the case of AQP above, we now turn to competition for the market, using competitive tendering. During the fieldwork we wanted to obtain comprehensive data on services which had been competitively tendered in the four case study sites. Ideally we wanted to find out the type of service tendered, date when it was tendered, the value of the contract, length of the contract and who was the commissioning authority (as some tenders were conducted jointly by several CCGs and others were conducted on behalf of the CCGs on a regional or national basis). Surprisingly, collating even such basic information about tenders in four case study sites was very difficult, as discussed in the methods section above.

Table 3 contains an indicative list of services which were put out to competitive tender in the four CCGs or their PCT predecessors. Where possible we included information about the date the tender was advertised and the amount of money that was involved. It shows that the services which were put to tender represent mostly primary care, community and diagnostic services.

Table 3. Indicative list of services tendered in the four case study sites (year of tender, value)

CCG1	CCG2	CCG3	CCG4
<p>Arbitration Grading Services for Diabetic Retinal Screening (2009, £110K-£130K)</p> <p>Second Full Disease Grading Services for Diabetic Retinal Screening (2009, £350K-£450K)</p> <p>NHS Primary Care Dental Services (2009, £2.6m)</p> <p>Clinical Pharmacy Support (2009, £500K- £700K per annum)</p> <p>Lymphedema Service (2009, £700K-£900K)</p> <p>Substance Misuse Inpatient Detoxification Service (2009)</p> <p>Independent Sector Treatment Centre (2009)</p> <p>Community Oxygen and Respiratory Support Services (2010)</p> <p>Intermediate Care Beds in a Care Home (2010)</p> <p>AQP Podiatry (2012)</p> <p>Orthodontic Service (2012, £3m)</p> <p>Intermediate Care Tier 2 Service / Intermediate Care Beds in a Care Home (2015)</p> <p>Diabetes service (2015)</p>	<p>AWP Chronic Disease Self-management programme (2009, £200K-£500K)</p> <p>Continuing Healthcare Nursing Home Framework (2010)</p> <p>Urgent Care Transport Service (2010)</p> <p>Breastfeeding peer support service (2011, £150K-£180K)</p> <p>Sexual Assault Referral Centre (2012, £960K)</p> <p>AWP Stop Smoking and Stop Smoking in Pregnancy (2012, £600K-£790K)</p> <p>Pathology laboratory testing services (2012, £1.8m-£2m)</p> <p>AQP Podiatry (2012)</p> <p>AQP Adult hearing (2012)</p> <p>AQP Wheelchairs (2012)</p> <p>Provision of care homes with nursing for Interim and Intermediate Care Beds to cover the Winter Period (2013, up to £500K)</p>	<p>GP-led urgent care centre (2009)</p> <p>Wheelchair Service (2013)</p> <p>Community Ophthalmology Service (2013)</p> <p>Midwifery (2014)</p> <p>AWP Community Endoscopy</p> <p>ISTC Orthopaedic treatment centre</p> <p>Health and Social Care Transport (joint national)</p> <p>Care Home Services (joint regional)</p> <p>Urgent Care Transport (joint national)</p>	<p>Urgent Care Centre (2008, £500K-£2m)</p> <p>GP-Led Health Centre (2009, £3m-£5m)</p> <p>Drug and alcohol inpatient detoxification Tier 4 service (2011, £4.8m)</p> <p>Primary Mental Health Service (2011, £3.3m)</p> <p>Chlamydia Screening Programme (2011, £1.8m-£2.4m)</p> <p>Children and Young People's Integrated Speech and Language Therapy Service (2012, £1.8m)</p> <p>Stop Smoking Service (2012, £1.1m)</p> <p>NHS 111 pilot service (2012, £880K-£1.3m)</p> <p>Clinical Assessment Service – Telephony booking and management</p>

	Palliative and Supportive End of Life Care Beds (2013, £36K) Assisted conception (2013, c. £8.5m) A nationally required new service (2014, £45m-£130m, joint with other CCGs in the region) Termination of pregnancy (2014, £5.3m) End of Life care service Elective care – diagnostics, care and treatment Home Oxygen Service Drug and alcohol services		service (2012, c. £200K) Health Improvement Service (2012, c. £1.2m) AQP MSK (2012) AQP Podiatry (2012) Rehabilitation Support Services (2013) Ophthalmology Phlebotomy
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A wide range of services was tendered and some services, such as patient transport or care homes, were tendered jointly with other CCGs on a regional or national scale. Occasionally, CCGs ventured into tendering larger service lines. This was the case in CCG4 which put their primary MH services out to tender.

Despite offering some indication of the type of services which were competitively procured we were not able to verify the accuracy of this information. Nationally, this constitutes one of the most significant gaps in the study of competition in respect of the NHS. It makes it difficult to compare the frequency of tendering in particular locations and the trends over time.

Commissioners’ experiences of the tendering process

We asked commissioners to tell us about their experiences of tendering out a service, once they had decided on this route. They reported on how they selected providers, as well as complaining about how long and expensive the process was.

Some commissioners stressed the importance of testing the market prior to issuing a formal invitation to tender. It was necessary to ascertain provider interest in order to avoid the situation of having to go through a costly tendering process to end up with the same or a worse quality provider. Hosting provider engagement events was seen not only as a way to gauge provider interest, but also served as a general tool for mobilising existing providers to improve their performance. Effectively such events were hinting at the fact that commissioners had a procurement route at their disposal if incumbent providers failed to deliver. Use of adverts and market engagement events was a warning sign for providers that they ought to take commissioners seriously.

But we just, sort of, put something out there where you – you know, out into the market to say, “Look, we’re interested in doing this, are – you know, and here’s how we think we might do it. Are there any providers out there who would be – who are interested in doing it?” And then we have a look at the – you know, we have a look through the, sort of – how many and who, what kind of providers we get then before we go out and go on the full-scale procurement. So it’s a bit of a toe in the water, really, to see if there’s any interest there in the first place (Commissioner 2, CCG2, Feb 2014)

The decision to procure something in terms of any service, no matter what it might be, does sort of stimulate the market and people then start to look at – to you as an organisation, knowing that, you know, you use – you’re using a procurement route more than you won’t, in terms of delivering services. So you then do build up a sort of – you get to look at – you get to see – they get to see us as an organisation using that mechanism and we get to see providers who we wouldn’t ordinarily see putting in bids for those procurement. (Commissioner 2, CCG2, Dec 2013)

When assessing the bids, commissioners applied a number of criteria to assess the suitability of potential providers. In particular they looked at whether providers were financially sustainable and capable of delivering the service.

Quality, value for money, safety, governance. What else would you look for? Whether the capabilities of whether somebody’s big enough to deliver it, if it’s big? If we’re talking about the community services, if it was are they big enough? Have they got the track record? So have they got expertise in this area? (Commissioner 4, CCG1, April 2014)

You’d have to follow the rules and that’s around them being financially sustainable, you know, all the tick box things, but...in terms of if you went out to tender, you’d have to make sure within your criteria that that organisation was financially sustainable going forward, because you don’t want them, in two years’ time, to go under and then you’re having to redo the whole thing again, but more importantly, your patients are left without a service, but you would be looking at what are the clinical outcomes, basically, elsewhere, you know, where else are they

delivering this service and what are their clinical outcomes? (Commissioner 6, CCG1, Nov 2013)

It varies from the service to service, but essentially, they're going to be some kind of combination of, first of all, a demonstrable ability to deliver the outcomes we're looking for, so it's quality. There's normally something about culture, you know, wrapped up in various ways, so their approach to training, development, quality, reporting, their ethos, their patient relationship, the patient experience, so, you know, you could kind of – it varies from service to service. There's something normally about their track record and their robustness, their reputation. And there would normally be something about people, you know, who they use, how they work, how they train, develop, recruit. And then, finally of course, price, you know, you look at value in a wider sense. It's – it is value actually rather than absolute price. (Commissioner 1, CCG2, Nov 2013)

Interviewed commissioners reflected on the tendering examples where things proceeded smoothly and those that were executed poorly. One commissioner from CCG1 stressed the importance of good project management and the importance of technology to support the tendering process. They pointed out some areas of commissioners' weakness in writing good service specifications, articulating clearly what type of service they wanted and specifying outcomes to be delivered (Commissioner 4, CCG1, April 2014). The tendering process was a big drain on CCGs' resources and some interviewed commissioners pointed out the lack of procurement skills among CCG commissioners.

Good contractors and good procurement people are like rocking horse poo. And if there are any good ones, they're in trusts because they're the people that do more procurements than others. (Commissioner 4, CCG1, April 2014)

Commissioners applied different procedures when assessing potential providers. For instance, CCG2 did not use the interview stage as part of the assessment of bidders' but as an opportunity to clarify the submitted bids. Commissioners felt that such an approach ensured a level playing field between bidders as well as more objective assessments. Any requests for clarifications issued to a provider were also sent to other bidders regardless of whether or not they raised the issue to ensure that all providers were equally informed at all stages of the process.

We only bring people in to interview to clarify things that are already in the ITT. So we'll have – we'll build an evaluation panel, and certainly we did this in-house, 'cause of course we don't now, but when we did it in-house we would always have a patient rep or, you know, someone from the public involved in that evaluation panel. So they would go off. They would score them against the criteria individually. We would then get together and have a modifying session, you know, to make sure that we're not miles apart, in terms of that. And then we'll come up with a – we'll have a score for each, then. If they – if we're still unclear about things then,

we'd then have an interview process where we'd invite the bidders to come in and clarify. And I think that's the important thing. It's not about, you know, it's not about them scoring additional points because they have – they give a great interview. It's about clarifying what they've written in their invitation to tender. (Commissioner 2, CCG2, Dec 2013)

Commissioners from CCG4 stated that they would have made more use of competitive tendering to procure services but felt constrained by the lack of resources to run such processes. One commissioner noted that one would need “*a whole army of people*” to use competitive procurement on a large scale (Commissioner 3, CCG4, May 2014). Such an approach was not feasible in a small organisation such as a CCG4.

I would be more aggressive and probably more prone to tendering if I had more resource devoted to it and I would be moving resource from serious redesign or basic commissioning function into procuring and doing things in a more structured market interventionist way. (Commissioner 1, CCG4, Nov 2013)

Procuring services via competitive tendering on a collaborative basis with other CCGs had additional complications of having to agree a common approach between commissioners. They also however reaped greater rewards of being able to realise economies of scale both in terms of reducing transaction costs and in terms of extracting value for money from the service providers. Among our case study sites, CCG2 was pursuing competitive procurement on a collaborative basis most actively. Although acknowledging additional complexities of joint procurements, CCG2 commissioners noted that such issues were mitigated by the long history of collaboration between commissioners in the region.

Almost all the procurements we do or any of the commissioning we do..., without exception, actually, every single element of it is in partnership with somebody, often quite complex partnerships that span dozens (...) of organisations, dozens of separate governances, so... (...) I regularly commission services for up to 22 CCGs. (Commissioner 1, CCG2, July 2015)

Commissioners raised the issue of the external support they receive for running procurement processes. Prior to establishment of Commissioning Support Units (CSUs) procurement processes were run in-house by PCTs. Following the restructuring of commissioning all four case study sites bought their procurement services from their CSUs. Interviewed commissioners had mixed reviews of commissioning support offered by the CSUs. Some interviewees agreed in principle with the need for an organisation such as a CSU in the HSCA 2012 commissioning system. This is because having commissioning support allowed the CCGs an opportunity to focus on strategic and creative planning of the local health economy and understanding the needs of population rather than committing all CCG resources on operational, administrative and other back office functions.

They do a lot of the clinical governance stuff for us, so they pick up things like serious incident reporting. (...) I'd like to see that model succeed because otherwise I think that we'll just become a PCT again and everything...if we brought everything back in-house then we might as well have not bothered with the whole restructure. And the whole point for me of this was for us as commissioners to truly understand that our local community and understand what the needs of that community were, but not to have to be so hung up on the back office stuff that we can't actually drive that innovation and transformation that I think we need to do to move us forward. So I'd like...would want to see the CSU model work and that we don't bring lots and lots of things back in-house. (Commissioner 4, CCG1, April 2014)

Yet other interviewees noted that the actual support on offer was inadequate and talked about strained relationships between them and their CSUs. The CCG1 commissioner mentioned that the CSU offered poor value for money (Commissioner 3, CCG1, April 2014). Commissioners complained about the lack of information from their CSU about service usage patterns required for stratification tasks and commissioning decisions. At the same time by having little in-house resources CCGs had little choice but to rely on help provided by their CSUs without being able to exercise control over it.

Crazy design of the system, everybody who was aligned to a CCG, the priority was getting your CCG authorised. (...) [CSU] was being set up, and actually we should have co-created that. But at the time, the area team...well, not the area teams, the cluster, the PCT told us not to, they were going to set it up. How is that co-operation and working together? So, you know, relationships aren't very good. Pricing is finger in the air, you know. And I think our CFOs, particularly a number of us, have got good experience of the system and we know how it works (Commissioner 3, CCG1, April 2014)

Some commissioners reflected that LAs might be best placed as providers of procurement support as they had a lot more experience in this area than CSUs.

Some commissioners noted how time consuming and expensive tendering was. The CCG4 commissioner reflected on the high costs of the primary care mental health service procurement. The process took 18 months to complete and cost around £250,000 spent on salaries and legal advice. These costs were necessary to ensure the procurement process was robust and able to withstand a prospect of a legal challenge from the incumbent provider.

We did it in-house led by the Commissioning Manager for Mental Health, but we had two Project Managers, you know, it wasn't cheap to do this. And in total, we probably – I think we spent a quarter of a million pounds doing the specification, the involvement and then the procurement. You know, most of it was on salaries for the Project Managers and legal cost in terms of getting expert advice from [legal firm], to make sure we ran the process. You've got to get it right, because you could be challenged. [The incumbent provider] tried to challenge

us and we had to send them all the documentation. No doubt their lawyers went through it, and they couldn't find anything with which to challenge us, and so I was delighted in terms of it withstood a test. So we did get it right by running that process. (Commissioner 1, CCG4, Nov 2013)

Competitive procurement is an expensive thing to do, so there's a proportionality and the costs associated with competitive procurement can outweigh its benefits if you're not careful. (Commissioner 1, CCG2, Nov 2013)

Summary of commissioners' experiences of tendering

Having decided to procure a service via competitive tendering, all commissioners had criteria to select the winning provider, which included quality of outcomes attainable and financial sustainability of the provider. But most commissioners found that this was a long, cumbersome and resource consuming process. The whole process from engaging the market, preparing specifications and invitations to tender, assessing bids to awarding contract could take 18 months or more. Moreover, the lack of resources in the CCGs forced them to use their local Commissioning Support Units (CSUs), which did not always provide a high quality service. Some commissioners (CCG 4) noted that the lack of commissioning capacity limited the number of procurements to fewer than they would have liked to carry out.

Commissioners' views on the effects of tendering services

Measuring the effects of using competition on the performance of providers was outside the scope of this study. The aim of the study was to gauge how and why decisions to use competitive or cooperative approaches were used by the CCG commissioners. Nevertheless our interviews with commissioners allow us to report their views about whether resorting to competition had any effect on service quality.

In some cases, as in AQP discussion above, the use of competition did not solve all problems with service delivery, in others it did seem to improve access to services but increased costs

Commissioners reflected on the impact of tendering in terms of costs and quality of services. Commissioners from CCG4 mentioned positive effects of tendering primary care MH services on service performance. Yet these alleged improvements came at a cost of an 18 months tendering process and required additional investment in the service.

If you think it's 18 months in, but what we have got is an experience that previously waiting times; six, seven, eight months for Primary Mental Health. So IAPT service, you know, awful. It's now two weeks. And actually, the experience of having a new provider, it's introduced a new – and

*to our specification it's introduced a better service. Patients, the feedback from patients is excellent. But we did invest probably £700,000 more, but the actual model of care or we are the best performing CCG for IAPT [in the region]. We're – because it was a priority. The service before was s***t. (Commissioner 1, CCG4, Nov 2013)*

There was... a really strong case for change with – the incumbent provider just wasn't delivering and we didn't see the potential for it to deliver. There was a lot of dissatisfaction, so the case for change was very strong. But we also really threw a lot of resources at it to do it. You know, that was a major procurement activity that took up a lot of resources and that is one of the key factors. But there was a very strong case for change and I think the commissioning model that was chosen, the procurement model, was the right model for that particular service. (Commissioner 3, CCG4, May 2014)

According to commissioners, tendering MH services had also some positive spill over effects on the performance of other providers in the system. Presence of competition motivated and mobilised other providers to improve their offer.

They [new MH provider] are more responsive. It's very easy to get a patient seen. You very easily can get people into talking therapies. And in fact, it's also improved the responsiveness of the [community mental health teams] because they also have had to recognise that the world is not theirs anymore. (Commissioner 2, CCG4, Feb 2014)

The tendering was not always associated with investment in services. In fact, the opposite was often the case as commissioners used the opportunity of putting services to the open market to reduce the budget for services. For instance, CCG4 managed to negotiate a lower tariff for the ophthalmology service in the community.

The other reason why they were selected we have community-based, but the tariff we pay is the base tariff, minus market forces factor. So you get round the national tariff, PbR rates, through some local agreement. (...) Lower tariff. It's about 23% lower than what you'd otherwise pay. (Commissioner 1, CCG4, Nov 2013)

It is important to note that these were commissioners' assessments of the effects of using competition on costs and quality and they were not independently verified. One CCG4 commissioner remarked that in their opinion competitive tendering did not create any tangible benefits and it ought to be viewed merely as a procedure used to commission certain services rather than a factor responsible for any potential improvements (Commissioner 3, CCG4, May 2014).

Relationships with independent providers

As part of our enquiry into how commissioners were using competition in the NHS, we investigated whether CCGs had a strategy to develop the market for non-NHS independent providers. This is an interesting question because it indicates the extent to which commissioners saw competition as a method of increasing diversity of supply. None of the sites had a deliberate strategy to enable greater involvement by for profit providers in the provision of services. Instead, they appeared as contractors to the NHS on an ad hoc basis. Attitudes to for profit providers varied between commissioners. One CCG (CCG4) was more enthusiastic about their entry into the NHS quasi market than the others

On the other hand, all of the CCGs were actively engaged in supporting local third sector organisations. In CCC1 independent providers were delivering a range of specialist services such as specialist mental health, termination of pregnancy, elective treatment centres and diagnostics centres. There was a number of non-NHS providers in the area but this accumulation was not a result of any conscious strategy to open up the market by CCG1 commissioners.

I think private providers have just cropped up with the advent of payment by results, you know, they've cropped up. (...) I don't think we've ever managed the market or brought them to the table to help design it and say, hold on a sec, they're really struggling, is there...no, we don't do that, no. We should do and I'd love to have time to do it. But we do inherently, oh, they're not NHS. And I'm not precious about the NHS as long as it delivers what we're set up to do. (Commissioner 3, CCG1, April 2014)

Another commissioner emphasised the need to support local NHS providers as ensuring their sustainability was a priority rather than developing the market for independent providers.

I don't think there is [a strategy to develop the market] at this moment in time if I'm being really honest. I think we'd want to support our NHS providers and local authority providers in the first instance. I'm not sure that we'd rule it out completely because I suspect if it was a service that may be that you didn't have an NHS provider that could do it then you might have to look down that route, but I don't think it would be something that we'd think to develop at this stage, I think we'd want to support our current providers wherever possible (Commissioner 4, CCG1, April 2014)

In CCG2 independent sector provision was unevenly developed with most services concentrated around continuing and residential care in the care homes. There were two for profit providers operating walk-in centres. One commissioner remarked that most of the primary care was delivered by 'private' sector GPs and thus definition of what is 'private' in the NHS remained ambiguous. CCG2 had tried to develop a market in respect of end of life care, in particular due to the lack of local hospice care, but this was not successful because the local independent providers would not engage. Commissioners used

independent sector for profit providers on an ad hoc basis around specific issues but no one was engaging in systematic scanning of the market for for profit services.

We've used the independent sector to develop services that are substitutional for secondary care, or to outplace secondary care services and some dermatology services. We've used them equally for some aspects of what's traditionally been community provision. So it – I don't think we've got a – we take it on a kind of an issues problem solving exceptional basis. So it's case by case. I don't think we have a – there isn't a kind of an overarching policy imperative to either grow or restrict the private sector. We use it where it's relevant, I think, is what I would say (Commissioner 1, CCG2, Nov 2013)

In contrast to the lack of engagement with the for profit sector, all the case study sites had a deliberate strategy of engagement with third sector not for profit providers. The CCGs invested in creating platforms or umbrella organisations to support local third sector services. In particular CCG1 was actively pursuing a strategy of engagement with third sector organisations and tried to use them as a resource. Similarly, CCG2 had a deliberate strategy of developing the third sector's capacity. They commissioned a desktop database for GPs with information on what services were available in the local voluntary sector, which was continuously updated. The deliberate policy of engagement with the third sector might have resulted from the need to fill the gap in service provision left by the LA funding cuts.

The relationships with third sector organisations were not without challenges as commissioners noted that voluntary organisations had been given grant based funding in the past and were not familiar with the idea of ongoing reporting and contract monitoring, therefore resulting in a clash of organisational cultures.

In some cases, instead of encouraging for profit providers, some CCGs were rather wary of their activities. At the time of the fieldwork CCG1 was in dispute with one particular for profit maternity care provider which began to offer its services to the local population. Commissioners were concerned that this particular provider was using loopholes in the system to get into the local market by charging the commissioners for the services they provided through the so called 'non-contracted activity' route. Commissioners were worried that the presence of an alternative maternity care provider might undermine the viability of the local acute trust and they also had some concerns about the quality of the care provided by the for profit organisation.

We have had a private maternity provider just come into our patch and started taking women on their books for antenatal, perinatal and postnatal care, we haven't commissioned that service, but they are offering that service to women actively through Facebook, Twitter. They are registered with the CQC in the [another CCG] and they feel that they can come and just offer a service to our women through non contracted activity, so we don't have to have a contract with them. There are no acute pathways with secondary care, so if anything goes wrong with the

woman, the woman has to go into [local acute] hospital, there are no pathways, they have no records, anything, but they say they can just do that and have invoiced us for 25 women, which we have not paid for, because that is actually admitting, that, yes, we've got a contract and we agree with what they're doing (Commissioner 6, CCG1, Nov 2013)

Commissioners were in contact with Monitor and CQC to try to clarify their position but felt that they were not getting clear advice.

We've informed the CQC, this has been going on now for five months, we informed the CQC about our concerns with quality [of the private provider maternity service], the CQC wrote back to us and said, this is fine, this is fine, because they've got a contract with [another CCG]. It is now with Monitor, they have complained to Monitor, this company, Monitor have written to us and said, we are breaking the competition laws, they feel, and that they're probably going to investigate us (Commissioner 6, CCG1, Nov 2013)

I think Monitor over the whole thing have been very wishy-washy, I'm not sure they've given us the guidance that we needed as an organisation in terms of letting us know really exactly what we can and can't do. I think we're now at a stage where we're fairly clear but so long as the GP doesn't refer to that service then we don't have to pay for it because it is a non-commissioned activity. (Commissioner 4, CCG1, April 2014)

CCG1 commissioners stressed that they had good relationships with other for profit providers with whom they held contracts and did not treat them differently to NHS providers. As an example of efforts to maintain a level playing field for independent providers, commissioners talked about their meeting with one local private provider in order to keep them informed about internal NHS restructuring.

We met with [a private provider] and tried to explain what was happening to keep them in the loop; because if you're not in the NHS and you don't get all the guidance coming through and you don't get this that and the other you're absolutely stuffed, aren't you, you're about six paces behind the others, and then it's not fair, then you get the unfairness that acute can just come in and sweep in and just do it because they know what's going on and we communicate (Commissioner 1, CCG1, May 2014)

Similarly, commissioners from CCG4 stressed that they were treating all providers in the same way and had no ideological preferences for one or the other type of provider.

I don't think we particularly favour any one over the other. We have a very active voluntary sector in [CCG4] and we've just commissioned a new model of commissioning for the voluntary sector in [CCG4], which has been –I think it's been a success, but was tough. And I mean, I don't have a view on whether it's a provider – a private provider or an NHS provider or a voluntary sector provider. It's –I'm not of a mind either way to promote any of those. I just

want the best for the patients. (...) I don't have a philosophical problem with whoever the provider is, I've worked with all sorts of providers, I don't have a problem with what their form or basis is or, you know, whatever, for me it is just – 'cause this is taxpayers' money, so we just have to get the best value for money and quality for taxpayers' money (Commissioner 3, CCG4, May 2014)

One CCG1 commissioner admired the private sector's apparent efficiency in running elective services and contrasted it with NHS inefficiencies.

How can a private sector hospital do almost production line operations? Do you know what I mean? The consultant will go in, they're fairly slick organisations, they're clean, they're professional. You go in, you're not waiting around, you know what time you're going to be seen to, you turn up, you're seen when you're supposed to be seen. And they'll do X amount of operations in a day. They'll just bang, bang, bang, bang. That's efficient, considering they're doing it on an NHS tariff as well. So they're making money out of it, aren't they? (...) I don't think NHS does, it'll just...I think they book things in, it's when theatres are available. There's no lean thinking mentality and they haven't learnt from that. And actually, is that where competition comes in, they can do 27 arthroscopies a week, you're doing 14. And actually, with that, do I go to them and say, well, can I pay you X rather than Y, and push efficiencies out of price and quality then? And should the NHS be more production line rather than what it is now of, you know, ringing up to see if you've got a bed, getting there at God knows what time of the day, sitting around 'til your surgery. You know, they're all inefficiencies that we've never taken out of the system because that's what you do. You turn up, you sit and wait. (Commissioner 3, CCG1, April 2014)

Another commissioner from CCG1 observed that the quality of relationships between commissioners and providers was determined by the personalities, not the sectors – independent or NHS.

It's sometimes just down to personalities and relationships, and that's as simple as it is, and you'll never get away from that. (Commissioner 5, CCG1, April 2014)

Summary of commissioners' relationships with independent providers

None of the commissioners had strategies to increase participation of for profit providers in their local health economies, but all were actively engaged in encouraging and supporting the third sector. Some commissioners were at pains to point out that they were careful to treat all providers equally, irrespective of whether they were NHS or not. And an interviewee in CCG4 (which was generally more in favour of competition) stated that he had no ideological preference between NHS and independent providers. And another expressed admiration for the greater efficiency of for profit treatment centres.

Commissioners' experiences following The Five Year Forward View (5YFV)

As discussed earlier, the 5YFV of October 2014 emphasised the need for NHS organisations to cooperate with each other, and did not appear to favour the use of competition as a mechanism to improve services. (Competition was not mentioned in the document).

When we went back into the field in 2015, we were interested to investigate what effect the 5YFV had had on commissioners' experiences of using competition and/or cooperation. Some sites had already begun experimenting with collaborative working between providers before the 5YFV was published.

We were starting to do that. We saw that. We'd done a lot of work as a pioneer group. We were part of a pioneer project who started looking at how patients do ping around the system. There's not a seamless move from acute to community and outpatients. (...) So we'd actually started doing that and then the Five Year [Forward] View came out and it was oh yeah, right, okay, this is where everybody needs to be going. So it sort of has took more pace I would say. (Commissioner 1, CCG1, Aug 2015)

But it was not the case that commissioners had abandoned the use of competition entirely. CCG1 commissioners were still planning to use competition in the future to commission some services which were under review

Obviously we'll be going out for the [XXX service]. That'll be soon. We'll be going out for a very mini tender for the new models of complex care. We could be starting at looking at enhanced primary care, and that might go out to competition. (Commissioner 1, CCG1, Aug 2015)

Competition was being used alongside work on various projects to integrate services. However the problem was how to integrate different integration work streams under one strategy.

You've got to understand how many bids there are going on, and that's the confusing thing. We're a pioneer. [Acute trust] are a vanguard for the care homes. I believe they've got a bid in as well with a group of other providers around something else, and there's so many things going off at the moment it's hard to keep a track. (Commissioner 1, CCG1, Aug 2015)

What they've done is just chuck loads of stuff out there just to see what works. But then are you putting more... Like with the vanguard thing at [local acute trust], how does that link in with what we're doing? (Commissioner 1, CCG1, Aug 2015)

On the other hand, competition in the market was not popular with commissioners, due to their incapacity to limit spending in respect of it. As part of its efforts to save money, CCG1 was considering moving away from AQP altogether, as well as other forms of activity driven contracts, towards the use of capitated budgets. The latter would be cash limited. The scarcity of money in the NHS also fed a

concern about using for profit providers. Clearly, in the case of for profits, surpluses would be distributed to shareholders and not reinvested in the NHS.

Another problem in relation to sustaining contracting, monitoring and procurement functions was noted by one commissioner, whose CSU had not achieved accreditation under the mandatory national framework for procuring commissioning support services.

I think the problem is we're small and finite funding, but we've still got to do the same level of work and reporting and we've got issues with our CSU because it wasn't given its mandate to carry on, (...) it wasn't deemed fit for purpose. (Commissioner 2, CCG1, Aug 2015)

Similar to the other sites, when we interviewed in 2015, the commissioners in CCG2 had been turning their attention to the new models of care programme under the 5YFV. It was a site of a vanguard project. According to the commissioner, none of the vanguards that he worked with had been “procured” competitively (Commissioner 1, CCG2, July 2015).

I've now got a vanguard provider with whom I can invest and develop services without having to go through formal procurement, knowing that if anyone comes in and challenges that on the basis of contestability, I've got a defence, which is, well, it's a vanguard. It's a national pilot and... And therefore I'm not unduly worried. So, um, can I award the vanguard a new contract for delivering an expanded range of primary care services? Absolutely, I can. In fact, I'm being expected to. (...) the vanguard is a new provider essentially entering the marketplace. But I will be able, and in fact I'm expected to award the vanguard financial support and service contracts, um, as part of the national vanguard pilot process. (Commissioner 1, CCG2, July 2015)

In addition to being a vanguard site, at the time of the follow up interview CCG2 was implementing a much wider local programme of service reconfiguration. Although commissioners from CCG2 had extensive experience of using competitive tendering to procure services in the past, the follow up interview indicated a shift away from relying on this mechanism to using it only if “legally required to”.

I would almost never choose [competitive procurement]. (...) If I can find a way around it, to use preferred provider networks or to use service development, I probably would. Most of my life now is spent, (...) I spend a proportion of my time on very large set piece formal procurements. And I spend quite a lot of my time trying to find ways to avoid getting truly into large, full-scale set piece procurements. (Commissioner 1, CCG2, July 2015)

Interviewed in 2015 the CCG2 commissioner stated that collaboration was their default approach, “a kind of way of life” which was “punctuated by odd moments where I have to formalise things... on

occasion into contractual or permanent or competitive relationships” (Commissioner 1, CCG2, July 2015).

The commissioner actively encouraged providers to collaborate with each other to avoid provider failure.

One of the things that I did as a commissioner was, I sat down with all my providers, eight months ago, nine months ago, and said, I've done some maths guys, and you're all gonna end up putting each other out of business if you're not careful. If I look ahead, at all of the things that could potentially be procured, and your assumptions about what you need to do to remain viable, you are all winning at each other's expense. It, you can't all succeed. So there's a problem. I don't want any of you to fail in an uncontrolled way 'cause that just gives me a colossal problem. So what are you gonna do about it? You know, do you want me to commission you differently? Do you wanna start to collaborate with one another anyway? What, what do you wanna do? And we, so we brokered some conversation. (Commissioner 1, CCG2, July 2015).

The participant welcomed a recent initiative to encourage closer collaboration between acute trusts in the region and also offered to commission certain services via route of co-commissioning with providers rather than traditional procurement. The commissioner noted that the current fiscal environment left providers with no option but “*to share and play nicely*” (Commissioner 1, CCG2, July 2015).

Despite preferring collaborative approaches, at the time of the follow up interviews CCG2 was involved in a number of long-standing and large procurement processes which were being carried out jointly with other CCGs in the area. Since the first phase of interviews had been conducted in 2013/14, CCG2 had also carried out a number of smaller competitive procurements by themselves.

Our outpatient modernisation program is looking at well, how do we get those [outpatient services]. And we'll... we'll commission those through procurement. Because outpatients ... outpatient services is definitely one of those where there will be a market. (...) that will give the hospital a problem. (...) If they don't win. But we think the absolutely right thing to do is to do... is to do a procurement on them on [the competitive] basis. (Commissioner 2, CCG2, July 2015)

CCG3, which had been the most collaborative of the sites in 2013/14, continued to pursue collaborative engagement with their providers in 2015. It decided to work with existing providers on some of the service transformation initiatives, involving multiple local providers rather than to procure those services in the market. A local agreement had been reached that the acute provider was to take the lead and coordinate the other providers (Commissioner 1, CCG3, July 2015). The acute provider effectively

had taken the initiative in coordinating a range of services in the community in order to reduce delayed discharges of care. This collaborative strategy was perceived as somewhat risky by another commissioner who newly joined the CCG3.

So we as a system agreed that it was [the local acute provider] would be best to lead on [XX service]. [The local CHS trust] weren't quite as convinced but they're comfortable with it. When you talk to other people, the interim [commissioner] who's covering my post, she's worked a lot in London, when we explained this to her she was horrified. She said competition, you'll get challenged. It's [locality], nobody even knows we're here! (Commissioner 1, CCG3, July 2015)

At the same time, by 2015 even CCG3 had also been using a full procurement route for commissioning some of the services which experienced “poor quality, poor outcomes” issues (Commissioner 1, CCG3, July 2015) or in order to increase patient choice.

It was the first time we've ever done this within [CCG3 area], a full procurement. So it went out to tender and a preferred provider was appointed, not [the local acute provider], although to be fair to [the local acute provider], they've now come to the table and are working with the new provider, but as a result of that, we have created a much better service for the patients because it's more locally focused. It's not hospital focused. (Commissioner 1, CCG3, July 2015)

The CCG3 commissioner had found the competitive approach useful in this case as it injected new ideas into “very conservative” local landscape. (Commissioner 1, CCG3, July 2015). Another CCG3 commissioner did not exclude the possibility of competitive tendering being utilised in future commissioning (Commissioner 2, CCG3, Oct 2015). CCG3, similar to other case study sites, were turning to their CSUs for expert, up to date procurement advice to make sure that they were not falling foul of the complex rules in specific cases.

On the other hand, interviews conducted in the follow up phase in 2015 suggest that CCG4 had dedicated all its resources to pursuing an outcome based commissioning model for its CHS.

We have an outcomes based commissioning project with a group of four providers, we've established that group. We went through a process approved by Monitor to determine who, who they should be. (Commissioner 4, CCG4, Aug 2015)

CCG4 did not use a competitive process in order to select the main providers for the outcome based CHS contract. Instead they followed a transparent process with clear criteria for selection. The process did not preclude other providers joining in at a later stage in some other capacity, for example, as subcontractors to the main providers. The commissioner summarised the process for re-commissioning CHS as “collaborative” (Commissioner 4, CCG4, Aug 2015).

It's a cooperative process, not a competitive process, yes. I mean we always, we always have the possibility to revert to a procurement model, a competitive model if, in the event that it's not achieving what we think is the best thing for the patients, and the level of transformation that's required. So that's recognized. But we wouldn't do that unless we were really, you know, felt we couldn't go further. (Commissioner 4, CCG4, Aug 2015)

Despite having appeared to be the most enthusiastic about using competitive mechanisms to procure services when interviewed in 2013/14, CCG 4 had not undertaken any competitive procurements for clinical services for several years (in fact not since the CCG4 was formed).

The outcome based commissioning project has mainly overridden any competitive procurement processes. (...) With all the energies focused into one, big, massive area, going through a big transition or a potential change, some of the other areas maybe have been rolled over, extended, (...) the outcome based commissioning, sort of, overrides that and it's got... anything has got the potential to be in it (Commissioner 5, CCG4, Aug 2015)

I think a lot things that you might have gone out to tender in that time have, sort of, been left to carry on, to see where they sit in this whole new, [outcome based commissioning] model. (Commissioner 5, CCG4, Aug 2015)

Nevertheless, this CCG4 commissioner saw a need for the competitive lever to remain and did not exclude a possibility of using competitive mechanisms in the future. Furthermore, CCG4 operated a joint commissioning arrangement with its local authority which continued to use competitive tendering for procuring health services falling under its remit.

Summary of commissioners' experiences following the Five Year Forward View

The follow up interviews conducted in the latter part of 2015 painted a mixed picture of commissioning practices in the four case study sites. On the one hand, all the case study sites were undertaking major local service transformation using collaborative working with providers. On the other hand, three out of four sites (apart from CCG4) were still using competitive tendering to procure some smaller, more peripheral services. And CCG4 did not rule out doing so in the future. This included CCG3, which had not undertaken any competitive procurement on its own in 2013/14, and had been the least keen to do so at that time. Although noticing shifts in policy rhetoric towards cooperation following the 5YFV, in their day to day practices, commissioners were exercising their own judgement and making use of all tools available to them. In fact, taking account of CCG3, we can see that, over time, a wider range of commissioning mechanisms was being used.

Summary of commissioners' experiences of competition and cooperation

We have uncovered a number of differences between the four case study sites in terms of the volume and mode of using competition as a commissioning mechanism. Although it was difficult to obtain exact data on the number of procurements conducted, arguably CCG2 and CCG4 had more experience in running competitive procurements than CCG1 and CCG3. Furthermore a clear dividing line emerged between CCG2 and the rest of the sites with the former doing most of the procurements collaboratively with other organisations. Such an approach was much rarer in CCG4, which appeared to have the largest degree of enthusiasm for the local use of competition in its CCG board, at least in 2013/14. Every site had undertaken at least one competitive tendering as a result of a decision taken at the local level. All sites had also undertaken tendering to increase competition in the market as a result of top-down pressure to use competition linked to a particular policy initiative such as AQP. And some had also tendered in order to deliver on the policy, Equitable Access to Primary Medical Care.

We also noted that the bulk of services tendered via the competitive route were commissioned by the four sites before 2013. In 2014 and 2015 one could note a slight decline in the appetite to use competition in some of the sites, especially for large scale services. For instance, following service reviews, CCG1 and CCG4 decided not to tender out their CHS but instead dedicated resources to the development of an outcome based contract involving existing providers. CCG4 also decided not to re-tender its primary mental health contract after the expiry of two-year initial contract.

On the other hand, CCG3 had had reservations about using tendering but in 2013 and 2014 it had in fact put two local services out to tender. Commissioners in CCG3 which did not have much experience of using competition reflected that competition had its benefits as it is able to stimulate and challenge existing providers out of complacency. This suggests that CCGs remained keen to experiment and try out all commissioning methods available to them. Competition remained an important lever for commissioning provided it was not enforced top down but left within the local decision making remit. It was useful at times to force providers to improve services.

All the commissioners noted, nevertheless, that a large call on resources was needed in order to carry out a procurement process, and that it was not possible to undertake many of these exercises, due to the limits on their resources. The process was time consuming and cumbersome.

At the same time commissioners in all case study sites provided many arguments why competition was not appropriate for implementing large, long-term service transformation programmes. This was because such programmes required full engagement of the providers to succeed. Competition was seen as a too confrontational method of commissioning, endangering relationships between commissioners and providers. Collaborative planning involving key local providers, creating a sense of shared ownership of problems faced by the local health economy was a preferred way for CCG commissioners to approach large commissioning tasks, as can be seen from our earlier discussion of the way in which the CCGs in

each case study site approached these. Moreover, commissioners feared that competitive tendering might financially destabilise local NHS providers if they were to lose income through the process. Competitive tendering was used mainly as a measure of last resort.

Providers' experiences of competition and cooperation

In order to offer a more complete picture of the interplay between competition and cooperation in commissioning practices, it was important to supplement the commissioners' perspectives with providers' experiences.

Apart from a specific local commissioning climate created by their main commissioning CCG, the different types of provider (acute, CHS and MH services) faced different constraining factors. Many of these constraints were determined at the national level, importantly, different pricing mechanisms for different types of services. Furthermore, due to their different sizes, and types of services being delivered, the market horizon of some providers stretched beyond one particular CCG area to other CCGs and to markets created by different types of commissioning bodies, e.g. local authorities (LAs). Thus the position of a particular provider within the NHS was a product of the number of factors such as the nature of the local market, the type of services they provided and whether they were able to reach to other markets.

Relationships between providers

Providers in our sites had a first-hand experience of how the principles of competition and cooperation worked together in healthcare delivery practice. Providers had to comply with dual incentives to both cooperate and compete with other providers in the system and, importantly, to engage with commissioners in service planning. This led to circumstances in which providers sometimes collaborated with their competitors and competed with their collaborators.

Basis for competition and cooperation between providers

Large service transformations programmes had the potential to put providers in competition with each other. One reason for this was given by an acute provider interviewee in CCG1. He claimed this was primarily because acute trusts wanted to acquire CHS in order to strengthen their position in the market (Provider 1, NHS, acute, CCG1, April 2014). A respondent from a local CHS trust concurred with this opinion by pointing out that CHS trusts were often in a precarious position, facing the prospect of being taken over by an acute trust.

I think we've spent so many years being worried about being taken over by other people, because we're not an FT, so we're still in...we're in our tenth year of staggering towards being a foundation trust and I think there's been a psychology from the top that there's been worry about being picked off by [X] Foundation Trust or [Y] Foundation Trust, that if there was some tendering going to go on for some of our core services, which there hasn't, and no one has indicated yet that they might do, but if they did, then you'd end up with [X] and swift, sort of,

moving into take over and there's...you know, that may still happen (Provider 2, NHS, community and/or mental health, CCG1, April 2014)

Some providers found a way to deal with competition from others by getting them to cooperate in service planning. In both CCG1 and CCG2 there were two separate CHS providers (a combined CHS and acute trust and a community trust) delivering services to different parts of the CCG. This put them in a position of having to cooperate with each other in respect of patient care when patients moved across the 'border'. At the same time, they saw each other as competitors, keen to monopolise the delivery of CHS in the CCG. But in the case of CCG2, the community trust sought to establish cooperation with the combined acute trust in delivering CHS as this was seen as the only way of preserving its business in a tricky local situation.

I know that [local acute trust] need that income in order to be able to balance the books on the new PFI that they've got going in, okay? So when the CCG's saying, "We want a single provider [of community services]," the only provider that that's going to go to is [local acute trust]. And I said to them, "That's not competition, 'cause I know that you can't take that income away from them 'cause you're kissing the goodbye to your new hospital if you do. So, you know, there's got to be some openness and transparency here, because if you put that out to tender and they win it, I'm going to put in, you know, an appeal against that because I know that you can't take that –" and I said, "This is silly." So I – the acting Chief Executive at the time, I said, "We should work together on this because if we can develop a model together, you could subcontract me. It doesn't matter." (Provider 4, NHS, Community and/or MH, CCG2, June 2014)

Providers also noted that they sometimes collaborated with each other in order better to compete against others. A community trust from CCG3 reported that it had formed partnerships to respond to tenders.

I don't see competition as being about, you know, red in tooth and claw, I see it actually about what makes sense. So, for example, if a tender came out in the specification was such that you knew that you couldn't by yourself provide all the services to the standard and to the cost that would be the best value for the taxpayer, and provide the best care for people, then you should collaborate with others, and say you're very good at doing that bit, let's do that bit together (Provider 2, NHS, Community and/or MH, CCG3, November 2013)

This point was also made by an acute trust in CCG 4.

And competitors of a particular provider varied, depending on the specific services being considered. An acute trust from CCG2 remarked that their "*competitors vary, depending on the market we're in*" (Provider 2, NHS, acute, CCG2, March 2014). Neighbouring acute trusts and a number of for profit providers were named as the main competitors for acute inpatient and outpatient services. They also spoke about an increasing competitive threat from new providers such as GPs who wanted to deliver some "*simple work*" and AQP providers who were "*nibbling away*" at some elements of acute services. In

addition, in CCG2 the local CHS trust was the main competitor for the combined acute trust as far as the provision of CHS was concerned.

Similarly, for the community trust in CCG4 the main competitors varied depending on the type of service. They reported losing some of the business as a result of AQP providers moving in.

I think it would be wrong ...if we didn't feel under pressure. (...) We seem to be, you know, winning a bulk of the work back, but we have lost business as a result of AQP. There's certainly a reduction in activity across both of those services as a result of the AQP, which does have an impact down the line. (Provider 1, NHS, community and/or MH, CCG4, Jan 2014)

The acute trusts noted that they were not subject to competition 'for the market' from rival providers, as there did not seem to be a possibility in any of the case study sites of acute services being put out to tender. On the other hand, acute providers were competing 'in the market' for additional patients. For example an acute trust in CCG4 stated that they were mostly affected by the competition 'within' the market for attracting patients and GP referrals to their acute hospital.

Furthermore, acute trusts in some case study areas were interested in taking over other services, both CHS and acute. The CHS trust in CCG4 reported interest from nearby acute trusts to take them over when their other plans failed.

Given where we are in terms of the uncertainty about the ICO and therefore the Foundation Trust, then in a sense there are several sharks circling around us. (...) you know, in different circumstances I might be one of the sharks. (...), so I'm not surprised by it, (...) that's realistically where we are. (...) we've got some people trying to be very nice to us at the moment (Provider 1, NHS, community and/or MH, CCG4, Jan 2014)

As well as trying to take over CHS, some acute providers were also considering takeovers and mergers with other acute trusts. For example, in London there were two ongoing major hospital reconfiguration programmes which required some shifts and closure of hospital services affecting CCG4. One acute trust in CCG4 pondered acquiring a neighbouring hospital, but decided against bidding to take over a failing hospital trust as it was not financially sustainable.

In another cooperative move, another acute trust serving part of the population in CCG4 wished to merge with another acute trust. The merger was portrayed as a solution to a large financial deficit, accumulated partly as a result of a Private Finance Initiative (PFI) debt and partly due to the reduction in activity as a result of concentration of tertiary services in other hospitals. The trust faced bleak financial prospects and was not able to achieve foundation trust status alone. Interestingly, the trust chose a limited competitive tendering route to find a suitable partner for the merger.

We went out competitively to market, to find a partner to achieve Foundation Trust status, to achieve financial viability and to improve clinical sustainability in the future. And we selected – we had a competitive process select at [a foundation trust]. (...)The SHA was in existence at that point, and we decided not to go out to full open market procurement, but to do an internal market exercise within the NHS. That was driven principally by the fact that we knew NHS providers were interested, so there was always – we knew there was a market interest. We first of all wrote out to a number of organisations across London saying, “We’re going to do a process and would you be interested in a discussion?” And 12 organisations came back. We had an informal discussion with each of those and then put an expression of interest out, and then quite a detailed memorandum of information and questionnaire to complete against criteria which we judge. And we got three bids in that basis, and then we evaluated those and selected the preferred partner. (Provider 4, NHS, acute, CCG4, April 2014)

In general, the very poor financial situation of acute trusts was mentioned as the main motive which forced acute trusts to collaborate with each other, and with other NHS providers.

The thing that’s had an impact on the way providers collaborate is the financial situation. And the financial situation has meant that in many situations we’ve had to co-operate with each other. So for example, in this patch I’ve been leading the merger of our Pathology Departments. So across our hospital, [acute trust X] and [acute trust Y], we’ve now merged our Pathology Departments to form a single Pathology Department that we’re all joint owners of and that will save us £8.2 million. And so it’s the – and it’s – and we wouldn’t have done that without the financial situation that we’re in. (Provider 3, NHS, acute, CCG4, April 2014)

In contrast to acute trusts, CHS trusts were more accustomed to competition because of the greater likelihood that their services could be put out to tender. This meant that they were more willing than acute trusts to put together a bid when necessary.

There’s an element of what the Mental Health Trusts provide and there’s a big element of what [acute trust] will provide that will go into that tender. Now, it’s a small bit for us at the moment, so it’s not a big service. It’s a small bit. It’s a massive thing for the Acute Trust. And we could just use it as an example to demonstrate, you know, that we are working really well with the Mental Health Trust about a new model of care for CAMHS to put into that tender to bid for that in a competitive environment. The Acute Trust, we wanted to do a three-way partnership with them. They ha – they can’t move past the fact that this is just terrible, that the Commissioners are putting this out to tender, because they’ve never – they’ve never – experienced it before, whereas [name] and I – the Chief Exec of the Mental Health Trust – [coughs] our services are put out to tender all the time [laughter] (Provider 4, NHS, community and/or MH, CCG2, June 2014)

Some of the provider interviewees pointed out that a fuller form of cooperation between all organisations in the local health economy was required to achieve large scale change. The fact that the health economy consisted of separate organisations which were required to consider their own interests (due to the way in which the system had been designed at national level) was not helpful.

Of course you would be able to do the transformational and change agendas if you worked closer together, because the here and now ain't going to be the same as the next five years or the next ten years, so some –you know, you've got to improve those relationships. (...) But it's really quite sad that we've had to go through that situation to create that. Human nature, maybe. But why have we created that situation as a nation, as a policy, as a, you know, successive governance? Why have we created that situation to force that agenda through problems, as opposed to the desire and want to work in parallel with one another? It's – it feels wrong. (Provider 5, NHS, community and/or MH, CCG2, June 2014)

This was echoed by another interviewee.

Generally speaking we're not very good at collaboration, you know, people in the nineties and noughties have grown up with this environment that it's about very much silo mentality. And, all about organisational survival as opposed to how do we really provide really good patient care. It came out didn't it in the Francis Report that organisations had lost their focus about what they were actually here to do, and it was much more about the organisation. (Provider 2,

Overall, the study showed that the relationships between providers were based on both competition and cooperation and indicated that, on the whole, the same organisations were able to switch from one mode of behaviour to the other, as the situation required.

How providers cooperated with each other

During the course of the fieldwork we have gathered many examples of both competition and cooperation between providers. This section will deal with cooperation, showing that this occurred at many levels: clinicians worked together in relation to patient care; partnerships were formed to deliver non-clinical services; organisations participated in local service transformation programmes; and they also formed partnerships to compete together for tenders.

Clinical collaboration between providers was widespread. For instance, in CCG1 the acute provider, district nurses and GPs collaborated in delivering care to care home residents. (This collaboration was facilitated by telemedicine technology which enabled sharing of the GP and secondary care records and cross-referring patients.)

Acute providers cooperated with each other in certain specialties to improve clinical care. For example, the local district general hospital in CCG1 established a partnership with a larger teaching hospital in order to improve their stroke services and prevent de-skilling of their clinicians by enabling their clinicians to work at the teaching hospital on a rotational basis. The collaboration between CCG1 acute trust involved running some joint clinics and providing some services from the larger teaching hospital.

Our stroke service is under pressure at the moment due to various reasons, some of it is sickness and I think longer term, our stroke service is at risk, but, yet, people down here should not necessarily have to travel to [regional city] or be driven through to [regional city] on a blue light when they're having a stroke. So let's talk with [regional city's acute trust] and we're doing this and I can see this across more specialties about doing some rotational stuff, so our clinicians get exposed to the excitement in a large teaching hospital and large volumes and equally we spread some of those skills here as well, so I think that's happening now, those conversations are happening now about stroke, but I think it will happen more and more with

The collaboration between different acute providers enabled smaller hospitals to retain good clinical expertise and at the same time ensured a steady patient flow for elective work to a major specialist hospital.

It means, for example, our Consultants are here identifying patients, you know, treating patients. But when that patient, for example, requires cancer surgery, they will go with the patient to [specialist hospital], to the surgery. From a patient perspective, they're getting their care close to home, their operation done in a specialised centre, but they're actually seeing the same Clinician. (...) So what does that give us? It gives us as an organisation the ability to recruit Clinicians who are very good and experts, and for [large acute trust], it gives [them] a flow of elective work into them that might not have gone directly to them unless they had a certain – do you see what I mean? (...) So there's, kind of, mutual benefit within that. (Provider 4, NHS, acute, CCG4, April 2014)

Apart from enhancing skills of clinicians and ensuring patient flows, another motivation to collaborate concerned reducing costs for some services, such as pathology, by using economies of scale.

There are some things which are better done at scale, so Pathology. [large acute trust] runs the Pathology for us and itself, us and [another acute trust]. So the unit price is smaller because you've got a bigger market. (Provider 4, NHS, acute, CCG4, April 2014)

On the other hand, not all of the acute providers found it easy to cooperate in respect of clinical services. This may have been due to the fear that the hospital would lose income to its collaborator.

We've had the occasional flirt with other providers. It's not led to as much concrete, in a way, concrete outcomes as I would've hoped. We've had discussions on Cardiology that have come to nothing, not initiated by us, but initiated by [large teaching hospital]. We've had discussions on Pathology with [another acute trust] that again have come to nothing. We are talking about, with [that trust], about whether, on a more strategic level, we should be collaborating on Stroke and possibly Vascular, possibly interventional Radiology services. It feels a little bit as though none of us are quite desperate enough yet to give up a degree of sovereignty or to give up a service, even in a kind of trade-off position. And I think – I personally think that's short-sighted. (Provider 2, NHS, acute, CCG2, March 2014)

CHS providers also cooperated on many occasions in respect of clinical services. For instance, in CCG3 a GP owned company was collaborating with the CHS trust on delivery of a number of services. In CCG3 clinical cooperation around specific diseases and conditions entailed different local forums with representatives of all provider and commissioning organisations. This often stretched beyond health care providers to the third sector, social care providers and patients themselves.

We've recently had a big health day for learning disabilities where all of us were involved in that so everybody providing services from the voluntary sector, third sector, us, local authority, acute trusts – we were all involved in that big health day when it was people with learning disabilities and their carers and families gave us the opportunity to tell us what they liked about our services, what they didn't like about our services, what they wanted more of and what they wanted less of (Provider 3, NHS, Community and/or MH, CCG3, November 2013)

In CCG3 there were also well-established, ongoing communication channels between community, acute and local authority providers, such as daily conference calls during winter periods to discuss capacity within each provider. This enabled better management of patient flows and diversion of patients from overstretched providers to those with some capacity. One interviewee from the CHS trust in CCG3 reflected that such close working arrangements between providers were facilitated by being “a small environment” where people know personally other people who work in other parts of the system.

We're quite a small health economy we all know people who work in other aspects of the health and social care economy, so a lot of my staff will have family or friends who work at the [acute trust]. Lots of the [acute trust's] staff have family or friends who work for us. (Provider 3, NHS, Community and/or MH, CCG3, November 2013)

In addition to cooperation at the level of clinical service delivery and back office functions, providers sometimes cooperated when bidding for tendered services. For instance, a CHS from CCG3 was in discussion with a local GP owned company aiming to submit a joint bid for a GP practice which was out to tender. Similarly, acute and community trusts were coming together and bringing their respective expertise to the table to bid together for services.

Sometimes when we go for tenders, we partner with people, anyway. So [local community trust], for example, we've shared different bids with them because, for example, we can bring in a Consultant and they can bring Health Visitors or whatever it is. (Provider 4, NHS, acute, CCG4, April 2014)

A community and mental health trust in CCG3 established collaboration with other partners (including national charities and other third sector organisations) to combine and utilise their respective clinical expertise in order to increase their chances of winning potential tenders.

If a tender came out in the specification was such that you knew that you couldn't by yourself provide all the services to the standard and to the cost that would be the best value for the taxpayer, and provide the best care for people, then you should collaborate with others, and say you're very good at doing that bit, let's do that bit together (Provider 2, NHS, community and/or MH, CCG3, November 2013)

There was a number of ways in which providers collaborated on submitting joint bids, including setting up a subcontracting arrangement, joint ventures and partnerships. We also came across one example where several providers knowingly submitted the same response to the market engagement exercise undertaken by CCG3.

On the soft market testing example, one of the ones I was just talking about, which is around urgent care, we just submitted a joint response to the soft market testing, which is us [acute trust], [community trust], the local authority and the community interest company I was describing, so we've all...we've not submitted one joint proposal, we've submitted the same proposal jointly, so we've all put a return in, but we've all submitted the same return, so they'll have got the same thing five times or four times, whatever it is, so that's an example (Provider 5, NHS, acute, CCG3, December 2013)

CCG3 had particularly close working relationships between its providers. Collaboration opportunities for joint bidding were identified during regular meetings of local provider leaders. CCG3 had also a wider forum bringing together representatives of acute, community and MH services and local authority services in areas of learning disabilities, mental health, respite and intermediate care. Such forums might have also facilitated providers' common approach to responding to tenders.

The CCG have put out something on supply to health around soft market testing for extended community service provision, and we've decided as a health and social care economy that actually we should put in a joint bid rather than all of us thinking about putting something in separately (Provider 3, NHS, community and/or MH, November 2013)

Not all of the joint bid collaborations were stable, however. In CCG3, the acute trust experienced a breakdown of such a collaboration when one potential partner decided to bid on a sole basis.

The close working relationships in CCG3 were also apparent in the fact that the CHS provider and acute provider had a long established bilateral working relationship. The managers from each organisation were mindful not to impact on each other's core activities.

I very regularly meet with my counterpart at [acute trust]. We meet on at least a monthly basis. We talk at least on a weekly basis. We tell each other about what we're thinking of around service redesign. I would never dream of putting a team together that impacted on what they do, and similarly with her, so we work in a much closer way than we ever did. We're also working extremely closely with our local authority provider colleagues who are looking for a home for their provider staff. (Provider 3, NHS, CHS and MH, CCG3, November 2013)

One can also find examples of 'enforced' cooperation where providers were ordered to come together by commissioners but bottom up provider engagement was lacking. This was the case of implementation of the Better Care Fund initiative in some case study sites. The acute trust from CCG4 echoed these concerns by stating that efforts to reconfigure services or increase out of hospital activity without bottom-up engagement of acute providers could not succeed.

They can only take money out if they take patients out and I don't see anything they're doing is going to take patients out. (...) 'Cause they're not doing it with us, they're doing it to us. (Provider 3, NHS, acute, CCG4, March 2014)

The importance of 'real cooperation' with provider engagement on big reconfiguration projects was repeated by an acute provider from CCG2. Good collaboration between commissioners and providers led to efficient closure of some services such as maternity. The acute provider also closed A&E services on one of the sites. They stressed that this sort of major service change was possible as a result of planning and was nothing to do with the markets.

We have closed down one of our sites for delivering maternity services and moved it. We've closed down one of our sites for delivering stroke services and moved it, with public consultation, with the public largely accepting that surgery, surgical centres as well, not entirely, but not people out on the streets protesting. And there aren't very many health economies that can claim to have achieved such a high degree of real service change and service agreements. That's been done in a planned way, in a managed way and in a collaborative way, with the CCGs actually leading the consultation process. And I think that's something we should all be hugely proud of in this part of the world. But it's not been market driven at all. (Provider 2, NHS, acute, CCG2, March 2014)

As well as finding many examples of collaboration between providers in order to bid for services, we also found that there were areas where providers were not prepared to collaborate with each other, or found it particularly difficult to do so. One example of the former related to securing high value tenders for CHS where acute trusts were competing with the incumbent providers, mostly community trusts. The stakes appeared to be too high for the acute providers to risk losing any of the potential income to CHS providers.

We've got community services, so that was a three year contract under transferring community services, when that first came about, we've had a one year extension (...) 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)

(In fact the CHS were not put out to tender in this CCG after all. The CCG opted for a collaborative outcome based solution instead.)

Collaboration between the health and social care sectors was seen as inevitable and necessary but challenging, not least because of the different eligibility criteria applicable in two sectors, health care being free and universal and social care being means tested and increasingly subjected to cuts in spending (Provider 1, NHS, community and MH, CCG3, November 2013). An additional challenge was posed by the different commissioning culture in LAs which were much more price oriented in their tendering decisions than NHS commissioners.

How providers competed with each other

The types of competition between providers included both competition 'within' the market, driven by patient choice; and 'for' the market, driven by commissioning decisions.

The way in which the AQP policy in each case study CCG entailed competition in the market for a limited number of out of hospital services was discussed earlier.

We also came across examples of competition for the market between local providers. The community trust in CCG2 won back some of its former services from an acute trust in competitive tendering issued by the local authority.

We were fortunate enough to win a £2 million annual contract off [acute trust] for school nursing services. Now, on one level, you wouldn't be surprised at that because we're a community service provider so we, in theory, should be better at Community Services. It's what we've always done. It's our bread and butter. So, we went in at the right rate. I think we threw the kitchen sink at it in terms of the level of input from the service to the tender exercise, and I don't know what it

started at as a budget, so I don't know what [the acute trust] had as a budget, but essentially, it was a £2 million yearly contract that we won. (Provider 5, NHS, community and/or MH, CCG2, June 2014)

However, providers expressed concern about barriers preventing fair competition. One such issue was the different pricing mechanisms for acute and out of hospital care. The interviewee contrasted the position of MH services (which had block contracts, effectively a fixed budget) with that of the acute trusts which could expand their provision due to being paid on a cost per case basis through Payment by Results.

A third of our Trust is Specialists, mostly Secure Services. But we can't say, "We're fantastic at Secure Services, we'll take five more patients," and get paid for it, because we're just on a block [contract]. So we've got no way of flexing up on services that we're good on. If you work in [local acute trust], big, gleaming, enormous university hospital, and they decide, "Actually, we've got some real Specialists in trauma," and the Air Ambulance starts flying people in from [locality X] who have trauma, they may not get exactly the money that they want, but no one turns round to them and says, "We can't pay you for that." So is the CCG in charge or not, and where does competition sit? (Provider 1, NHS, community and/or MH, CCG2, April 2014)

Many interviewees distinguished between being 'forced' to compete or 'forced' to cooperate by different parts of NHS organisational hierarchy and choosing to compete or cooperate as a result of provider's internal decision. The top down 'enforced' competition seemed to have affected both CCG commissioners and providers and was viewed as counterproductive.

They tried tendering Pathology, but that was an interesting example because that was being forced by the old Strategic Projects Team in [one region] Health Authority, and it was – it's fascinating as an exercise. (...) They tried imposing the same sort of model in the [region of CCG2], and so long as an SHA was there to wave the big stick, the PCTs played along with it. And six months after the SHAs were abolished, the CCGs said, "No, we're not going to do that anymore. We never wanted to do it in the first place. You were forced – you forced us into it." There's a huge degree of inertia in all parts of the system. (Provider 2, NHS, acute, CCG2, March 2014)

Relationships between providers and commissioners

In addition to understanding how providers both competed and cooperated with each other in our case study sites, it was important to understand providers' perceptions of their relationships with the commissioners. This shed further light on how commissioners were using the mechanisms of competition and cooperation to improve local services. We found that, in different circumstances,

providers experienced both threats of competition and also encouragement to collaborate with the commissioners and each other. They took the view that both of these techniques were being used by commissioners to influence their behaviour, and thus improve services. Providers of services out of hospital were more susceptible to threats of tendering than acute providers. But all types of provider could see the advantages of being encouraged to collaborate, and of having good working relationships with their commissioners. These might even obviate the need for commissioners to put services out to tender.

The threat by commissioners to open up services to competition was understood by providers in all the case study sites as a powerful lever for changing their behaviour. As CHS were particularly exposed to potential competition, such threats were especially effective with regards to community trusts.

I'm talking nationally, in some instances what I've observed, rightly or wrongly, and that maybe again it's a perception on my part, is that people have wanted to assert their power and authority over providers by saying, well actually if you don't we'll put it out to tender. (Provider 2, NHS, community and/or mental health, CCG3, November 2013)

One provider of MH services in CCG2 experienced such commissioners' threats directly but viewed them in a positive light.

Providers are so slow. We're so archaic. We never move. Yeah, and you threaten us and we move. Yeah, and maybe there are examples, and there may be examples even in my own Trust where that's right and I wouldn't deny that. (...) We've experienced that directly. "If you don't do that, we'll tender it." (...) I wouldn't deny them when the Commissioner would say, "Well, if you don't do that, we'll tender." And they may well have actually improved services. (Provider 1, NHS, community and/or MH, CCG2, April 2014)

As community trusts had to take such threats seriously, in some sites they tried to engage with commissioners to "understand exactly what it is that commissioners have been wanting" (Provider 2, NHS, community and/or MH, CCG1, April 2014). This was in order to change their practices as desired by the commissioners without the need for competition. In CCG1 this strategy had paid off as commissioners decided not to put community services out to tender.

So trying to understand, and obviously working with GPs at a grass roots level all the time, so actually that trying to, sort of, analyse what it is that they really want or what it is that they don't like about what's actually happening at the minute, we're putting, if you like, more effort into doing that, not so much, I would think, to stave off any potential competition, but obviously that would be...if you could get everybody thinking, well, they're doing a really good job and they're good value for money, then that puts, if you like, the necessity for your commissioner to tender if they think they're getting a good value (Provider 2, NHS, community and MH, CCG1, April 2014)

It was often important to providers to preserve their good relationships with commissioners, especially in the case of CHS providers, as they knew they were vulnerable to threats of tendering. A number of providers mentioned that in some cases they did not want to challenge commissioners in order to preserve these long-term relationships. For instance, a community trust in CCG2 did not challenge commissioners when the CCG commissioned a community based step up step down intermediate service from the local acute provider without tendering it. The community trust was not happy about additional funding that the acute trust received from the commissioners to run the new service but decided that what mattered in the end was improved patient care and acknowledged the motivation of the hospital which was “*trying to do something to empty the beds but not in a collaborative way*” (Provider 4, NHS, community and/or MH, CCG2, June 2014).

It was a £3 million service at [acute trust] over two years with no tender for it. I could have made hay about this, but I thought, I've got to live in this – you know, I've got to have good relationships with my fellow Chief Executives, but – so, you know, I can't cause a fuss.
(Provider 4, NHS, community and/or MH, CCG2, June 2014)

The tactical threat of tendering services used by commissioners was often successful in shaping provider behaviour. For instance, in CCG2 the use of threats worked for reorganising CHS.

[the CCG] said that they weren't going to put it out to tender, but they wanted us, two organisations, to work together with them in order to be able to provide a single model of care across the patch, even though there were two providers that did it. What they wanted was, “We want this. We want it to look like this and we want the specification to be this.” (...) we worked with them and we developed a service specification which is radically different, you know.
(Provider 4, NHS, community and/or MH, CCG2, June 2014)

In other circumstances however, threats to put services out to tender were not effective. In the case of large, complex service reconfigurations which required genuine provider buy-in to be successful, threats were not sufficient, or maybe not even credible. A community trust respondent from CCG4 in the follow up interview conducted in autumn 2015 stated that the threats by the CCG to put services out to tender as a key method of steering provider behaviour were “meaningless” by that time (Provider 5, NHS, community and/or MH, CCG4, Oct 2015). This was because successful implementation of the ambitious local change programme depended on full engagement from all key local providers which, in fact, gave some leverage back to the providers. (Although it is arguable that it was the initial threats to use tendering in 2013/14 which had forced the providers to cooperate with the process of reconfiguration.)

Once the four key local providers started to engage fully in the process of CHS redesign, the commissioners became dependent on the providers to propose workable solutions, and the threat of tendering became less credible.

Interestingly, the CCG have throughout held up the back of this, well, 'we all go to market', basically if you four don't get your act together we will go to market. (...) They still keep saying that. I think increasingly though, so number one – you've got four providers who are working in a collaborative way, and are working with the commissioners in a collaborative way. (...) so from a provider perspective, (it is) clear that that threat is a little bit meaningless. Because if the CCG wants to go to market or forces its hand to go to market, then it's going to have to take some time to design a really detailed service specification for that, it's going to have to procure it and who would it get to provide its acute services or its GP services other than the three providers? (Provider 5, NHS, community and/or MH, CCG4, Oct 2015)

Threats of putting services out to competition were not the only lever available to commissioners to instigate change in provider behaviour. In CCG2 the acute trust was incentivised by commissioners through a CQUIN scheme to increase collaboration between acute and community trust services.

The commissioners have incentivised us through the CQUIN scheme this year to do a number of individual indicators across providers. Now, the way the CQUINs work is that you do your bit, you do your bit, but you do have to both do them to get the benefit out of it. (...) So gradually, they are using things like that as the lever and mechanism to actually drive through some of that collaboration between various providers on particular areas, particularly at the moment ourselves and the [community] care trust, you know, in the aspects of community services, things like liaison psychiatry training and all that. So, yeah, there's a vast range of stuff going on with a trend of actively collaborate, promote collaboration between providers. (Provider 1, NHS, acute, CCG1, April 2014)

Community and mental health providers thought that the balance of power rested firmly with the commissioners. This is because CHS were more likely to be put out to tender and because block contract payments prevented expansion of services on providers' initiative.

The commissioner has all the power here because they can tender. And if I don't win the tender, I lose it. (Provider 1, NHS, community and/or MH, CCG2, April 2014)

In contrast to services out of hospital, respondents took the view that acute trusts had more leverage when dealing with commissioners. When contractual discussions took place between acute providers and commissioners, providers made attempts to retain the initiative by undertaking service reviews in

problem areas themselves rather than allowing commissioners to conduct such inquiries. This was a way of keeping control over their business.

The contractual discussions are robust, I mean, no question of that, actually both in terms of the quality agenda and the...so they're unhappy about maternity services, but so are we! You know, so that's good, that's helpful. They're unhappy about urology and so are we, we've just done a service review on urology, now, they could have done a commissioning review on urology, but actually we've done a service review, included them in it and shared the published results with them, which is much more effective. And, for us, it means the future of urology services is in our hands with their influence, which feels a better way around than in their hands, kind of, with some quasi influence from us What the service review is concluded with is six options, which we've short listed to three. One is to partner with the [another acute trust], the other two are, in effect, shift the balance of the service, so it does more in the community fundamentally, so, yes, that's what we're doing and we've shared that with them and they are supportive of our direction really. (Provider 5, NHS, acute, CCG3, December 2013)

But this approach did not always work. The acute provider in CCG3 had also done a service review of another service area. But this service had still been put to tender by the commissioners and awarded to a different provider.

As mentioned in the section on cooperation between providers above, the organisations in the CCG3 case study area had close working relationships, and this included the CCG itself. Providers had a sense of ownership of the local health economy and shared the information with other actors in the local system on an ongoing basis.

We [commissioning and provider managers) basically have a little secret meeting every week for half an hour, where we, you know, around the kitchen table, we sort stuff out and really what we do is we chat and gossip about what's going on and there's no notes taken, we sneak in and out of each other's buildings, it works brilliantly well and we've done it since I first arrived and as a consequence of that, we pick the phone up to each other. (Provider 5, NHS, acute, CCG3, December 2013)

One clear example of the good quality relationships between local providers and CCG3 was the fact that the CCG decided not to put their CHS out to tender early on. This was described by the community provider as “a brave decision” given that at the time there was a general expectation that CHS would be tendered (Provider 1, NHS, community and MH, CCG3, November 2013). According to the community provider such a decision was made because agreement was reached to ensure a trajectory of service improvement and this was enabled by mutual trust between commissioners and providers. Such a collaborative approach helped to keep providers engaged and to own the problems faced by the local health economy rather than just stick to their narrow organisational interests and priorities.

I think providers have to start getting their head around that. We have to help, in a really, really constrained environment. How we can help, with the same resource, so this is not just suddenly that there's an extra resource there. No, no, the same resource. How do we help get the answer that we can all see that we need from our health economy. So almost it becomes, within that framework, it becomes a very real problem solving process. (Provider 1, NHS, community and/or MH, CCG3, November 2013)

Overall community provider from CCG3 praised the collaborative approach of CCG3 commissioners as a “mature” (Provider 3, NHS, community and/or MH, CCG3, November 2013) and “supportive” one (Provider 5, NHS, community and MH, CCG3, November 2013). They praised the commissioners’ readiness to discuss any issues with the provider..

I think that if there are services that they are unhappy about they will vocalise that, and then, as a provider, you have a chance to do something about it. If you choose not to then actually perhaps your services should be tendered – is how I would view it. So actually I think that they're probably going about it in a very mature way, to not destabilise the health and social care economy. (Provider 3, NHS, community and/or MH, CCG3, November 2013)

Overall relationships between providers and commissioners in CCG3 were described by the acute provider interviewee as “fascinating” as “they are both our commissioners and our partners” (Provider 5, NHS, acute, CCG3, December 2013). Because of the importance of preserving good relationships the acute trust decided not to challenge the commissioners’ decision not to put CHS out to tender.

We've made a decision that it would be damaging to our reputation and potentially to our relationship with them and so we very clearly articulated to them our disappointment, we very clearly articulated the fact that our view is, our advice was that we could have challenged the process, but actually, you know, I think...and this is, I guess, where I can see a difference, if I'd been [any large private provider] or even an NHS provider from another bit of the country, potentially not looking for a relationship, but looking to tender for a service, I would have challenged it, we're not in that position. The longer term, even the medium term relationship is much more important (Provider 5, NHS, acute, CCG3, December 2013)

The relationships between providers and commissioners in the other case study sites were less close. It is difficult to speculate about why this might be. The geographical area covered by CCG3 was small and well defined, and the clinical networks between senior clinicians and senior managers were long standing. In contrast, two of the other case study sites (CCG2 and CCG4) were situated in part of large conurbations. The fourth case study site (CCG1) was mainly rural, but covered more than one local authority, as well as having a complex pattern of service provision.

When commissioners in CCG4 chose not to engage with the community provider prior to opening up services to competition, as in case of AQP services, this was met with disappointment.

The one thing we would probably have said could've been done better was that we were the incumbent provider and there was very little discussion from Commissioners ahead of going out to tender as to pathways and understanding the service. And there were some key elements of service provision which weren't allowed for and we had to fudge back after it had gone out to competition. So I think there could've been an element of liaison at an earlier stage before putting it out to tender, whereby they could've engaged with us as the incumbent provider to work through what the issues might've been of putting out just one element of the service. (Provider 1, NHS, community and MH, CCG4, Jan 2014)

However, in CCG2 CHS providers engaged with their commissioners to change their services in order to avoid tendering. The provider acknowledged that CCG2 commissioners were trying to improve collaborative working between providers and find a “win-win” solution (Provider 4, NHS, community and MH, CCG2, June 2014).

In addition to good relationships between providers and commissioners which enabled tendering to be avoided in some areas, the role of commissioners in coordinating the behaviour of providers was also apparent to the providers. In all the case study areas, the providers noted that the CCG took a lead in encouraging collaboration between local providers, as a way of coordinating activity across the local health economy in order to achieve the service improvement and reconfigurations it desired. . In CCG1 local NHS providers were strongly encouraged by the commissioners to collaborate especially in filling the gap left after the private independent treatment centre provider withdrew from the contract.

I do think [commissioners] encourage [collaboration], I haven't seen any examples of them discouraging, so I think it's always on the table and they would like us to collaborate more and the demise of [independent] Treatment Centre under [private provider] I think has brought that to a head, the commissioner sent a very strong message, now granted this was [neighbouring] Commissioners, sent a very strong message through [CCG1] as the host commissioner to say, we are looking for the providers to work together to discuss how these services can be continued. (Provider 4, NHS, acute, CCG1, June 2014)

But providers reported that their commissioners were limiting themselves to bringing different providers to the table. Then the providers were encouraged to work together to find solutions to specific problems.

They don't encourage or get really involved in collaboration between acute providers. We're left to our own devices. They do I think have a role in ensuring collaboration in [CCG4] between ourselves and the community services and the Council. But the CCG have not really got involved in that very much either. (Provider 3, NHS, acute, CCG4, March 2014)

Providers had experience of dealing not only with NHS commissioners but also with other commissioning bodies such as local authorities. Some providers noted that local authorities as

commissioners were less willing than the NHS ones to engage with providers on potential service redesign and often went straight for tendering route.

Now, we've got School Nurses, school nursing sitting with the Local Authority at the moment. They have said that they're going to put that service out to tender. We've tried to work with them on, "Okay, then, let's have a look at School Nursing Service. You talk to us. We'll give you some idea about what we think you could stop doing and – but also about what you absolutely have to do. And then we can work with you about where you want to draw that line, as opposed to just saying, you know, "This is the whole service and this is what you're going to go out, because we can work with you on that basis because, you know, we can cut the cost as long as we work out what, you know – what's not going to be done." They keep changing their mind about whether they want us to do that or not and whether they're just going to put it out to tender (Provider 4, NHS, community and/or MH, CCG2, June 2014)

A community provider operating in CCG2 was concerned about the tendency for local authorities to award tenders based on which organisation can provide the service at the lowest possible cost, as opposed to taking into account quality.

The Local Authority, because they are used to working in a tested market, because they are providing services that people pay for, so it's homecare, you know, that's – they're used to commissioning services from providers that are very low end of the market, providers who have the ability not to be hampered by the agenda for change structure in the NHS, who can pay, you know, minimum wage, who – you know, so that their service that they can provide comes out from a cost basis. It's much, much cheaper than the NHS can pay for it, and they compare that. So, with the Local Authority, they look at it purely from a monetary perspective. So, we've had some really challenging times over the last couple of years with the Local Authority in terms of Learning Disability Services (Provider 4, NHS, community and/or MH, CCG2, June 2014)

The same respondent reflected that post-Mid Staffordshire Francis inquiry (there had been a welcome renewed focus on quality of care in NHS organisations). In contrast, the local authorities remained focused on costs. This made the relationship between providers and local authorities challenging as the latter were looking for ways to reduce the funding for services including those they commissioned from NHS providers. The CCG2 community provider described their local authority approach as “slash budgets, go out to market, and you have to get something for that rate” (Provider 5, NHS, community and/or MH, CCG2, June 2014).

Providers relationships with regulatory bodies

In order to understand how the mechanisms of competition and cooperation were used, we needed to investigate how the providers experienced the regulatory regime to which they were subject, as this would affect their attitudes to competing and cooperating with other providers. We found that providers were subject to detailed regulation in relation to their plans for new service configurations, and that the concern of the regulators to avoid financial risk could sometimes impede innovative arrangements.

Many providers were in contact with regulators – mainly with Monitor and the TDA – in order to discuss the potential structures for their organisations, including mergers, partnerships and collaborations. For instance, an acute trust serving CCG4 sought some early assurances from Monitor about their plans to merge with another trust.

We've had...(...) informal discussions with the CCD at Monitor and the OFT, 'cause that was the – people that were there now, it's now the CMA. So the system is aware that we are approaching, and we've had the informal advice and also done quite a lot of assessment round the competition issues with independent people, as well, so(...) The view at the moment is that there is little overlap in market at present and, therefore, the risk of a significant lessening of competition is very low, which is good.(Provider 4, NHS, acute, CCG4, April 2014)

Several provider interviewees pointed out that the regulators took a detailed interest in their affairs, which was not compatible with the light touch one would expect from regulators in a functioning market..

I'm sorry to labour the point, but again, it's a classic – this is a plan, this is an old-style managed healthcare system. And the irony of course is in order to get our new hospital plans approved, we've got to present them with a detailed ten year activity and income and cost model. So they want absolute certainty – I'm exaggerating, they want a fair degree, Department of Health, before they're willing to sort of sign off on this new hospital, how do you know you're going to get the patients coming through in ten years' time? Well, we've sort of agreed with the CCG, not in detail, but a rough idea of, you know, the sort of work they're going to give us for the next ten years. How is that compatible with, let the market rip? (Provider 2, NHS, acute, CCG2, March 2014)

Similarly, a community trust interviewee in CCG4 reported their engagement with the regulators prior to setting up a partnership vehicle for the delivery of a CHS outcome based contract. The regulators required evidence of long-term financial sustainability of new entity with detailed long-term income predictions.

So in my case it's the TDA. I need them to understand what it is we're collectively trying to do, understand how that fits into a three to five year time horizon, and how actually that could end

up with a contract which gives us security of income, and an increase in scope around income that will go out for ten years. That will look different to a current standard NHS Block Contract for community services. So I need them to understand that, because if they don't, then they will look at my five-year business plan and say, well, you can't give me any surety of how you're going to pay the bills over the next five years, therefore you are not viable. (Provider 5, NHS, community and MH, CCG4, Oct 2015)

Providers' responses to competitive tenders

In order to understand how competitive tendering worked in practice, we investigated the attitudes and policies of the providers in our four case study sites in respect of responding to invitations to tender from their local CCGs. We asked providers about their internal decision making processes about which tenders to respond to. Such decisions were not straightforward given the considerable amount of resources required to bid and the need to make assessments of the likely benefit of winning. Most providers had a set of variably formal decision rules which they applied. These focussed on issues such as the profitability of the new service, how it would fit into the strategic plan for the organisation and the likely capacity of the organisation to provide a high quality service.

Most providers we spoke to had some internal processes in place for deciding which tenders to bid for. For example, in case of the acute trust from CCG1 the business development department was in charge of scanning the market for tenders and a process for deciding which to respond to.

What they do is they have a watching brief of things that are put out there through the various journals and stuff and I believe there is a matrix we use which well, there's a general assessment anyway, something we'd be interested, but there's a matrix that they use which aligns to, you know, does it fit with our strategic plan right now or in the future? Does it fit with the business that we're in? How does this sit with long term commissioning intentions, and all that, and then it goes through a process of going through the business development function and then it eventually goes through the various stages up to the execs to make a decision about whether we make a formal submission for that, so there is a process for doing that. More often, I mean, I used to sit on the business development board and there was quite a lengthy list, obviously, of things that were out there, but the actual ones that we translated into actual bids were limited. (Provider 1, NHS, acute, CCG1, April 2014)

Does it fit with our strategy? Who are our competitors? Do we already deliver this service? What's our market share in that service? What's our reputation like? What's the intelligence? Do GPs, do commissioner want us to deliver that service? Is it going to stack up? Are we going to get the income to support this? And this doesn't happen often, or is it something we would be willing to do as a break even or loss leader to get more of the market? We have a

stop go matrix, which we deploy to say, is this something we should be bidding for? And we used that on the endoscopy, that gave us a score of and hence the reason why we withdrew (Provider 4, NHS, acute, CCG1, June 2014)

The acute trust from CCG1 tended to respond to big, local tenders or those that involved one of their specialty areas. This trust had also been gathering intelligence from local GPs on potential market openings in respect of certain services and by looking at the condition of nearby hospitals which might be struggling.

These processes allowed providers to decide that it was not worth bidding for some services, as they would not be profitable.

And the NHS at one point probably, you know, it's probably four or five years ago now, was very much into income generation and growth, so you saw all organisations wanting to compete for business and grow. And because it's financially more difficult now, you see people saying, "But I'm not making any money from this, so why would I want to do it?" And there's a bit of that going on, I think. (Provider 4, NHS, acute, CCG4, April 2014)

On the other hand the same trust in CCG4 still provided a number of outpatient clinics in the community despite them not generating any profit. The interviewee from the trust said this was because the consultants enjoyed working outside of hospital and (probably more importantly) because such clinics served as a 'feeder' bringing in elective inpatient work to the hospital.

An interviewee from an acute trust in CCG3 stressed that the two main concerns involved in the decision making process about tenders boiled down to knowing "the things you're good at" and "what your margin is", as well as taking account of the costs of bidding (Provider 5, NHS, acute, CCG3, December 2013).

We're being quite thoughtful about what we bid for. We choose not to bid for far more than we do bid for, because of the bidding costs, which are exorbitant. The skill set is difficult to have. The amount of clinical time it consumes is significant and there's no point bidding for something that you don't want, which is the other thing. (Provider 5, NHS, acute, CCG3, December 2013)

Some community trusts were reluctant to expand their business outside of their current area, while it was noted that not all community trusts followed this policy. The interviewee attributed such an approach to their community trust's reflection on their core business activities and their place within the local landscape of providers.

So locally, well, particularly from our perspective, the only service that's actually moved to be tendered was podiatry under AQP, so that's the only thing we've had locally here. We've pitched in for a couple of things outside of [locality] that have been tendered, up in the [region] there

was some child and adolescent psychiatry services and there's been one or two other areas, a bit of speech therapy that we've toyed with, but, again, from our perspective, we've made a great deal of play about being a local provider and working with the local community. So, again, I don't think our exec team are on board, even though sometimes they talk about expanding the services and, et cetera, moving outside of the (...) area for which we provide all of our services, I think is still a bit of an unknown quantity for us. Whereas, you do get other organisations, I'm aware of, who, you know, they might be based in [locality X] and run something in [locality Y] or whatever, but, at the moment, we're not geared in that way (Provider 2, NHS, community and/or MH, CCG1, April 2014)

Similarly, the community trusts in CCG2 and CCG4 were also cautious about getting involved in out of area service provision. Although they were keen to expand their business they were mindful of overextending themselves and were keen to maintain their reputations for a high quality care.

The decision about whether to respond to a tender carried risks not only of potentially losing market share to a competitor but also of taking on services which could overextend the provider and prove to be loss making. One acute trust from CCG4 warned against responding to tenders just for the sake of it.

Just the nature of tendering is you really need to want to do it, and I think I've learnt from having a bad experience in going for a tender, which was dermatology, which I talked about, is you have to really want to win something, and not just win it 'cause you're the winner. (...) You actually have to really believe you can deliver it. (...) And we ended up with a contract that was impossible to deliver, which gave us all a headache and, actually, I was very pleased when we decided let's just withdraw from it and give the service back, 'cause it was just too much. So I definitely think that's a challenge with tendering, is you just don't do it for its sake. (Provider 4, NHS, acute, CCG4, April 2014)

Providers' experiences of the tendering process

We also asked providers about their experiences of participating in a tendering exercise. They reported that tendering was very resource intensive for them, and that it was made more difficult by the lack of experience of many commissioners. This affected the efficiency of the processes. Moreover, several providers were concerned that commissioners were relying on them to provide information required to write the tender specifications, rather than being able to do this themselves.

Before the formal process of tendering began, providers reported that some commissioners conducted market engagement events to gauge provider interest. However from the providers' point of view such events were often problematic. For instance, the CCG3 acute provider we interviewed saw the market engagement event as an opportunity for commissioners to take provider's best ideas and put them into the specification for the tender. He saw the approach of commissioners as "farcical" as it exposed the

lack of clinical expertise of commissioners. They were not able to write the specification for the service. Many providers noted that commissioners were still not able to specify the service at later stages of the process, and relied on each provider tendering to give details about what the service should comprise. Furthermore, the market engagement exercise was described as a “courting process” which was difficult to manage from the provider’s point of view. This was because the provider was trying to convince the commissioner that tendering the service was not necessary, but at the same time trying to remain part of the tendering process. It was a difficult balancing act for the acute provider which wanted to maintain their chances of winning the bid, knowing that at the same they might disclose something that would feed into the service specification and work to their disadvantage.

The level of trust that, you know, how open you are and how much you’re giving to a specification because if you give too much, they use that for the specification that someone else can then win for. So it’s quite a difficult one. (Provider 4, NHS, acute, CCG3, December 2013)

Once the formal tendering process was underway it was characterised by one interviewee as “chaotic” due to the short notice periods for submitting the returns. They also complained about arbitrary scoring rules.

Quite often the process seems somewhat chaotic, we tend to get these ridiculously short notice periods, so whether it’s going through the PQQ stage, whether it’s going through the first invitation stage, whether it’s going through the formal operation, it all seems to be on this chaotic timeline and everybody is, you know, you’ve got to be allocated a bit to do and you’ve got to...and then you get these, I mean, you do get a range of documents, sometimes the documents are quite good and quite well constructed, but there are others where it seems to be asking for a mass of information and whether you’re actually contributing and whether you’re reading it, I don’t know, sometimes I don’t think it makes any sense and there seems to be a mass of information requested. Also I think there’s variability, isn’t there, in terms of the scoring mechanisms that are applied (Provider 1, NHs, acute, CCG1, April 2014)

It was also pointed out that the tendering process was characterised by a lot of uncertainty as often both commissioners and providers “are feeling their way in the process in equal measure” (Provider 2, NHS, community and/or MH, CCG1, April 2014).

Particularly once you engage clinicians in the process and they’re coming up with, you know, lots of practical nitty gritty type questions about what will happen here and what will happen there? Everybody’s looking fairly blank and, as you say, there’s a lot of “I’ll get back to you on how we think that’s going to work” (Provider 2, NHS, community and/or MH, CCG1, April 2014)

A common complaint was the large amount of resources that NHS providers had to dedicate to pursue competitive tenders. Although the competition was done in the name of improving patient care, the resources needed to operate the market seemed disproportionate to the potential returns.

We lose sight of while every provider's bidding for this work the resource involved to answer them and particularly the stages depending on what process they use is substantial. So, you know, you've got a pre-qualification questionnaire, then you have an invitation to tender, then you have a presentation, then you've got mobilisation. And the amount of resource and financial input into them is significant and you question how much that benefits the patient. The outcome possibly does but if you've had seven organisations doing that and only one is successful. (Provider 4, NHS, acute, CCG3, December 2013)

In fact, some providers could not afford to bid, due to their poor financial situations..

I suppose 'cause we're in an organisation that's now looking at being acquired, it's unlikely we'll go for a lot of tenders just because we've got enough distraction to get on with. I think the challenges are making sure that you have sufficient money to invest in bidding for things, because it takes a lot of time and effort, particularly from an Operational Team, a Clinical Team, but also the finance and information you support. And traditionally, you know, 'cause we don't have any money, we're poor, we don't have a budget set aside, so you're asking people to do it acro – on top of their normal job. (Provider 4, NHS, acute, CCG4, April 2014)

Some providers were concerned that commissioners did not adhere to procurement regulations, and thus it was possible for time to be wasted in fruitless efforts.

Another frustration would be how important or how much attention do people truly pay to procurement law? I know we and our head of procurement do it absolutely by the book, we've had a very recent experience of an enormous tender, value wise, that was being run through...we got through stage one, PQQ, then we went to tender, but it was being run through competitive dialogue and three stages of competitive dialogue, three days in every week was spent over with that organisation, talking to them about how we could provide that service and things started to go a bit quiet and then we received notification that the procurement exercise had been abandoned and it had been awarded to the incumbent provider and that incumbent provider didn't even get through stage one. 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)

Often the information released by commissioners was not sufficient for a provider to make a cost benefit assessment before deciding whether the tender would be viable.

We've recently bid for a [XX] service in [locality X], now we made a tactical decision in doing

that to actually massively inflate the costs, the price, because the case mix information on the service was none existent, so they told us the kind of service they want, they couldn't tell us how many of what, well, I mean, again, it's just...as far as I'm concerned, it's appalling! (Provider 5, NHS, acute, CCG3, December 2013)

In order to learn from their experiences, some providers conducted annual reviews of tenders that they won and lost. For instance, one community and mental health provider from CCG2 estimated that they win about a quarter of tenders that they bid for (Provider 1, NHS, community and/or MH, CCG2, April 2014). Another acute provider from CCG3 admitted to participating in some tendering in areas further afield not necessarily with the purpose of winning the tender but in order to gain intelligence on the service specifications and gain more experiences of the process.

We got to ITT on some stuff at [locality X]. We do look further afield, sometimes not necessarily for us to bid for it but to learn lessons. So we would look at the sexual health services at [locality Y], only because we'd look at their specification and partly the reason for doing that is because our experience locally, is that they're not necessarily that clear on their specification. (Provider 4, NHS, acute, CCG3, December 2013)

Providers' views on the effects of tendering

Although this study was not designed to measure the effects of tendering, we investigated the providers' views about the effects of competitive tendering on service provision and their financial situation. Providers did not report services having improved due to tendering and moreover, they thought that tendering was damaging to their organisations as services were often interdependent in ways which were not taken into account in the tendering exercises. They were concerned about the fragmentation of services, the possible negative effects on staff morale, the excessive reduction in costs and the opportunity cost to the NHS of the processes.

Community and mental health trusts reported that their core business was more affected by competitive tendering than acute trusts because CHS were more susceptible to being put out to tender. Furthermore, if the incumbent community trust lost a particular tender, due to the absence of a pricing system that paid on a cost per case basis, they could not compete on quality to attract patients, and thus more money.

I'm currently being tendered for Drug and Alcohol Services. They're just about to tender for 0-25 Year Old Services. So even if I do a fantastic service and patients choose to come to me, if I don't win the tender, they can't come to me. (Provider 1, NHS, community and/or MH, CCG2, April 2014)

This meant that losing a tender could have a catastrophic effect on a community or mental health trust.

The competition is all or nothing 'cause you either win the tender or you don't win the tender.
(Provider 1, NHS, community and/or MH, CCG2, April 2014)

As these providers had little bargaining power, they were willing to accept reduced budgets or to change the scope of services following the tender.

so you've got vastly different systems which, when you – which mean you get different reactions of people, so this hospital Trust that's never tendered for anything can't get their heads round us as a Trust saying, "So, the tender's come out, we know it's far less money than the current service provided." And we've said, "That's okay, we'll live with that. We'll tell you with what – we'll describe to you what we can do for that amount of money. (...) It means we end up thinking not like an Acute Trust, we're not thinking cost and volume. We end up thinking, what can we do for 16 million?" (Provider 1, NHS, community and/or MH, CCG2, April 2014)

Some interviewees thought that tendering was not a lever to improve quality but actually designed to reduce costs.

I think tendering is happening more and it's being used as a lever to reduce costs of services.
(Provider 4, NHS, acute, CCG4, April 2014)

Commissioners told us that they thought that tendering had improved the quality of services. It was less clear that providers thought this was the case.

In fact, community providers tended report negative consequences of tendering. These included fragmentation of service provision between several providers; adverse knock on effects; cherry picking of services by for profit providers and increased overhead rates for losing bidders.

You can translate that principle to community based services as well, that says if you take off the bit that the private sector wants to do, which is the planned and the easy bit and you tender that in isolation, from a Commissioner perspective you are likely to, forgetting all the issues about block contracts and so on, but from a Commissioner perspective, you are likely to make a financial saving. (Provider 1, NHS, community and/or MH, CCG4, Jan 2014)

As it was noted earlier, dealing with the very cost-conscious attitude of local authorities as commissioners was challenging for some NHS providers. One community trust respondent worried that combining social care and community health services might lead to race to the bottom in care standards and wages if NHS providers were to successfully compete for services in this area.

As you move more to the Social Care end, that thing I was describing previously about, you know, city councils, county councils going out to market, they'll be going out to private providers who, you know, pay 3% superannuation as opposed to our 14, employer and employee, you know. And they're on less pay and they're less skilled staff, and that's why I use the derogatory term warehousing, because, you know, you pay for what you get, at the end of

the day. Now, we wouldn't want to move into that market purely, but we do appreciate that to move in partially into the Social Care and healthcare provision market, you know, the combined market, we need to do something with our pay rates. (Provider 5, NHS, community and/or MH, CCG2, June 2014)

Another disbenefit of using competitive tendering to save money was thought to be that the delicate financial balance that providers achieved by cross-subsidising some services within their organisations would be disrupted.

It was costing us a third more to run those inpatient units than it was – than the getting an income. But we were subsidising it from the other bits that we got, and they wanted to cut the income that they were giving us by another third, and we said, “We can't.” So they are closing those units now and they're re-providing them with other providers. Now, I can't believe that other providers can provide what we provide at the level of quality that we provide (Provider 5, NHS, community and/or MH, CCG2, June 2014)

This was related to the concern that there would be negative effects on remaining services if providers were to lose some services in tendering exercises.

If you're going to carve orthopaedics out, well you're carving trauma out, actually, you're affecting A and E and I think that's...I certainly believe there's a level of political naivety about all of that, you know, there are some things you can carve, ophthalmology is arguably one of them. (Provider 5, NHS, acute, CCG3, December 2013)

There was concern that the “unintended consequences” of competition would destabilise existing providers.

I don't think the system's matured enough yet to understand the unintended consequences of what you're doing through it. So, you know, I mean, [CCG4] – as I'm sure you know, there's been lots of talk about whether the CCG4 go out to retender all their community services, which would fundamentally destabilise [community trust], so it has to destabilise an organisation. Now, you know, there's two questions with that. Are those services so unsatisfactory that they feel they have no choice to do that and, therefore, it's worth the pain, etc., but have they realised the risk to the rest of that business, you know? (Provider 4, NHS, acute, CCG4, April 2014)

A further disbenefit of tendering was thought to be the negative effect of competition on staff morale.

People say well the staff will get TUPE'd that's okay, well how would people feel, you know, how do you feel if you're treated like a commodity, that you work for them tomorrow, and someone else the next day. That's not very humanistic, how would you like it if it was you, it's

the friends and family test, not only to the service we provide but the staff who work for us.
(Provider 2, NHS, community and/or MH, CCG3, November 2013)

Another disbenefit of introducing competitive tendering was said to be the creation a geographical patchwork of service provision whereby local contracts were awarded to providers from further afield whilst local providers won some tenders to provide service in more distant geographical locations. This created a web of suboptimal service distribution and additional overheads of running services in distant locations.

You know, we might end up doing Paediatric Speech and Language Therapy in [another London borough] and [that London borough's community trust] might end up doing it here. (...) And where's the sense in that?(...) And we put in an overhead, a significant overhead actually across the system in achieving that.(...) So I am a Luddite, but I'm going, "Well, I – this is making no sense to me." (Provider 1, NHS, community and/or MH, CCG4, Jan 2014)

The providers mainly reported problems which had been caused by tendering, and did not see many benefits. This might be understandable from their view point, but might not give a balanced picture of the effects of tendering. Thus, this section should be read in conjunction with commissioners' views reported earlier.

Independent providers' experiences and relationships

We have chosen to devote a section of this report to the experiences and relationships of independent providers as these varied to some extent from those of the NHS providers. In presenting their point of view separately from NHS providers we can highlight the similarities and differences.

We interviewed five independent providers spread across the four case study sites. All were for profit companies, They delivered a range of services such as diagnostics, CHS and primary care through the AQP mechanism and other contracting arrangements for the NHS patients in the four case study sites. The independent provider (provider 3) in CCG1 was a very small one person concern; provider 3 in CCG2 was a medium to large size firm delivering community outpatient and diagnostics services; provider 6 in CCG2 was a national chain; provider 6 in CCG3 was a GP owned primary care company; and provider 3 in CCG4 was a small to medium sized company delivering a range of CHS.

Independent providers' relationships with other providers

Starting with their relationships with other providers, independent providers reported that they maintained many relationships with other providers seeing them as both competitors and collaborators, much in the same way as NHS providers did.

As in the case of NHS trusts, it was necessary for independent providers to cooperate with other providers in respect of current patient care, even if they were competing for more patients. An interviewee in an independent provider of diagnostic and outpatient services named the local acute trusts as their employer's main competitors but at the same time mentioned their firm had good relationships with all the hospitals for onward patient referrals (Provider 3, independent, CCG2, May 2014). Another remarked that all providers cooperated along the patient pathway.

There's no issue with the pathway and there's no issue with moving the patient along the pathway. We won't compromise them and, in fairness, I don't think any of the Acute or community care providers compromise the patient pathway. (Provider 2, independent, CCG4, Jan 2014)

An independent diagnostics provider stressed the importance of maintaining good relationships with local acute trusts and having local clinicians involved in the provision of services. This was key for smooth onward referral and handover of patients if problems arose.

I have Consultants from the local hospitals working for me. I don't have non-Consultant Doctors working for me that have come from 200 miles away, they're all local. So I believe – I do believe that you have to have your local Consultants, 'cause if you have a problem, you're able to shove it straight into your own Trust. (Provider 3, independent, CCG2, May 2014)

And clinical cooperation was also necessary at times between independent AQP providers. In this example, the AQP providers were working to slightly different specifications and in different areas, which created confusion amongst referring clinicians.

So GPs, because the rules all changed with the AQP for who they could refer to are still quite confused who they should be referred to. So they're often going, oh, well, we'll refer here but maybe we should refer there as well, so sometimes they're getting duplication of services. So trying to reduce the duplication of services is quite important. Also I deliberately didn't want domiciliary visits on my contract, but at least one of the other two [AQP providers] does. So if we have a patient who wants a domiciliary visit you refer on to them. (Provider 3, independent CCG1, May 2014)

As explained earlier, the AQP system was set up in such a way that all accredited providers (NHS and independent) were competing for patients. Thus one of the independent AQP providers named the local CHS trust and two other independent AQP providers as their main competitors (Provider 2, private, CCG4, Jan 2014). Interesting, they competed with them not only for patients but also for premises from

which to deliver their clinics. The poor relationships with some NHS providers in relation to nonclinical issues such as IT infrastructure and estates were widely reported.

In a lot of areas they – the incumbent or ex-NHS community providers, sometimes they were given the buildings, although a lot of those have now gone to NHS Property Services as a separate entity, but in most cases they were given ownership and control of the IT systems used in all of the community buildings in most CCG areas. Which presents problems because they will not allow access to those IT systems to any other provider. Unlike GPs, who are essentially independent, they welcome us in and say “Here you are, here’s your login for the system, off you go.” We can use their machinery. So, yeah, we’ve come up against this in almost every CCG that we’ve come across that we’ve got very good relationships with the Secondary Care teams, the Primary Care teams and with the other independent providers, but generally speaking the sort of ex-community health providers that we have to deal with are very restrictive in what they will – because they’ve got control, particularly the IT they won’t let anyone use it. So they’re kind of, in terms of a level playing field it’s not there in many situations (Provider 2, independent, CCG4, Jan 2014)

At the same time independent AQP providers also maintained close relationships with their main independent competitors at times. This was in order to exchange their ‘know-how’ on best ways of dealing with the NHS and increase their overall power in the local quasi market. The participant described the relationship with other independent AQP providers as “*the minnows getting together to have a little bit more power*” (Provider 2, independent, CCG4, Jan 2014).

In the same manner as NHS organisations, independent providers were also actively looking for partners to bid for tenders. In one case the national chain independent provider had approached some large, incumbent NHS providers with a proposal to create consortia and subcontracting arrangements (Provider 6, independent, CCG2, June 2014). At the other end of the scale the relatively small independent provider operating in CCG4 built on its clinical partnerships with diagnostics and pain management providers to form a consortium enabling the submission of joint bids for tendered services.

As with any organisation, independent providers chose their collaborators carefully. For instance, an independent provider operating in CCG4 turned down an offer of collaboration from another company offering to handle its calls, as it wanted to retain full control over the service.

Independent providers’ relationships with commissioners

Similar to NHS providers, independent providers stressed the importance of building good relationships with commissioners. The importance of personal communication, having someone to speak to if

problems or issues arose was stressed by the national chain independent provider in CCG2 (Provider 6, independent, CCG2, June 2014). This provider noted that local commissioners are actively engaging with them and treating them the same as other providers operating locally. And an AQP provider in CCG4 reported that communication with CCG4 with regards to their AQP services and monitoring of their contract was good. They appreciated having a named person as a contact.

But not all independent providers reported having been treated the same as NHS organisations. A small independent AQP podiatry provider from CCG1 noted an arms-length approach from commissioners, with few meetings and communication between the parties. And the small independent primary care provider in CCG3 complained about the lack of communication from CCG3, stating that commissioners put more effort in maintaining engagement with large local NHS providers.

The two trusts are kept informed but we're just treated terribly, I would say. We're not kept informed with things, although they do come to us often if they need – for instance, the hospital were under pressure, winter pressures, and they didn't have enough doctors. The commissioner came and said, I wonder, could you put some of your GPs in there just for the next fortnight, just to take some of the pressure off A&E? They'll do that all the time but they won't keep us informed about anything else that's going on around our contract, et cetera. (Provider 6, independent, CCG3, March 2014).

It appeared that on the whole small and medium size independent providers did not experience the same level of communication and engagement from commissioners as larger independent providers or NHS trusts.

Independent providers reported some reluctance on the part of the commissioners to expand the use of independent providers in their areas. The national chain CHS provider operating in CCG2 noted that the CCG was reluctant to expand the scope of the provision of their diagnostic services.

We just do ultrasound, non-obstetric ultrasound for [CCG2] (...), we do the [one] side of [CCG2 area], and not the [other area]. Again, we do a good service; the GPs are happy with it. You know, you have the odd problem, which, you know, everybody will have. But again, I've said – tried to say over the last couple of years, "Look, why don't you push it out, pilot it in the other half. You're going to be saving money, you're going to be saving. It's 80% of tariff, you're going to be saving, why not pilot it?" But nobody will pilot it. Nobody... (Provider 3, independent, CCG2, May 2014)

One of the independent providers reflected on their experience of AQP. This mechanism had given an opportunity for small and medium size companies to enter the NHS market and had allowed their own company to grow. However, one of the obstacles to expansion was their absence from the computer Choose and Book system used by GPs to help patients chose where they wished to be referred (despite the fact that they had been assured that they would be included) . This meant that the patients and GPs

were not well informed about the existence of their service. In addition, this provider noted that in some cases commissioners carried out an AQP accreditation process despite a lack of will on the part of GPs to change their referral patterns.

If you take [locality X], for instance, they said “We’re going to do AQP Physiotherapy.” GP said, “Well, we’re not going to use it, but we’ll still go through the accreditation just to tick the box.” So what’s the point in going through the accreditation process? (...) they’ve gone out and they’ve accredited providers who sit there and there’s no activity for them. (...) because there was a consensus there, the political belief from the GPs in the area we’re not interested in independent provision, it should stay with the NHS. (Provider 2, independent, CCG4, Jan 2014)

Independent providers’ experiences of the tendering process

Independent providers’ experiences of tendering were similar to those of NHS organisations in respect of issues such as finding the tendering process very time consuming and thus costly. Some had found ways of reducing these costs by outsourcing tendering work or developing standard answers. Smaller providers reported that tendering documents were designed for large providers.

In common with NHS providers, independent providers had internal processes for deciding which tenders to undertake, and the criteria seemed similar. One independent provider reported looking for tenders which were a “*natural fit for our organisation*” and over the years had developed specialisms in a number of service areas. They noted that they had some ‘red lines’ that they were not prepared to cross concerning pricing and quality.

We will not submit a bid if we don’t believe we can deliver the quality at the price that’s going to be paid. And even if you’ve worked on something for eight months [laughs](...) and you have a fantastic quality of service, if it’s not going to be deliverable because it’s not affordable, then we will not submit. (Provider 6, independent, CCG2, June 2014)

There were some costs of providing the service which had to be considered carefully when deciding whether to respond to an invitation to tender. Two common areas for concern were the costs of transferring the employment to them of NHS staff under the current legal rules whereby the staff had to be offered the same terms and conditions (TUPE); and the cost of premises.

Historically, where NHS services ran out of GP practices, they never even paid anything for rent. And sometimes we wonder whether there is one set of rules for us and one set of rules for them and that makes the playing field very, very hard for us. And if you look at AQP, for instance, and even access into GP practices, very, very hard these days, and they’re all squeezed for room. Some GPs, in some affluent areas, are quite happy to use rooms for their

private GP work as well as their NHS work and – but they won't be able to accommodate NHS AQP services. (Provider 2, independent CCG4, Jan 2014)

The smaller independent providers delivering AQP services had found the tendering process to be accredited for AQP very onerous. It was a time consuming process not least because of the problems with the IT system set up to process the AQP applications. (Provider 3, independent, CCG1, May 2014). Furthermore the forms were generally geared towards large provider organisations.

A lot of the questions you're thinking, well, that's a little bit ambiguous especially for smaller providers. One of them is about how many millions do you have in your bank account. Well, if I had millions, I wouldn't be doing this. I would be retired on the beach. (Provider 3, independent, CCG1, May 2014).

The national chain large independent provider in CCG2 noted differences between tendering processes with some being unproductively complicated and others more straightforward.

The previous tender we did was over 200 questions. It took, I would say from start to finish, between the ITT – between the PQQ and the ITT and the presentation, I would've thought it took four months. Awful lot of time asking the same questions in a different way. Whereas the one that we're doing now, the [XX] one, is 50 questions and it's all combined, ITT and P – PQQ and ITT combined, that's a sensible tender. The other one was just ridiculous, ridiculous in its length. Not to mind the amount of prep that had to be done by the, probably, ten people sitting behind, that were being paid to do that for the last year. And that just, you know, that was just an astronomical amount of questions. (Provider 3, independent, CCG2, May 2014)

Some independent providers had found ways of coping with the burdensome accreditation processes for AQP services. Two had accumulated a bank of draft policies and a “database of answers” which could be reused and adapted for future AQP submissions (Provider 2, independent, CCG4, Jan 2014; and Provider 3, independent, CCG2, May 2014). One small provider told us that some smaller independent providers formed partnerships and jointly outsourced the paperwork associated with responding to tenders.

I know quite a lot of chiropractors and osteopaths and they say that's what's coming up. They've just formed a conglomerate (...) and they just pay someone to do all of their tendering work, which I think is becoming increasingly popular, paying someone to just do it, then getting a group of people who would then work for that area. (Provider 3, independent CCG1, May 2014)

On the other hand, one provider did not think that the accreditation process was sufficiently rigorous.

There's no discrimination because, you know, it's – how are you going to choose between the real clinical quality of a provider when you're [only] asking for a detailed explanation of your service model in 250 words? (Provider 2, independent, CCG4, Jan 2014)

Similar to observations made by some NHS providers, independent providers agreed that commissioners faced no consequences for abandoning tendering exercises.

Where we went through, you know, writing up a tender document through a full tender process is, for us, is a large amount of commitment. It's a large amount of our resources for, you know, a significant period of time. We're talking weeks, and put that in in good faith and got a message the week later saying they'd decided not to proceed and they've just cancelled the whole thing. (Provider 2, independent CCG4, Jan 2014)

Independent providers' views on the effects of tendering

Unsurprisingly, given that tendering was a major way in which they were able to enter the NHS quasi market, independent providers were generally positive about the effects of competitive tendering on service provision, as long as sufficient funds were made available to pay for good quality care.

Independent providers took the view that contracting with them could improve the quality of care provided to NHS patients.

If you were sitting there and the GP said, "Look, you can be seen within two weeks in [locality] just round the corner from you or I can send you down to the local hospital and you're going to be waiting six weeks," it's a no-brainer, patients will come here. And they've all been happy. We've never had a patient ring and say, "No, I don't want to come here, I want to go to the hospital." They've always been happy. We've had excellent patient surveys and they've done their own patient surveys as well. So, you know, I'm 100% happy that the way the service is provided and how it's provided for the patients is good. (Provider 3, independent, CCG2, May 2014)

On the other hand, in common with some NHS providers reported earlier, independent providers were concerned that tendering could have the effect of reducing prices paid for services to unrealistic levels.

There are Commissioners now who are increasingly – they are having to squeeze the envelope. We're seeing tenders come out where they're specing a higher level of service they want for less money than they were paying the incumbent. And you see some of these tenders and, you

know, you wonder the feasibility of them getting what they want (...) – where are providers going to have to cut those corners? (Provider 5, independent, CCG2, June 2014)

So if you drive [the price] down too far (...) to keep saving, saving, saving, you're not going to get the service of the lead – you know, what's the saying, pay peanuts, get monkeys? You know, you have to be realistic as well. You need to make your saving as a CCG, but don't be greedy. (Provider 3, independent, CCG2, May 2014)

A large independent provider attempted to argue against a common perception that for profit providers tended to cherry pick the services that are profitable. It gave two examples: itself providing end of life care; and Hinchingbrooke Hospital, where a for profit provider (Circle Health) had contracted to provide all the services in a district general hospital.

You've got Hinchingbrooke. You know, we do end of life care, you know, these aren't easy services. They're not cherry picked services, they're services that are done – they're hard services, but we want the challenge. (Provider 6, independent, CCG2, June 2014)

(However since this interview was conducted the provider Circle Health withdrew from running Hinchingbrooke Hospital as it found to be financially unviable . This indicates that profitability remains key to private providers' involvement in running services for the NHS.)

Summary of independent providers' experiences

Independent providers reported that they saw other providers both as competitors and collaborators, depending on the circumstances, much in the same way as NHS providers did. Independent providers were keen to build and maintain good relationships with NHS commissioners, as were NHS providers, on the whole. But some of the independent providers reported having been treated differently from NHS organisations, to their detriment. Their experiences of tendering were similar to those of NHS organisations in respect of issues such as finding the tendering process very time consuming and thus costly. Smaller independent providers reported that tendering documents were inappropriate for their small scale organisations, having often been designed for large scale NHS trusts. As expected, independent providers held positive views about the effects of competitive tendering on service provision, as long as sufficient funds were made available to pay for care of high enough quality.

Providers' experiences following the Five Year Forward View (5YFV)

In the second phase of the field work in 2015 we were keen to find out how providers' experiences had changed since the introduction of policies (principally the 5YFV) which placed less emphasis on competition and more on cooperation.

As reported earlier, it proved impossible to re-engage most of the providers who had participated in the first phase of field work. As we were only able to interview one provider in the follow up phase, we can only present a limited view.

However, it is clear from other data we reported earlier that a mixture of competition and cooperation continued to be used in the case study sites, despite the greater emphasis on cooperation in national policy. There was less reliance on competition in CCG4 (where the provider interviewee was based), but all three other sites had continued to use tendering alongside forms of cooperation.

The interviewee (who worked for an NHS CHS trust) explained that, although the commissioners had decided to use a more cooperative approach to redesign local CHS, having abandoned the original plan of using competitive tendering, this did not mean that market regulatory mechanisms could not be used if necessary. If his trust had not been included by the CCG in the cooperative plan to redesign local CHS, they would have considered mounting a legal challenge to that decision.

I think in a way some of that anti-competitive law and that legal framework is not serving the NHS in the best interests per se, because people are getting distracted by, oh we can't possibly have a mature conversation with a couple of providers because that would seem to be anti-competitive. Whereas in my view, no, what we need to do is have that conversation, if somebody wants to challenge it, then they challenge it. Because if we're doing it in the best interests of patients, and we're using taxpayers' money effectively, then good luck I'll see you in court.
(Provider 5, NHS, community and/or MH, CCG4, Oct 2015)

The interviewee noted that commissioning was still fragmented between a series of commissioning bodies, which did not coordinate their approaches. Moreover, although the commissioners in the case study site were focussing on more cooperative approaches, this was not the case in respect of other commissioners.

So I think in (CCG4 area) in particular, the CCG have been focused on this outcome based commissioning approach for [CHS], and that has therefore dominated their agenda. (...) It certainly hasn't stopped other commissioners from going out to market with much smaller tenders, so re-procurement of [XX]services. There's a lot of stuff around the Health agenda and the Health and Wellbeing agenda, which are services which are being commissioned by local authorities or public health, which are going through a very bureaucratic procurement process. (...), It shows a lack of join-up between various commissioners in terms of

understanding what are we trying to achieve. So, tendering school nurses separately to tendering health visitors separate to tendering a whole range of child services or Health and Wellbeing services is a nonsense, what we need to do is say, what are we trying to do for children and families and how is the best way of providing that.(...) Commissioners are still too focused on individual silos rather than looking at a, what are we trying to do in terms of the best use of our money and the needs of our population. It's still very contract-based as opposed to commissioning for a health need, and that in itself is very difficult. There's just no coherence either within a CCG or between CCGs and other commissioners, and so (neighbouring CCG area) are doing something different to CCG4 who are doing something different from (another neighbouring area). (Provider 5, NHS, community and/or MH, CCG4, Oct 2015)

Although working cooperatively was preferable to being forced to compete, cooperating closely with other organisations was difficult, and not without risk. The proposed joint venture between three NHS trusts and the local GP federation had to be both financially viable and capable of delivering an improved service. The interviewee reflected on having to overcome initial distrust between the four partners, and on the challenges of working out detailed arrangements for risk and income sharing.

There is an enormous amount of risk for any of the individual organisations and for the group of organisations in taking on a range of contracts and being given a, effectively a block amount of money. (Provider 5, NHS, community and/or MH, CCG4, Oct 2015)

In addition, the sector regulators (who still had to abide by the regulatory regime which encouraged competition, rather than cooperation) had to be convinced about the viability of providers' plan.

Nevertheless, there was a lot of enthusiasm amongst the four providers who were working hard for this new arrangement to succeed.

I don't think I've seen four providers so strongly aligned anywhere, in my experience. (Provider 5, NHS, community and/or MH, CCG4, Oct 2015)

Summary of providers' experiences

We uncovered considerable differences in the way providers experienced competition and cooperation in the NHS quasi market.

Dealing initially with NHS owned providers, there were two important dimensions. First, the attitudes and behaviour of their commissioners determined the level of competitive pressures to which they were exposed locally. Providers in the CCG3 case study site reported high levels of cooperative behaviour, both led by their commissioners and between themselves. The latter was being encouraged by their commissioners. Providers in the other three case study sites were more attuned to the possibility of their

commissioners using competition to improve services. Moreover, many providers' horizons stretched beyond one CCG area, and they were also affected by the attitudes of other commissioning bodies – other CCGs, NHS England and LAs. Secondly and perhaps crucially, providers' experiences differed depending on the type of services they delivered. Our study suggests that acute providers were more concerned about competition in the market, as they were able to increase their incomes by treating more patients under the Payment by Results cost per case pricing scheme. On the other hand, they were not greatly affected by competition for the market, as commissioners did not attempt to tender out significant amounts of inpatient services, and had not contemplated tendering whole hospitals. However, commissioners were tendering out services which affected outpatient activity, so acute trusts were not entirely immune to competition for the market. As CHS and MH services were not subject to PbR, these providers were not subject to competition in that respect. On the other hand, AQP services were usually delivered out of hospital, so these providers could be subject to competition in the market if they were accredited AQP providers. (And indeed, some acute trusts were also accredited AQP providers in respect of some outpatient services.) More importantly for CHS and MH service providers, there was a real threat of competition for the market, as it was clear that these services could be subject to tender, and had been in many other areas.

We found that all types of provider were using a blend of competitive and cooperative behavioural strategies in their strategic planning and day to day practices. Providers played a complex game of cooperating with their competitors and competing with their collaborators at times. Apart from cooperation about clinical issues, which was widespread, some providers collaborated by sharing back office functions. Many also collaborated to prepare joint bids to respond to invitations to tender, and some also went as far as looking for partners to merge or form joint ventures. At the same time, all providers were aware of their competitors and, in some circumstances, engaged directly in competitions against their fellow local providers, as well as possible market entrants from further afield.

Nevertheless commissioners' efforts were required to transform this competitive energy into collaborative way of thinking by engaging providers in large service transformation projects.

Independent providers were subject to similar competitive and collaborative pressures as NHS organisations, and responded accordingly by cooperating in respect of clinical issues and competing to enter the NHS quasi market on occasions when they were invited to do so by tendering or becoming an accredited AQP provider. The main difference was that, at times they reported not being treated equally by NHS commissioners and NHS providers, who were sometimes reluctant to share information and other resources with them.

Discussion and conclusions

Summary of findings

This study was designed to investigate how commissioners in local health systems managed the interplay of competition and cooperation in their local health economies, looking at acute and (CHS). The research questions were:

- 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.

It should be noted that the study was not designed to assess the actual *effects* of competition (or indeed cooperation) on service efficiency or quality, nor on outcomes for patients.

The design of the study consisted of four case study sites centred round four CCG areas, spread across England, encompassing rural, suburban and inner city environments. Our main method of data collection consisted of interviews with senior commissioners in the CCGs, as well as senior managers in a selection of local provider organisations, both NHS and independent. Further data were collected by examining nationally and locally produced documents, such as local strategic plans. There were two phases of data collection. The main phase occurred in 2013/14, which was soon after the HSCA 2012 came into force (in April 2013). The follow up phase was after the general election in 2015.

We found that when the HSCA 2012 came into effect in April 2013, it introduced a complex regulatory scheme to govern the use of competition and collaboration in the English NHS quasi market. Our findings concerning the understanding of the regulatory context of the NHS market by both commissioners and providers of care indicate that that the 'rules of the game' are not clear to all 'players'. The written material issued by the national authorities and the regulators was seen as unclear. As the time line shows, the national professional press frequently published stories about conflicting decisions on how to interpret the regulatory framework and how local actors across the country were behaving in practice. One important example was the CC decision to veto the merger of two FTs in Bournemouth and Poole in 2013, which was followed by a speech by the Secretary of State in March 2014 urging the competition authorities to go easy on the NHS after this costly, failed merger. He stated

that the new competition regime introduced by the HSCA 2012 had not been “smooth sailing.” He suggested that the competition authorities may have been over interpreting their role in such hospital mergers as the one that fell foul of the authorities in Dorset. Then by May 2014 the proposed acquisition of Heatherwood and Wexham Park Hospitals FT by Frimley Park Hospital FT was cleared by the CMA. And the regulators of the system (especially Monitor) were not perceived as giving adequate guidance to actors when consulted about specific local problems.

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 in light of them. 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 failing to give clear guidance about 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. However, after the publication of the 5YFV, all the commissioners reported that there was less emphasis at national level on using competition, although the formal regulatory structures had not been changed. It was even less clear what the rules were, but they all seemed inclined to decrease their use of competition as a commissioning mechanism. This increased use of cooperation was thought to be more appropriate when making major service changes locally. But most of the respondents expressed the opinion that it was still necessary for commissioners to be able to use competitive processes at times, when they judged it necessary. Although all sites preferred to use collaborative approaches to achieve major transformation of services, we found that during the first field work period, 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 a greater number of potential providers (being in London) or due to the personal preferences, experiences and convictions of senior managers and leading GPs. By the time of the second phase of field work, the commissioning personnel at CCG4 had changed. The new staff appeared to be much less enthusiastic about competition, and were advocating the use of cooperative methods to reconfigure local CHS services.

Provider managers shared many concerns that were expressed by commissioners about the rules governing competition with the NHS. 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 NHS acute 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 provider

managers such changes could not be delivered through greater use of competition due to additional costs that accompanied operation of the market within NHS. In contrast to the NHS provider managers, the employees of independent providers we interviewed were much more enthusiastic about competition, as this was their route to market entry. The NHS provider manager respondent in the follow up interview in 2015 thought that the national enthusiasm to use competition was waning, following the publication of the 5YFV, despite no changes having been made to the regulatory framework. He welcomed the greater opportunities to use cooperative methods to reconfigure services.

As far as actual commissioning behaviour is concerned, it appears that there was a number of differences between the four case study sites in terms of the volume and mode of using competition as a commissioning mechanism. Although it was difficult to obtain exact data on the number of procurements conducted, arguably CCG2 and CCG4 had more experience in running competitive procurements than CCG1 and CCG3. Furthermore a clear dividing line emerged between CCG2 and the rest of the sites, with the former having very close cooperative relationships with local providers and carrying out most of its service changes collaboratively with other organisations. Such an approach was much rarer in CCG4, which appeared to have the largest degree of enthusiasm for the local use of competition in its CCG board, at least in 2013/14. Nevertheless, every site (including CCG3, which had claimed in 2013/14 that it had no interest in doing so) had, by 2015, undertaken at least one competitive tendering for the market as a result of a decision taken at the local level. All sites had also undertaken tendering to increase competition in the market (as opposed to for the market) as a result of top-down pressure to use competition linked to a particular policy initiative such as AQP. Commissioners saw that competition had its benefits as it is able to stimulate and challenge existing providers out of complacency. CCGs remained keen to experiment and try out all commissioning methods available to them. Competition remained an important lever for commissioning provided it was not enforced top down but left within the local decision making remit. It was useful at times to force providers to improve services. All the commissioners noted, however, that the procurement process was very resource intensive, as the process was time consuming and cumbersome. Therefore, given current resources available for commissioning, it was not possible to undertake many of these exercises.

By 2014 and 2015 one there was a slight decline in the appetite to use competition in some of the sites, especially for large scale service reconfigurations.

Commissioners in all case study sites emphasised that competition was not appropriate for implementing large, long-term service transformation programmes. This was because such programmes required full engagement of the providers to succeed. Competition was seen as a confrontational method of commissioning, endangering relationships between commissioners and providers. Collaborative planning involving key local providers, creating a sense of shared ownership of problems faced by the local health economy was a preferred way for CCG commissioners to approach large commissioning tasks. Our study has shown that all the sites used cooperative approaches to carry out major service reconfiguration. The

commissioners in each area acted as coordinators of the process. Moreover, commissioners feared that competitive tendering might financially destabilise local NHS providers if they were to lose income through the process. Competitive tendering was used mainly as a measure of last resort.

We found there were differences in the way providers experienced competition and cooperation. NHS owned providers were affected by the attitudes and behaviour of their local commissioners, which determined the level of competitive pressures to which they were exposed locally. In addition, providers' experiences differed depending on the type of services they delivered. Acute providers were more concerned about competition in the market, as they were able to increase their incomes by treating more patients under the PbR pricing scheme. On the other hand, they were not greatly affected by competition for the market, as commissioners did not attempt to tender out significant amounts of inpatient services, and had not contemplated tendering whole hospitals. Commissioners did, however, tender out services which affected outpatient activity, so acute trusts were not entirely immune to competition for the market. As CHS and MH services were not subject to PbR, these providers were not subject to competition in that respect. On the other hand, AQP services were usually delivered out of hospital, so these providers could be subject to competition in the market if they were accredited AQP providers. (And indeed, some acute trusts were also accredited AQP providers in respect of some outpatient services.) More importantly for CHS and MH providers, there was a real threat of competition for the market, as it was clear that these services could be subject to tender, and had been in many other areas.

All types of provider were using a blend of competitive and cooperative behavioural strategies in their strategic planning and day to day practices. Providers played a complex game of cooperating with their competitors and competing with their collaborators at times. Apart from cooperation about clinical issues, which was widespread, some providers collaborated by sharing back office functions. Many also collaborated to prepare joint bids to respond to invitations to tender, and some also went as far as looking for partners to merge or form joint ventures. At the same time, all providers were aware of their competitors and, in some circumstances, engaged directly in competitions against their fellow local providers, as well as possible market entrants from further afield.

Independent providers were subject to similar competitive and collaborative pressures as NHS organisations, and responded accordingly by cooperating in respect of clinical issues and competing to enter the NHS quasi market on occasions when they were invited to do so by tendering or becoming an accredited AQP provider. The main difference was that, at times they reported not being treated equally by NHS commissioners and NHS providers, who were sometimes reluctant to share information and other resources with them.

Limitations of the study

The study has certain limitations. *First*, as the study design consisted of four in depth case studies, it is not possible to make statistically based generalisations to the whole NHS. However, as the study is based on a strong theoretical framework, it is possible to make analytical generalisations. Nevertheless, it should be noted that none of the CCGs in our study had decided to use competitive tendering to achieve major service reconfiguration. The time line indicates that some CCGs who were not participants had done so, although with variable results. See, for example the history of the NHS owned Hinchingsbrooke Hospital the whole of which was put out to tender and run by a for profit company, Circle. By 2015 Circle had withdrawn from the franchise contract because it was unable to achieve the financial savings it had promised the NHS, and the hospital's services had been subject to critical inspection reports by the CQC. On the other hand, some major tenders appear to have been more successful. For example, in 2014 Circle was awarded a five year £120 million MSK contract by Bedfordshire CCG and a consortium of NHS and independent providers won a £210 million MSK contract in Sussex. *Secondly*, it was not possible to find the exact details of the tenders undertaken in our four case study sites, due to the very poor quality of routine data available. This problem affects the whole of the English NHS and means that one cannot ascertain with any certainty the extent and nature of the use of competitive commissioning across the NHS, nor the extent of market entry by independent providers. The time line was an attempt on our part to mitigate this problem, but it cannot be regarded as definitive. (The time line had other purposes as well – it shows the evolution of the regulatory environment during the course of the study, which is also important in understanding local NHS managers' behaviour.) *Thirdly*, it was regrettable that only one provider manager agreed to participate in the follow up phase in 2015. This was probably due to the increased financial pressure to which providers were subject by this time. However, the interviews with commissioners in 2015 enabled us to obtain a clear picture of the extent to which the market and regulatory landscape had (or had not) changed by then, as well as any changes in commissioners' attitudes and behaviour.

Discussion and conclusions

Our findings concerning the lack of clarity of the regulatory regime for local actors are important. As Ostrom (2005) points out, actors need to understand the rules of the game in order to know how to relate to each other, and these rules are vital in setting the context and limits within which local actors can operate. As we have shown, the interpretation of these rules by regulators, national authorities and local actors (if not their actual form) changed over time.

It remains government policy (as well as being enshrined in the European procurement regulations) 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. Just as important is that commissioners actually treat all providers equally, which our study indicated they were not doing at all times.

It is not surprising that commissioners and providers used a judicious mixture of competition and cooperation in their dealings with each other. This behaviour is common in most markets for complex goods and services (Evans, 2001; Sabel, 1994). One of the important reasons for doing so is to reduce transaction costs, as our participants explained. This links directly to the arguments made by eminent institutional economists referred to in the introduction to this report (Coase, 1937 and Williamson, 1985) – there are certain goods and services whose characteristics indicate that non market institutional structures will be more efficient than using markets, due to the transaction costs incurred in operating such markets.

Furthermore, the influence of the 'institutional logics' identified by Tuohy (1999), and also discussed in the introduction, are also important to understanding how the NHS operates. The NHS has a long history of hierarchical modes of control which it is difficult to change in a short period of time. As discussed in the introduction, previous research on the NHS has indicated that the earlier versions of the quasi market introduced by the Conservatives in the 1990s and New Labour from 2001 onwards had not blunted the dominance of hierarchical methods of coordination despite the introduction of market like structures (Le Grand et al, 1998; Mays et al, 2011). Checkland and colleagues (2012), utilising theories of new institutionalism (Scott, 2008), identified a lack of fit between the norms permeating the NHS such as the focus on individual patients and seeing the NHS as a common enterprise, and the formal rules of commissioning pushing for greater marketisation of relationships between different actors within the health system under the New Labour version of the quasi market. Checkland et al's study suggests that hybridity instigated by marketisation of the NHS was present at that time only at the level of structures, whilst norms governing actors' behaviour remained relatively unaffected. Our study has shown that this is substantially true in respect of the third incarnation of the NHS quasi market under the HSCA 2012.

However, it is important to note that this is not the whole story. Checkland et al (2012) point out that institutional change may occur in future if commissioning principles become more embedded in the NHS culture. Our study shows that there are signs that competitive forces are gradually taking hold in respect of some more marginal services, and especially in respect of CHS and MH services. It appears that it is possible for NHS norms and culture to change.

Implications for policy and practice

The implications of our study for policy makers are several.

Local commissioners should be allowed to make their own decisions about which modes of commissioning are most appropriate in their particular circumstances, and in respect of particular services. Setting up nationally imposed rules about what mechanisms must be used is unhelpful (and probably will not be adhered to, in fact).

It appears that in most circumstances, (especially in respect of major service reconfigurations) the use of cooperative modes of coordination are likely to be more appropriate. Fortunately, the recent policy developments under the 5YFV indicate this is the direction of travel.

At the same time, it is important to clarify the rules of the game for local actors. It may be politically unpalatable, but the regulatory framework of the HSCA 2012 needs revisiting.

Implications for research

The implications of our study for research are important.

As we have noted, it is currently impossible to ascertain the extent of the use of competitive mechanisms by commissioners (especially in respect of competition *for* the market), as there are no sources of routine data. In order for researchers to investigate the effects of this type of tendering, it is necessary for these data to be collected centrally on a longitudinal basis. This would facilitate quantitative research on the relationship between the use of competitive tendering (on the one hand) and outcomes for patients and the effect on the efficiency of services (on the other). In order to measure efficiency accurately, this research should attempt to take account of the magnitude of transactions costs incurred in the tendering process by all parties. It should be noted that this question differs from research already undertaken concerning competition *in* the market between NHS providers by Gaynor et al (2011) and Cooper et al (2010).

Furthermore, it is not currently possible accurately to ascertain the extent of market entry by independent providers, due to the lack of centralised data collection from CCGs and other commissioners. In order for researchers to investigate the effects increasing diversity of providers, it is also necessary for these data to be collected centrally on a longitudinal basis. This would facilitate quantitative research on the relationship between market entry by independent providers (on the one hand) and outcomes for patients and the effect on the efficiency of services, including NHS incumbents

(on the other). It should be noted that to date, research on this issue has been confined to diversity of provision in respect of limited aspects of acute care, namely independent sector treatment centres (Browne et al, 2008; and Perotin et al, 2013), and that, as we found in this study, there appears to be more diversity of healthcare providers in CHS and MH services. (Centrally collated routine data in respect of activity and quality of all CHS and MH services are also required.)

References

Allen P. (2002), 'Plus ca change, plus c'est la meme chose: to the internal market and back in the British National Health Service' *Applied Health Economics and Health Policy* 1 (4). p. 171-178.

Allen, P. (2006), New localism in the English NHS: what is it for? *Health Policy* 79 (2-3). p. 244-52.

Allen, P. and Jones, L. (2011) Increasing the diversity of health care providers in Mays, N., Jones, L. and Dixon, A. (eds) *Understanding New Labour's market reforms of the English NHS*. London: King's Fund.

Allen, P., Keen, J., Wright, J., Dempster, P., Townsend, J., Hutchings, A., Street, A. and Verzulli, R. (2012) Investigating the governance of acute hospitals in England: multi-site case study of NHS Foundation Trusts *Journal of Health Services Research and Policy* 17 (2). p. 94-100.

Allen, P. Petsoulas, C and Ritchie, B (2014) *Final report from study of the use of contractual mechanisms in commissioning* Policy Research Unit on Commissioning and the Healthcare System.

Browne J, Jamieson L, Lewsey J, Van der Meulen J, Copley L, Black N (2008) 'Case-mix and patients' reports of outcome in independent sector treatment centres: comparison with NHS providers'. *BMC Health Services Research*, vol 8, no 78.

Checkland, K., S. Harrison, S. Snow, I. Mcdermott and A. Coleman (2012) Commissioning in the English National Health Service: What's the Problem? *Journal of Social Policy* (41). p. 533-550.

Coase, R. (1937) The Nature of the Firm *Economica* 4 (16). p. 386-405.

Cooper, Z., Gibbons, S., Jones, S., McGuire, A. (2010) *Does hospital competition save lives? Evidence from the English NHS patient choice reforms* (LSE Working Paper No 16/2010).

Croxson, B. (1999) *Organisational Costs in the New NHS: an introduction to the transaction costs and internal costs of delivering health care*. London: Office of Health Economics.

Co-operation and Competition Panel, (2009). *Launch documents*. Available from: www.ccpnl.org.uk. [accessed 2nd March 2009].

Davies, A. (2004) Foundation Hospitals: a new approach to accountability and autonomy in the delivery of public services *Public Law*. p. 808-828.

Davies, C. (2014) Role for competition in new provider landscape *Health Services Journal* [Online] 28 November 2014.

Den Exter, A & Guy, M. (2014) Market Competition in Health Care Markets in The Netherlands: Some lessons for England? *Medical Law Review* 22 (2). p. 255-273.

Department of Health (1989), *Working for Patients* White Paper Cmd 555 HMSO London

Department of Health (2005) *Creating a Patient-led NHS: delivering the NHS improvement plan*. London: Department of Health.

Department of Health (2005a), Department of Health website, London: Department of Health. Available from:
www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/SecondaryCare/NHSFoundationTrust/fs/en. [Accessed: 16th March 2005].

Department of Health (2005b), *Health Reforms in England: update and next steps* Department of Health, London

Department of Health (2006), *Health Reforms in England: update and commissioning framework* July 2007 London: Department of Health.

Department of Health (2007a), *Brief for Health Reform Evaluation Programme* January 2007 London: Department of Health.

Department of Health (2007b), *Options for the future of Payment by Results 2008/9 to 2010/11*. London: Department of Health.

Department of Health (2009) *National evaluation of integrated care pilots*. London: Department of Health. Available from:
www.dh.gov.uk/en/Healthcare/IntegratedCare/Integratedcarepilots/DH_109493#_2.

Department of Health (2010) *Principles and rules for cooperation and competition* (revised edition).

Enthoven, A. (1999), *In pursuit of an improving National Health Service* Nuffield Trust, London

Evans, N. 2001. Collaborative strategy: an analysis of the changing world of international airline alliances. *Tourism Management* 22 (3).p. 229-243.

Ferlie, E., Addicot, R. Exworthy, M., and Fitzgerald, L. (2010) Final report on *Networks in health care: a comparative study of their management impact & performance* NIHR SDO programme.

Gaynor, M., Moreno-Serra, R. and Propper, C. (2011) *Death by Market Power: Reform, Competition and Patient Outcomes in the NHS* Working Paper 10/242 CMPO Bristol University.

Goddard, M., Mannion, R. (1998) From Competition to Co-operation: New Economic relationships in the National Health Service *Health Economics* 7. p. 105-119.

Ham, C., Baird, B., Gregory, S., Jabbal, J., Alderwick, H. (2015) *The NHS under the Coalition Government: NHS reform*. London: The Kings Fund February.

House of Commons Health Select Committee (2006) *Independent Sector Treatment Centres* [Fourth report of Session 2005-6, HC 934-1]

House of Commons Public Administration Select Committee (2007) *Announcement of enquiry into Commissioning public services from the third sector*. Available from: www.parliament.uk/parliamentary_committees/public_administration_select_committee/pasc_commissioning.cfm. [Accessed 3rd April 2007].

Hughes D. and P. Vincent-Jones (2008) 'Schisms in the Church: NHS Systems and Institutional Divergence in England and Wales' *Journal of Health and Social Behaviour* 49 (4). p. 400-416.

Hunt, J. (2014) Patient choice is not key to improving performance *Health Services Journal* [Online: 26 November].

Jones, L. and N. Mays (2013) Early experiences of any qualified provider *British Journal of Healthcare Management* 19 (5). p. 217-224.

Joskow, P. (1987) Contract Duration and Relationship-Specific Investments: Empirical Evidence from Coal Markets *The American Economic Review* 77 (1). p. 168-185.

Kurunmaki, L. (1999) Professional vs. financial capital in the field of health care-struggles for the redistribution of power and control *Accounting, Organisations and Society* 24(2). p. 95-124.

Le Grand, J. N. Mays and J. Mulligan eds. (1998) *Learning from the NHS Internal Market A review of the evidence* (London: King's Fund).

Mays, N., Jones, L. and Dixon, A. (eds) *Understanding New Labour's market reforms of the English NHS*. London: King's Fund.

Monitor (2013) *A Fair Playing Field for the Benefit of NHS Patients* London: Monitor. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/284634/The_Fair_Playing_Field_Review_FINAL.pdf

NHS England (2014) *Five Year Forward View*. London: NHS England.

Odudo, O. (2011) Are State-Owned Health-Care Providers Undertakings Subject to Competition Law? *ECLR*, 32 (5). p. 231-241.

Ostrom, E. (2005) *Understanding institutional diversity*. Princeton: Princeton University Press.

Perotin, V., Zamora, B., Reeves, R., Bartlett, W., Allen, P. 'Does Hospital Ownership Affect Patient Experience? An Investigation into Public-Private Sector Differences In England' (2013) *Journal of Health Economics* 32 (3), 633-646

Sabel, C. (1994) *Learning by Monitoring: The Institutions of Economic Development*. In Smelser, N. & Swedberg, R. (eds.) *Handbook of Economic Sociology*. Princeton, NJ.: Princeton Sage.

Scott, W.R. (2008) *Institutions and Organizations. Ideas and Interests*. 3rd edn. Los Angeles: Sage Publications.

Secretary of State for Health (2006) *The government's response to the Health Committee's Report on Independent Sector Treatment Centres* SO (Cmd 6930).

Secretary of State for Health (2010) *Equity and Excellence: Liberating the NHS* (Cm 7881).

Tuohy, C. (1999) *Accidental logics : the dynamics of change in the health care arena in the United States, Britain and Canada* Oxford: Oxford University Press.

Williamson, O. (1985) *The Economic Institutions of Capitalism*. New York: Free Press.

Appendix 1. Timeline of policies, regulatory decisions and key events

(See separate document)