Next Steps in Commissioning through Competition and Cooperation (2016-2017)

Additional Report
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Dorota Osipovic¹
Pauline Allen¹ (PI)
Christina Petsoulas¹
Valerie Moran¹

Contact: Professor Pauline Allen (Pauline.Allen@lshtm.ac.uk)

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¹ London School of Hygiene and Tropical Medicine, 15 Tavistock Place, London WC1H 9SH.
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Executive Summary

Background

In 2016 we reported our research on NHS commissioners’ and providers’ understandings and use the rules on competition, and our investigation of how commissioners used competitive and cooperative commissioning mechanisms at local level from 2013 to 2015. Since 2015, when the last phase of field work was undertaken, the legal framework governing the procurement of clinical services has not changed. The generally pro-competitive provisions of the Health and Social Care Act 2012 (HSCA 2012) remain in force. In addition, the Public Contracts Regulations 2015 (PCR 2015) came into force in April 2016 introducing further requirements in respect of competitive procurement.

Despite no substantive changes in the legislation governing procurement processes, since 2015 there has been a considerable national policy shift towards cooperative methods of commissioning. Firstly, the ‘Five Year Forward View’ (5YFV) published by the NHS England (NHSE) in October 2014 instigated a number of the New Models of Care (NMC) vanguard sites. Many of these involved the merger or at least closer cooperation of a range of NHS organisations. This view was reinforced by the national planning guidance issued in late 2015 (Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21). This document stated that the NHS should concentrate on local, placed based planning to be achieved by cooperation between local stakeholders. The plans were to be called ‘Sustainability and Transformation Plans’, and the groups of organisations were named ‘Sustainability and Transformation Partnerships' (STPs). These cooperative modes of coordination were regarded as the preferable (and in fact, mandated) method by which health services would be planned and commissioned. Lastly, the notion of Accountable Care Organisations (ACOs) or Systems (ACSs) was introduced in 2017. These were seen as natural successors to STPs under which NHS organisations would either merge formally or work in close cooperation.

In the light of these policy developments there was a need to investigate the way in which local commissioners and providers managed the interplay between cooperation and competition in commissioning clinical services.

Aims

The aims of this stage of the field work remained the same as those of the initial study. The 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 the commissioning strategies of Clinical Commissioning Groups (CCGs) 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

To explore the views on and practices of commissioning we looked in-depth at four CCG areas in England, adopting a qualitative, longitudinal case study research design. The case study sites comprised a mix of rural and urban settings and were located in the North, the Midlands and London.

The findings presented in this report stem from the third round of interviews conducted in 2017. We returned for a third time to the four case study sites and conducted fifteen interviews with senior commissioner and provider managers. The interviewed providers comprised NHS acute, community and mental health (MH) services providers and two private sector community services providers.

We also consulted local documents such as CCG governing body papers and procurement portals to gather information on commissioning strategies, financial status and use of competitive tendering in each CCG under study.

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 announcements, regulations and guidance pertaining to competition and cooperation in the English NHS covering the period between November 2015 and October 2017 (see Appendix 1).

Results

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

Commissioners and providers noted a marked change in policy direction towards more cooperative mechanisms of commissioning NHS services, whilst at the same time observing a lack of change in the rules governing procurement of services. Very few participants were aware of the provisions of the PCR 2015. Both commissioners and providers found that the existing rules did not support the national policy direction. Although the focus of most senior managers was firmly on searching for local solutions to implement the national policy turn towards collaboration, some participants were concerned about the feasibility of accomplishing such tasks without the help of a supportive legal framework.
On the whole, the participants found that the use of competitive methods of commissioning clinical services in the present financial context of the NHS was inappropriate. Nevertheless, some commissioners also commented that the possibility of using competitive mechanisms in commissioning ought to be retained in order for commissioners to be able to discipline and incentivise providers.

The interviews indicated overwhelming support for the use of cooperative methods in strategic planning and commissioning. Despite this, commissioner and provider managers could not ignore the rules entirely, partly for fear of legal challenge and partly as the sector regulators still appraised the financial and clinical performance of their organisations as individual entities.

**Competitive and cooperative behaviour**

In all but one case study site commissioners used competitive tendering less frequently than during earlier waves of the fieldwork. The services which were put out to tender did not amount to a major procurement and as previously, tended to be community based services, rather than inpatient work.

In a marked change from earlier fieldwork, the acute providers perceived other acute providers more as collaborators than competitors and turned their focus to exploring new governance and clinical cooperation arrangements. On the other hand, community health service providers simultaneously competed and collaborated with each other, depending on which approach appeared more advantageous.

Although the frequency of putting services out to tender by NHS commissioners in the four case study sites decreased, where procurement was used, it was usually because of the perceived availability of a number of potential providers and for the fear of falling foul of the procurement rules. In addition to traditional competitive tendering, interviewees reported the increasing use of hybrid forms of competitive tendering. This referred to the open procurement processes which were conducted on the basis of existing competitive procurement guidance and infrastructure, but which explicitly aimed at putting in place a collaborative arrangement between identified providers for provision of a particular type of service. The creative use of the procurement framework by commissioners to ‘procure collaboration’ had an impact on provider behaviour, encouraging cooperation.

According to some NHS providers, joint responsibility and accountability for local health systems not only entailed commissioners eschewing competitive tendering which could undermine key local providers, but also put responsibility on the providers to continue offering services which were vital to the population, despite those services being unprofitable.

Independent providers were wary of the turn towards cooperative mechanisms in commissioning services as it would decrease opportunities for market entry. Yet at the same time they had begun to explore working in partnership with NHS providers as another way of gaining market entry.
Discussion and conclusions

As we found in earlier fieldwork, it is not surprising that commissioners and providers used both competition and cooperation in their dealings with each other. This behaviour is common in markets. Despite the recent decline in the use of competitive strategies by commissioners and providers, there is still a place for competition at times, where the processes of enacting it (or even the threat of doing so) do not outweigh its benefits. Thus, 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.

The study uncovered a pressing need for better alignment between the regulatory framework and current national policies. Given the existing policy commitment to the collaboration and financial imperatives, adjustment of the regulatory framework is needed to facilitate these developments.
**Glossary**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5YFV</td>
<td>Five Year Forward View</td>
</tr>
<tr>
<td>ACO</td>
<td>Accountable Care Organisation</td>
</tr>
<tr>
<td>ACS</td>
<td>Accountable Care System</td>
</tr>
<tr>
<td>AQP</td>
<td>Any Qualified Provider</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CHS</td>
<td>Community Health Services</td>
</tr>
<tr>
<td>CMA</td>
<td>Competition and Markets Authority</td>
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<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
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<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
</tr>
<tr>
<td>CSU</td>
<td>Commissioning Support Unit</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>FT</td>
<td>Foundation Trust</td>
</tr>
<tr>
<td>GP</td>
<td>General Practice</td>
</tr>
<tr>
<td>GU</td>
<td>Genitourinary services</td>
</tr>
<tr>
<td>HSCA 2012</td>
<td>Health and Social Care Act 2012</td>
</tr>
<tr>
<td>ICO</td>
<td>Integrated Care Organisation</td>
</tr>
<tr>
<td>LA</td>
<td>Local Authority</td>
</tr>
<tr>
<td>LES</td>
<td>Local Enhanced Services</td>
</tr>
<tr>
<td>MCP</td>
<td>Multispecialty Community Provider (New Models of Care programme)</td>
</tr>
<tr>
<td>MCProv</td>
<td>Most Capable Provider</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MSK</td>
<td>Musculoskeletal Services</td>
</tr>
<tr>
<td>NHSE</td>
<td>NHS England</td>
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<tr>
<td>NHSI</td>
<td>NHS Improvement</td>
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</tbody>
</table>

The 2013 Procurement Regulations
The National Health Service Procurement, Choice and Competition Regulations No.2 2013
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NMC</td>
<td>New Models of Care</td>
</tr>
<tr>
<td>OBC</td>
<td>Outcomes Based Commissioning</td>
</tr>
<tr>
<td>OJEU</td>
<td>Official Journal of the European Union</td>
</tr>
<tr>
<td>PbR</td>
<td>Payment by Results</td>
</tr>
<tr>
<td>PCR 2015</td>
<td>Public Contracts Regulations 2015</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>PFI</td>
<td>Private Finance Initiative</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention programme</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability and Transformation Partnership</td>
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<tr>
<td>TUPE</td>
<td>Transfer of undertakings protection of employment regulations</td>
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</table>
Introduction

Following on from the final report of our study of the use of competition and cooperative mechanisms for commissioning (Allen et al, 2016), we undertook a further round of field work to investigate how the situation was changing in the light of more recent policy developments. This additional work was approved by the Department of Health as part of the overall PRUComm research plan. We were able to return for the third time to the same case study sites which enabled us to find out how matters had changed by 2017 in response to local conditions and national guidance.

Since the second round of fieldwork in 2015, there had been several relevant policy developments, although it should be stressed that no changes had been made to the competition regime set out in the HCSA 2012. In addition to the Act, a new set of pro-competitive regulations with statutory effect had come into force in respect of the NHS in April 2016: the PCR 2015. Application of the PCR 2015 to commissioning NHS services has been interpreted (Mills&Reeve 2016) as having introduced a requirement to advertise in the Official Journal of the European Union (OJEU) any contract for health services whose value exceeds a stipulated threshold. The prevailing view is that they do not however require a full competitive procurement to be followed. As a result, this process has been labelled a ‘Light Touch Regime’ (Crown Commercial Service 2016; Mills & Reeve 2016). This view has been supported by the DH (2016), the regulator, NHS Improvement (NHSI) (2016) and NHSE (undated). A popular method of procurement which has developed under the auspices of the guidance from NHS national bodies since 2013 is that of ‘Most Capable Provider’ (MCProv), under which commissioners use a transparent process to identify the best provider but do not continue with a full formal competitive procurement process once this provider has been chosen. According to Mills and Reeve (2016) ‘MCProv’ is an unofficial expression, which is used by commissioners and has been approved by Monitor (the predecessor to NHSI) as a process compliant with the 2013 Procurement Regulations. It refers either to: (a) a competitive process (generally featuring dialogue or negotiation) involving the selection of potential providers from a limited pool who are either identified by the commissioner as being possible suppliers following a research or consultation exercise, or who might have responded to an advertisement or engagement event (but possibly with a limited geographic reach) and are therefore interested in participating; or (b) a negotiated procedure with a single provider identified by the commissioner as obviously being the most capable of providing a particular service in a particular locality. The MCProv process may not be compliant with the PCR 2015 as the latter only allow a Light Touch Regime for procurements under the stipulated financial threshold, and MCProv is undoubtedly light touch and being used for procurements over the relevant financial threshold. As far as we are aware, this point has not been subject to dispute, and thus to any external decision making from the courts or other regulators, to date. During the same period, there were several policy developments instigated by NHSE which promoted the increased use of cooperative modes of coordination and downplayed the role of competition in the NHS. Firstly, the NMC vanguard sites to be established
according to the 5YFV (NHSE, 2014) came on stream. Many of these involved the merger or at least closer cooperation of a range of NHS organisations, and ran directly counter to the view that NHS organisations should compete with each other. This view was reinforced by the national planning guidance issued in late 2015 (NHSE et al, 2015b). This document stated that the NHS should concentrate on local, placed based planning to be achieved by cooperation between local stakeholders. The plans were to be called ‘Sustainability and Transformation Plans’.

“Place-based planning

7. Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn’t make sense to staff or the patients and communities they serve.

8. System leadership is needed. Producing a STP [Sustainability and Transformation Plan] is not just about writing a document, nor is it a job that can be outsourced or delegated. Instead it involves five things: (i) local leaders coming together as a team; (ii) developing a shared vision with the local CHS, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting.[ ...]

(NHSE et al, 2015b).

The STP process continued to be central to NHS commissioning at local level and the term ‘STP’ mutated to mean ‘Sustainability and Transformation Partnerships’, indicating that these cooperative modes of coordination were regarded as the preferable (and in fact, mandated) method by which health services would be planned and commissioned. Furthermore, the notion of ACOs was introduced by NHSE (2017). These were seen as natural successors to STPs under which NHS organisations would merge formally. By March 2017 NHSE had issued a document entitled, ‘Next Steps on the NHS Five Year Forward View (NHSE 2017). Its purpose was to take stock of the NMC programme and appraise future challenges. The document described a new organisational vehicle to deliver greater integration between providers in the form of an ACS. The idea of an ACS was presented as open-ended. The document acknowledged that this was in response to the legal obstacles to creating more formally merged organisational structures, such as ACOs. Under an ACS, NHS organisations would increase their degree of cooperation with each other. Furthermore, NHSE issued draft forms of contract designed to facilitate new forms of cooperation between NHS organisations (NHS E, 2017).

Alongside published policy documents, guidance and regulatory decisions, the role of more nuanced policy signals conveyed in speeches and statements by the influential policy makers in this period was crucial to how managers on the ground interpreted the policy direction. On several occasions Simon Stevens (CEO of NHSE) stated that competition was not appropriate for NHS organisations, which
needed to reduce their ‘institutional self-interest’ in the interests of the whole local health economy (e.g. Dunhill, 2016; Thomas and West, 2017). A particularly salient regulatory decision was news that the two NHS Foundation Trusts in Bournemouth and Poole, which were prohibited from merging by the national competition regulator in 2013 (Competition Commission, 2013) could merge after all (Carding, 2017).

**Aims**

The aims of the further fieldwork remained the same as those of the initial study.

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 CHS 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.
Study design and methods

At the end of 2016 we contacted the same four CCGs in England which participated in the previous two phases of the study (Allen et al. 2016), and secured their agreement to continue to take part. This enabled us to collect longitudinal qualitative data on the understanding and use of competitive and cooperative mechanisms in commissioning over a period of five years.

In all, the study consisted of three waves of interviews with commissioners and providers in four case study sites and explored how commissioners approached their roles as shapers of the local health system in respect of competition and cooperation issues in the changing policy context. The use of case studies was deemed the most appropriate research design as case studies allow for exploration of mechanisms, processes and phenomena in the real life contexts (Yin 2009). Focusing on four areas of the country, we were able to pursue our research questions in depth, informed by three waves of in-depth interviews and examination of local documents (such as CCG commissioning strategies and board minutes).

The findings from the first two waves of data collection conducted between August 2013 and June 2014 (Wave 1) and between July and October 2015 (Wave 2) have been reported extensively elsewhere (Allen et al. 2014; Allen et al. 2016; Allen et al. 2017; Osipovic et al. 2016). This report outlines the findings from the third wave of in-depth interviews conducted between February and September 2017.

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. In order to carry out a third wave of interviews, we applied for an extension to the original study. In July 2016 we secured the LSHTM ethics committee approval for the extension of the study, followed by the Health Research Authority’s approval in October 2016. We then approached each organisation that participated in the first two waves of interviews to give them notice of the extension of the study and ascertain their continuing capacity to take part in this study. This was a time consuming process characterised by a lack of clear procedures on the ground and difficulties in establishing the appropriate local research governance offices. The process of securing local research governance approvals ran concurrently with data collection, with the last local approval being secured in September 2017, just before the end of the fieldwork.

During the third wave of data collection, we re-contacted all the commissioning organisations which took part in the first wave of the research. We also re-contacted all original providers that were still providing services to the four CCGs and two additional independent provider organisations which were not part of the original fieldwork, but which had begun to provide services in two case study sites. After approaching 20 organisations, between February and September 2017, we carried out 15 interviews with senior commissioner (5) and provider managers (10), including two interviews with independent
providers, in four CCG areas across England. Case study sites comprised a mix of rural and urban settings and were located in the North, Midlands and London (see Tables 1 and 2).

Table 1 Interviews by case study sites (third wave)

<table>
<thead>
<tr>
<th>Case study site</th>
<th>Location of CCG</th>
<th>No. of third wave interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG1</td>
<td>Rural, North</td>
<td>3</td>
</tr>
<tr>
<td>CCG2</td>
<td>Urban, Midlands</td>
<td>4</td>
</tr>
<tr>
<td>CCG3</td>
<td>Mixed, North</td>
<td>3</td>
</tr>
<tr>
<td>CCG4</td>
<td>London</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>15</td>
</tr>
</tbody>
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Table 2 Interviews by case study site, type of service and provider (third wave)

<table>
<thead>
<tr>
<th></th>
<th>CCG1</th>
<th>CCG2</th>
<th>CCG3</th>
<th>CCG4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioners</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Acute</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>CHS and/or Mental Health</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Independent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Acute</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CHS and/or Mental Health</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
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</table>

Interviewed commissioners were senior level managers at chief executive or director level. In the majority of cases the participants had no clinical background. The interviews lasted about one hour, were conducted over the phone, recorded and transcribed. All participants signed a consent form agreeing to the interviews being recorded and for anonymised quotes to be used in any publications. The transcripts were analysed using a thematic coding framework derived from the interview schedule and previous data analysis phases. 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 on the regulatory landscape, in particular their understanding of regulations, the impact of the NMC Programme, the STPs and the PCR2015. In the second part, we explore commissioners’ use of competition and cooperation commissioning mechanisms and providers’ experiences of competition and cooperation.

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 announcements, regulations and guidance pertaining to competition and cooperation in the English NHS covering the period between November 2015 and October 2017 (see Appendix 1). The timeline was compiled by including official guidance and decisions from websites such as NHSI and the NHSE.

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 was an NHS trust dedicated to CHS.

The local acute trust was involved in the provision of a NMC vanguard scheme, which was established without recourse to competitive tendering.

CCG1 governing body papers stated that in 2017 the CCG had begun working towards establishing an ACS for the local population.

Since January 2015 CCG1 had issued a new invitation to tender for a diabetes service.

According to the governing body papers, CCG1 reported a small surplus at the end of the 2016/17 financial year.

CCG2

CCG2 was located in the middle of England and crossed the boundaries of two LAs, covering all of one and part of another. In both LA 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.

There were several acute providers to the CCG, many of which were FTs, 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 also provided by several trusts. The major provider of CHS was an acute trust.

MH services were provided by three trusts. All three provided services to other CCGs in the region.
CCG2 had a local NMC vanguard scheme set up by local providers with the aim of improving integration of CHS with primary care. At the time of the fieldwork, CCG2 commissioners were considering whether and how to procure this model on a larger scale.

CCG2 was pursuing partnerships with other local commissioners and providers working towards ACO arrangements.

Since January 2015 CCG2 had put a CHS ultrasound diagnostic service out to competitive tender. It was also in a process of concluding a large and complex competitive procurement of urgent care services on behalf of a number of CCGs.

According to the governing body papers, CCG2 reported a surplus in the budget for financial year 2016/17.

The CCG was involved in ever closer collaboration with other CCGs in the area, forming joint commissioning and management arrangements.

**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 FT status, was extremely tight. There was also one main provider of both MH services and CHS, also a foundation trust.

There were two local NMC vanguard schemes. The first scheme was a primary care based programme focused on prevention and better service integration. However, this vanguard was not able to secure the continuing level of funding and had to be scaled down. The second scheme was focused on the acute sector collaboration.

At the time of the fieldwork, CCG3 had held preliminary meetings discussing plans for establishing an ACO.

Since January 2015, CCG3 had put out a new invitation to tender for a wellbeing service. It was also finalising a tender process initiated prior to that date.

According to the governing body papers, CCG3 was in financial deficit at the end of the 2016/17 financial year and was implementing a recovery plan.
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 lesser extent. Over the years, there were many attempts at hospital reconfigurations, aiming to change the service mix or concentrate services onto fewer sites in this part of London.

The commissioners had a long-standing strategy to move more care out of hospital and into CHS settings. There was one main NHS CHS provider. The CCG recommissioned the CHS provider to lead the provision of CHS based services under the outcomes based commissioning (OBC) approach. Other providers, including acute providers, a GP federation and social care providers were also engaged in this process.

CCG4 had two MH service providers. The primary care MH services were put out to tender 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 third wave of the fieldwork, the programme to recommission MH services under the OBC approach was ongoing.

CCG4 had no local vanguard scheme. The STP plans were focused on hospital reconfiguration and creating locality hubs for out-of-hospital service delivery.

CCG4 had no plans to establish an ACS or ACO but was pursuing complex outcome based contracting arrangements for delivery of community based physical and MH services, involving a competitive dialogue process engaging local providers.

Since January 2015, CCG4 had put only one clinical service out to competitive tender. The service was for learning disabilities. At the time of the fieldwork the procurement process was ongoing.

According to the governing body papers, CCG4 was in deficit at the end of 2016/17 financial year and was implementing a turnaround plan.

CCG4 suffered major senior management turnover during the period of the fieldwork for this study. More recently, CCG4 formed a joint senior management team with the neighbouring CCGs. It also had a longstanding joint commissioning arrangement with the LA.
Commissioners’ attitudes towards competition and cooperation

We begin by reporting the views of commissioners concerning the current regulatory structures. There had been several national policy announcements emphasising the importance of cooperation and diminishing the role that competition should take in the NHS. It is important to take stock of commissioners’ understanding of the legal framework, as the understanding of the rules concerning competitive and cooperative mechanisms in commissioning impacts commissioners’ practices.

Commissioners’ understanding of the rules and policy in 2017

Overall, interviewed commissioners noted that the rules on the use of competition in commissioning clinical services have not changed since their consolidation in the HSCA 2012, but the policy context had changed substantially. This situation made some commissioners cautious in expressing their views, as they were mindful, as representatives of statutory organisations, of following legal requirements, even if such requirements did not fit well with the current policy. CCG1 and CCG4 interviewed commissioners exemplified such caution stressing that CCGs followed transparent and fair procurement processes:

*I have to follow EU law. (...) Whatever the service is, we would get a look at the circumstance of the environment, the context and always clearly, in mind with a statutory requirement.*

(Commissioner 1, CCG4, Feb 2017)

Other commissioners were more upfront in observing a policy turn away from competition, noting that although the rules have not changed, “the mood music has” (Commissioner 1, CCG2, June 2017).

*I think [the rules] are unchanged really, if I’m honest. I think the context is changed and I think the political imperatives around this are changing, so it feels to me increasingly that the NHS is unhappy with the concept of the internal market and PBR and contracting and everything else, and is focusing or trying to focus much more on collaboration and partnership and, you know, work through STPs and that kind of approach.* (Commissioner 1, CCG2, June 2017)

The discrepancy between the rules and the policy priorities led to a situation whereby large parts of the HSCA 2012, not just the ones pertaining to the procurement of services, but also those setting out the role of CCGs as clinically-led and statutorily accountable bodies for commissioning, were interpreted broadly. According to CCG2 Commissioner 1 this was exemplified by the development of STPs as non-statutory organisations that were being increasingly held to account for services reconfiguration in a particular region. This was coupled with encouraging CCGs to join up their management and commissioning functions, thereby diluting the power of individual CCGs. Furthermore, health commissioners at all levels from CCGs to NHSE increasingly made use of cooperative or hierarchical planning mechanisms for commissioning clinical services. One commissioner observed that this was
often enabled by framing such practices as piloting or using other exceptional circumstances which justified an avoidance of the full competitive procurement process.

*It’s illustrative of a desire I think to operate in spite of rather than with the flow of the rules. So the rules are still the same, but the attitude, the context feels to me to be extremely different than it was even a couple of years ago.* (Commissioner 1, CCG2, June 2017)

Echoing the findings from the previous waves of interviews, the CCG3 commissioner admitted that they had “a semi-vague recollection of the rules as they stand” (Commissioner 1, CCG3, March 2017) but that they checked the rules thoroughly at the point, when they had to decide whether to embark on procurement of certain services.

**Impact of STPs**

The establishment of STPs was the most important policy development impacting application of the procurement rules at the time of the third wave of fieldwork. Interviewed commissioners emphasised that as far as the regulatory framework was concerned, STPs were not statutory organisations and lacked statutory power. Being part of an STP did not change commissioners’ understanding of the rules on competition. Commissioners noted that STPs could not act as commissioners or procure services directly. CCG4 commissioner emphasised that any procurement on behalf of the STPs had to go through a statutory organisation, a CCG or a provider, via a hosting arrangement.

*Any decisions are taken back to the statutory governing bodies* (Commissioner 1, CCG4, Feb 2017)

Commissioners also stressed their duty to comply with the regulations. CCG4 commissioner noted that the rules on competition ought to be clearer and more “supportive” especially when it came to implementing STP plans or setting up ACOs. CCG3 commissioner reflected on the fact that existing procurement rules did not keep up with the development of ideas around setting up ACOs as part of the STP footprint.

*Some people assume that the ACO will kind of circumnavigate the procurement laws. But (...) actually, that isn’t the green light just to go ahead and kind of merge organisations and create one super-provider. So, we developed an STP footprint, that is a piece of work that’s going on, but as far as I’m concerned, there’s still all of the old legislation that we still have to follow.* (Commissioner 1, CCG3, March 2017)

Overall, commissioners felt that the question of whether the services established as part of the STP plans had to be procured via competitive tendering, remained open to debate.

**Impact of NMC programme**
Similar to STPs, the NMC programme initiated by the 5YFV made no difference to commissioners’ understanding of the rules about competition in commissioning. Commissioners also stressed that the procurement of NMCs had to be conducted through a hosting arrangement with a provider or a CCG. CCG2 commissioner 2 observed that it is more likely that commissioners would need to procure NMC services via open tender, if they wanted to scale them up.

There are, if you like, virtual MCPs all the way through to fully-blowen ones and in between...
So, at the start of those you’re almost looking at working with your existing providers under an alliance arrangement up to the point of actually we’re going to commission the whole thing, we’re going to procure the whole thing, I mean tender for it, which is the sort of [CCG X] approach. (Commissioner 2, CCG2, May 2017)

The CCG2 commissioner 2 was referring to a procurement of a Multispecialty CHS Provider (MCP) initiated by one CCG, which was not our case study site. The procurement resulted in selection of a consortium consisting of local NHS acute, CHS, MHand GP providers, who would enter into “a dialogue” with commissioners to agree a single, long-term contract for provision of CHS services on a whole population budget.

**Impact of the PCR 2015**

The PCR 2015 added yet another layer of complexity to the rules governing the use of competition and cooperation in the NHS. CCG4 commissioner stated that because of such complexity the CCG took a specialist legal advice at a point when they needed to make a procurement decision, as they did not have necessary expertise to interpret the rules.

We have the briefings from NHS England and we’ll take specialist advice as we need. So procurement, the procurement that we’re doing as a CCG at the moment we’re doing through the Local Authority Procurement Team. So, you know, we don’t have a Procurement Team in the CCGs, but the local authorities do, so we use their specialist team rather than trying to do it ourselves. Because it’s, you know, the law is changing all the time, so we – so, rather than falling foul, we buy in the service, technically. (Commissioner 1, CCG4, Feb 2017)

CCG3 commissioner admitted that they were not familiar with the PCR 2015. They stressed that the legal position was checked at a time when a relevant decision about procurement needed to be made.

I wouldn’t say I’m 100% up-to-date with the regulations, but at the point where we – you know, where we’d need to start looking at procurement, that’s the point where we’d have to go out and check out all of the current legislation and so, I wouldn’t say I am, but it hasn’t impacted on anything we’ve done ’cause we haven’t had any procurements last year. (Commissioner 1, CCG3, March 2017)
Although some commissioners, such as CCG2 Commissioner 2, were aware that the rules had changed as a result of the PCR 2015, they were not able to identify the details. CCG2 Commissioner 2 noted that the procurement team from the Commissioning Support Unit (CSU) delivered training to the CCG staff when the new rules came into force. They also planned to offer PCR 2015 training to the governing body members, as they make the ultimate commissioning decisions.

**Impact of other policy initiatives**

A number of other policy initiatives and policy actors may have impacted on commissioners’ understanding of the rules about competition and cooperation in commissioning during the fieldwork period. CCG2 Commissioner 2 noted that each new policy development prompted a rethink of how the procurement rules should apply in the new circumstances (Commissioner 2, CCG2, May 2017). They used an example of how a policy to co-commission primary care services by CCGs required a reflection on the optimal way to commission Local Enhanced Services (LES), such as minor surgery or flu vaccinations, usually provided by the General Practitioners (GPs).

> When we were given delegated authority for primary care and obviously alongside that came the local enhanced... or local incentive schemes or enhanced services came alongside those. So, we then had to reflect in terms of that policy change, how we would go and procure those services because that was the first thing that we had to do as an organisation, (…) Then that was down to specification, you know. We were trying to think, well, actually, in order to be able to deliver this service, fundamental to that is having a GP-registered list. So, you'll then... if you like, you're procuring it and you're putting it out there but because of the way it's specified, what you're doing is saying... it is basically saying only these guys can provide it, in the same way as you would for an acute service, really. (Commissioner 2, CCG2, May 2017)

**Personal views on the use of competition as a commissioning mechanism**

In addition to their understanding of the rules, we also asked commissioners about their personal views on the suitability and acceptability of competition as a way to commission services. The views ranged from seeing positive aspects to competition in principle, but qualifying this by the inappropriate use of competition in practice.

> [Competition] clearly has a place. But I think there’s a constant challenge around making sure that it’s not regimented and it’s flexible enough to ensure that we get the most out of – to get the best quality of services to patients. (Commissioner 1, CCG4, Feb 2017)
I think the competition is healthy and has worked in a lot of scenarios. It’s not always the right answer, not always the right answer, no. (Commissioner 1, CCG4, Feb 2017)

I’ve always believed that, you know, in order to be effective as a commissioner you need to have a wide range of techniques available to you. So, you know, all of these different strategies, collaboration, procurement, AQP, you know, capitated contracts, cost and volume contracts, they’re all... all have a place. They all have merit. They’re all suitable for different things and the key thing as a commissioner of course is to make sure that you match the technique, or the contract type, or the procurement process to the issue at hand. And the frustration I’ve had is that sometimes national policy becomes dogmatic about one approach or the other and I think generally that’s unhelpful. (Commissioner 1, CCG2, June 2017)

CCG2 Commissioner 1 called for eschewing dogmatic, prescriptive policies around the use of competition and leaving a degree of flexibility and discretion to local commissioners. Similarly, CCG2 Commissioner 2, coming from a private sector background, had a positive attitude to competition in commissioning, stating that competition is “a good thing” (Commissioner 2, CCG2, May 2017).

NHS providers can become very set in their ways, can become very... Services can become very stale and actually adding the elements of competition to it, adding elements of private provision to it have made NHS providers sit up a little bit, I think, and I think, you know, there’s a very different ethic in terms of the delivery of those services from private providers than there is from NHS providers. So... And it’s back to... For me the private providers think more about the patients as a customer and what their... you know, what their experience is like whereas to some degree... I won’t say all, so it’s a very sweeping statement, NHS providers don’t... have not necessarily in the past thought that way. (…) Anything that we can do to make the experience of the patient better, both through NHS providers and private providers is a positive in my eyes. (Commissioner 2, CCG2, May 2017).

According to CCG2 Commissioner 2 the positive effect of putting services out to tender was also indirect, insofar as it made commissioners reappraise, cost and specify the service that they commissioned. At the same time, this commissioner admitted that sometimes commissioners made mistakes when specifying the service and this turned out to be a very costly way of gathering more in-depth information about the service.

A lot of services that are delivered by acute hospitals that either have not been specified at all or have very old specifications attached to them whereas going out to procurement you’ve mobilised yourself to write a new specification. So, you can specify a better quality of service. (Commissioner 2, CCG2, May 2017).

CCG1 commissioner thought that competition is useful, but not always appropriate.
I think sometimes it’s we get stifled by the rules and regulations of things we can and can’t do just to tick a box that we’ve gone out to a procurement, when it’s really quite clear that we... that some of the services would not be able to provide the things that they need mainly because they’re A&E requirements, etc. And we’re put into a position where it’s unnecessary. But I believe that there does need to be competition, because there is other providers out there that can do things just as well, and might actually do things a bit more efficiently. (Commissioner 1, CCG1, June 2017)

CCG3 commissioner remarked that although competition could work in principle for discrete services and private providers offer innovation, it was not suitable to the whole system provision, as it could easily destabilise a key provider.

In isolation, I think competition would work, but because of the way big hospitals work, everything’s interlinked, so if they lose one service, so if they’re not – competition means that they’re not competitive enough in one area, then that works. But what it kind of leaves behind potentially, is that it very easily could destabilise the whole hospital, by just taking out a few services, so it doesn’t work on that footprint. And personally, when you look at the private providers that we have dealt with, so moving away from the big hospitals, we’ve found that they’re very adaptable and they’re actually very kind of supportive to the – they’re quite innovative. So yeah, so that bit helps, it just – it doesn’t work. (Commissioner 1, CCG3, March 2017)

However, CCG3 commissioner added that even if competition did not work in the NHS system, “it’s something that you need to have, because even the threat of going out to competition, helps change things” (Commissioner 1, CCG3, March 2017).

We also asked the respondents whether using competition in the NHS had become more or less acceptable. There was a divergence of opinion in this case suggesting that commissioners struggled to identify a clear trend with regards to the acceptability of competition as a commissioning method.

Despite having a positive view on competition, CCG2 Commissioner 2 thought that the use of competition was becoming less acceptable as the NHS was executing a turn towards collaboration.

I think to continue with [competition] will be a challenge is my honest statement. I think given the make of the STPs and the fact that, you know, we’re talking about not only commissioning organisations, but also provider organisations being part of the STP, making hard decisions about going out to procurement which will, you know, which potentially could destabilise those... some or all of those providers is now becoming... those decisions will become increasingly challenging. (Commissioner 2, CCG2, May 2017)
Similarly, CCG3 commissioner noted that competition was becoming less acceptable in the NHS and as a consequence “it’s becoming more of an idle threat than a real threat” (Commissioner 1, CCG3, March 2017).

In contrast, CCG1 commissioner thought that the competition was becoming more acceptable in the NHS. Perhaps this can be attributed to CCG1 being a slow adopter of competition in the first place and noting that other CCGs were still using competition as a commissioning mechanism. CCG4 commissioner thought that although there were some questions and challenges around the use of competition in commissioning, this did not necessarily equate with competition being less acceptable or desirable by commissioners.

> It’s an issue people feel they need to address. But I don’t think it’s something that people are seeing as less acceptable. I think people are raising it as a constant thing that they need to look at, but it’s not something that’s stopping us doing what we need to do at the moment, no. (Commissioner 1, CCG4, Feb 2017)

**Summary of commissioners’ views**

Commissioners reflected on a disjuncture between the rules, stipulating transparent procurement processes for clinical services involving a degree of competition, and policy developments, steering commissioners towards bold initiatives promoting greater collaboration and integration between providers in the context of great financial challenges. Interviewed commissioners observed that the procurement rules consolidated in the HSCA 2012 had not changed, i.e. the rules did not keep up with the new policy direction in commissioning. Yet although the rules had not changed, some interviewees noted a distinct change in the way the rules were being applied, or circumvented, to enable collaborative approach to commissioning involving existing providers of services.

Overall, commissioners perceived the new policy initiatives, such as ACOs/Ss and NMCs, as being independent from the rules. These initiatives did not impact the understanding of the rules directly. Some commissioners noted that there was a tacit assumption that the competitive procurement did not need to be followed when procuring services under these policy umbrellas, however others stressed that all commissioning ought to be done within the existing rules and thus the ACO or NMC could and should be competitively procured in some circumstances.

The previous final report from this study found a widespread confusion as to the exact nature of the rules governing the application of competitive tendering in commissioning services, which commissioners interviewed between 2013 and 2015 found deeply frustrating (see Allen et al. 2016). This is because of contradictory requirements of having to drive both competition and cooperation and because of lack of clarity as to how prescriptive the requirement to tender services was. This finding featured less prominently this time round. Although clarity about the rules was still lacking,
commissioners put less stress on this issue, perhaps due to a shift away from focus on competition altogether. Instead, commissioners focused their attention on the gap between the rules (regardless of how opaque they might be) and the policy focus on delivering complex organisational and service transformations that required new governance structures and processes. Coming up with the viable models for the latter preoccupied commissioners this time round.
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 their understanding of the rules and their views on the impact of new policy developments. The views of independent providers are presented separately at the end of this chapter.

Providers’ understanding of the rules and policy in 2017

All interviewed providers had to manage multiple relationships with different commissioners of their services, exhibiting different commissioning styles. In line with interviewed commissioners, providers noted that although the rules had not changed, there was a distinct change in how the rules were being applied by the NHS commissioners, eschewing competition. One exception to this trend was LA commissioning, where services were still being tendered by default.

“Our understanding is that the rules haven’t changed, it’s just how they might be applied is changing over time.” (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

“Have there been any legislative change or change since I was last interviewed, which would be a year or two ago? No, there haven’t been. But are they being applied very differently? Yes. And has the whole language and culture around them changed? The answer is yes to that again.” (Provider 2, NHS, CHS and/or MH, CCG2, Sep 2017)

In addition, acute and especially CHS providers were also increasingly exposed to a different commissioning culture of LA commissioning. LAs were responsible for commissioning of a number of health care services under the auspices of public health function, which was transferred to LAs in the aftermath of the HSCA 2012 (Peckham et al. 2016).

CCG4 acute provider 2 noted that CCGs tended to be “a little bit inconsistent about how they apply the legal framework” and “tokenistic” in their approach to competition by subjecting only small number of services to competition and excluding other. They contrasted it with LA approach for which competitive procurement was usually a default option.

“It almost seems to be the reverse for the Health Commissioners. You know, a direct settlement, a negotiated settlement is the default and the competition would apply otherwise.” (Provider 2, NHS, acute, CCG4, June 2017)

Similar to commissioners, interviewed providers noted a shift towards cooperation in the NHS policy environment and commissioning outlook and the lack of alignment between the procurement rules and the cooperative turn.
I think there’s been a shift. So, I’d say within the relatively small schedule of services which the DH framework, where effectively competition is encouraged, yeah, those continue. But I think increasing we’re seeing a dialogue, we’re seeing us being asked to collaborate (Provider 2, NHS, acute, CCG4, June 2017)

It was notable that the providers paid a lot of attention to policy messages with respect to the use of competition and cooperation in commissioning, operating somewhat independently of the formal rules. The policy messages delivered by different civil servants and health officials through workshops, conferences, speeches, statements, letters etc. could act as a dial to emphasise or tone down the competitive tendering, without the need to change the underlying rules. In addition, the inherent ambiguity of the rules allowed the space for the local interpretation of the rules. This observation was made by the CCG2 MH provider.

When CCGs were setup about four years ago, there were a whole series of courses given by the great and the good of the NHS, telling CCGs everything has to go out for competition, competition’s good, you know, you can drive efficiencies and deliver great changes in the NHS. But the rules never actually said you had to do that, but the language people were using or what they were hearing was implying that they had to do that. The language now has changed quite dramatically and as we get more and more evidence that actually, one of the real problems in the NHS is fragmentation, and everything about the language and organisational structure is moving towards partnership (Provider 2, NHS, CHS and/or MH, CCG2, Sep 2017)

Also, the CCG3 CHS provider reflected that the shift towards the cooperation occurred without a change of legislation through subtler means of soft policy messages.

I think some of that comes from – again, without formal policy changes, sort of, you know, national triggers be they within the regulators or even politicians standing up and saying that, you know, “Maybe we’ve gone too far, from a competition perspective. It’s not getting out as we thought it would be.” But without actually changing the legislation. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

Some providers attributed this shift to the dire financial situation of the NHS where the demand for services outstripped available resources and the organisations could not afford to bear the high transaction costs of operating the internal market in health care. Collaboration in such circumstances was described as an “obvious reaction” (Provider 1, NHS, acute, CCG1, May 2017).

The NHS at the moment is facing a situation that does not necessarily fit nicely with opening up to, completely open to competition. So, the collaborative work that is going on is the first and obvious reaction about, right, here’s a set of high level macroeconomics, right, let’s, if we just, if cut straight to the chase the money does not fit the demand. So, you’ve got a triangle of
trying to maintain the finances and maintain the quality, the safety and outcomes of services. It doesn’t fit. (Provider 1, NHS, acute, CCG1, May 2017)

Some providers voiced their scepticism as to the appropriateness of competition in the current financial context.

If CCG colleagues are going to use [competition] as a process, you can’t afford to sit and ignore it. (…) But I’m not sure it’s a productive way of managing an ever-decreasing pot against an ever-increasing demand, particularly as the NHS appears to be in a collaboration phase. I think you need to go with the grain really. (Provider 1, NHS, acute, CCG4, June 2017)

Against this backdrop “the thing that seems to be on the backburner at the moment, appears to be competition” (Provider 1, NHS, CHS and/or MH, CCG3, June 2017).

It almost feels as though the playbook that’s there that everybody could use, but actually, it’s always on the shelf. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

Yet at the same time providers noted that the competition rules could not be ignored entirely, especially when deciding on a major service reconfiguration as commissioners have to insure against potential provider challenges, where current legislation could be relied on.

Until such point I suppose, until very major change is required and then – so if you take what’s happening in [region A] and their CHS services offer, almost then going, oh, do you know what? We need to make sure this is safe, from a legislative perspective, therefore we have to at least do, you know, the expressions of interest kind of process when it comes to tendering, etc. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

As a result of lessening the focus on competition for the market and at the same time having to follow procurement rules, some hybrid or quasi forms of competition were being used, such as competitive dialogue or supply chain management.

We’ve been at least looking at from what’s called the supply chain work, is very much around, I suppose, a managed market, but a managed market whereby all the competitors are working together. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

The CCG2 CHS provider 1 noted that commissioners considered both quality and continuity of the service against the value for money of the services that they commissioned to “ensure that every pound that [commissioners] spend is spent in an efficient and an effective manner” (Provider 1, NHS, CHS and/or MH, CCG2, June 2017).

My understanding is that CCGs can make the judgement. They need to ask themselves the question, fundamentally, about whether they’re achieving value for money. So, they need to be clear on their clinical strategy and what they’re trying to achieve, and then, when they’ve got
to that point, how are they going to get the best value for money? There are a whole variety of mechanisms available to them to do that, both to make the judgement on value, and also, how they might best achieve it, and competitive tendering is one of them. (Provider 1, NHS, acute, CCG4, June 2017)

CCG2 CHS provider noted a lack of clear direction in the evolution of the rules in respect of procurement of clinical services.

When the regulations, sort of, came out, I guess they were driven, originally, by a combination of central government policy and the EU stuff. It was quite clear back in 2011/2012 I suppose, before we started using them. I think it’s become less and less and less clear, what it is we’re trying to achieve. (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)

CCG3 CHS provider concurred that the way CCGs applied the procurement rules was becoming less clear. In particular, it was not easy for providers to judge which conditions needed to be fulfilled for the commissioners to put a service out to tender.

It’s almost like, sword of Damocles is still hanging over us, in terms of, yes, we will have to go out to tender on certain things, but when push comes to shove, it’s not quite clear what those circumstances for that are and what the triggers might be (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

CCG1 acute provider noted that the rules did not create a level playing field for NHS providers compared with private acute service providers because the latter were allowed to cherry pick the most profitable services, whilst NHS acute providers had a duty to provide all services, including the most expensive and least profitable ones.

I think for me the competition, the straight competition rules as they stand at the moment don’t work equally fairly and leave the biggest headache in terms of urgent care with the NHS provider trusts, and there’s nothing ground-breaking what I’m saying there. You’ve heard that played out, I mean it might have been sort of a ground-breaking thing to hear it from somebody within the service two years ago. But over the last, the course of the last 12 months it’s been played out in the media that message so much because NHS trusts were actually at breaking point probably between, I would say between May and August, September last year, it was horrendous, absolutely horrendous. (Provider 1, NHS, acute, CCG1, May 2017)

CCG3 CHS provider reflected also on the danger of stagnation in terms of innovative service and organisational solutions, which might be associated with the trend towards collaboration:

Well, actually, you’re just creating more and more of a closed shop that actually, almost can’t innovate. So, with the scale of the challenge that we’ve got, almost you’re hardwiring yourself
to what you’ve always done as opposed to what you should be doing. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

**Understanding of the role of independent providers**

Some interviewed providers reflected on both negative and positive implications of the policy to extend the provision of the NHS services to independent providers.

CCG1 acute provider reflected on a change in policy towards using independent providers pre- and post-2010. During the New Labour government, the focus was on using private sector’s capacity to bring down waiting lists for elective surgeries. In contrast, more recently, in the prevailing discourse of austerity, this was deprioritised and private sector capacity was used on an ad hoc basis. It was noted that in the post-2010 period the NHS providers, as opposed to commissioners, gained more say as to whether, when and how to use the private sector. This was viewed as a positive development.

> It is a very different dynamic that we’re working in. (...) Oh, yes, well, from my experience I mean we still use [private providers] because we still have to, we have waiting list specialists here particularly in our surgical specialties and when it gets tight, you know, I’ve agreed to contract with our local [private] hospital down the road so we have a spot purchase agreement which makes it easier for us to just ring them up and say, can you use 20 orthopaedic sets because we’ve got a bit of a bulge in terms of the waiting list we’ve got to get this work clear. We’ve no capacity to do it here, can you do us a bid to help us out and we’ll pay, obviously. (Provider 1, NHS, acute, CCG1, May 2017)

These views were echoed by the CCG3 CHS provider who argued that a positive way to harness the capacity of private sector and competition without the danger of destabilising NHS providers was to give the NHS providers, as opposed to commissioners, the reins in developing the market and managing relationships with private providers. The CCG3 CHS provider noted that they worked with many voluntary and private organisations utilising prime contractor and subcontracting relationships.

> We recognise that in being able to respond better to meeting the needs of our population and what our Commissioners want, that there are lots of things that we do well, but lots of things that third sector voluntary organisations and other, maybe not for profit, but some for profit organisations actually do better than us. (...) we’re actually doing a lot of market development as an NHS provider, as provider as opposed to a commissioner. In the past, the competition stuff was used to develop the market by commissioners, whereas now, we’re actually developing the market in a very positive way to help improve the outcomes for the people we serve, which is a different kind of dynamic (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

CCG3 CHS provider noted that although the recent turn to collaboration might be welcomed by most NHS providers, non-NHS providers might take a different view on these developments:
If I was a non-NHS, I might say, “Is the NHS creating barriers of entrance into the market or making it more difficult to be in the market?” (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

Impact of STPs

Providers noted that the impact of STPs was primarily in bringing all partners to the table to talk about difficult issues and potential consequences of difficult decisions on the providers. According to the CCG2 CHS provider, the STPs were designed to challenge the providers and understand “what the art of the possible is” to squeeze all possible efficiencies at the local level, before the conversation about how the NHS should be run moved to the regional and national levels (Provider 1, NHS, CHS and/or MH, CCG2, June 2017). The nature of the partnerships was to promote communication between stakeholders.

In a partnership, you don’t do things that are going to destabilise other bits of the partnership, do you? So, I think it puts commissioners in quite a tricky place actually, about – and it comes back to the value for money thing. What are they supposed to be achieving? If it – if they’re using competitive tendering to try and make change happen or improve quality, should they be using that mechanism? Probably not. If they’re trying to save money, should they be using that mechanism? Well, probably not, actually. (Provider 1, NHS, acute, CCG4, June 2017)

This was echoed by the CCG2 CHS provider. According to this provider, the STPs already had some positive impact on relationships between commissioners and providers (Provider 1, NHS, CHS and/or MH, CCG2, June 2017).

I think what [STP] has done is influenced perhaps how [commissioners] approach it in that now they’ve got effectively all of the providers around the table in arguably a closer set of communications, conversations than before, then it gives them, it gives us collectively the ability to debate things rather than issues escalating to, you know, basically straight to a let’s test the market piece. (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)

However, the same interviewee noted that the danger of the STPs was that they could be easily hijacked by the strong personalities.

So it's become more collaborative and the communication has improved to an extent, but the STP specifically that we predominantly sit in [local area] is also complicated by some strong characters I think it's fair to say. That does mean that although theoretically communication improves, it depends on who’s doing that communication at the end of the day and we’ve got some quite loud voices in [local area] that don't like not to be heard. (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)
The CCG2 CHS provider noted that the flaw of STP policy is down to the fact that they were based on the survival of the ‘loudest’ rather than any form of the hierarchical planning by the independent parties.

_The theory about STPs is all well and good, but the STPs have a risk of being flawed because of the very issue I described in [local area], that you’ll have influence in STPs based on potentially who shouted the loudest and who’s the strongest personality and that can’t happen. It needs to be more of a collaborative approach and, you know, I can’t believe I’m saying it... but back in the day when we had regional offices, at least you had an office and officers who had no particular bias and were able to move the pieces around, who effectively managed the system. And that’s perhaps something that we need to think about, creating more of an overarching board that doesn’t have bias but has influence._ (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)

Some providers reflected that because the rules did not change, different STP initiatives would have to be reassessed in the light of the existing rules. As CCG4 acute provider 2 put it, the focus on the STPs did not mean that competition “is off the table” (Provider 2, NHS, acute, CCG4, June 2017).

_I have seen nothing that would suggest that means procurement is off the table. In fact, quite the opposite, as colleagues have thought about these long-term contracts, yeah, they’re very conscious and there are private sector providers out there who would probably be interested. They’re very conscious that they are – there are other people who could add a lot of value._ (…) _But in terms of the competitive process, yeah, no. I’ve seen nothing that would suggest just ‘cause you’re a constituent member of an STP that means, you know, competition rules don’t apply._ (Provider 2, NHS, acute, CCG4, June 2017)

Providers speculated that commissioners might resort to the already mentioned hybrid, quasi-competitive methods to commission large, long-term contracts as part of STP or NMC initiatives. CCG4 acute provider 2 noted that commissioners may use the pre-qualification stage of the procurement process to identify the providers that were capable and willing to take the financial risks of becoming lead providers and then engage in a dialogue with them rather than progress to a full-blown competitive procurement process.

_[Commissioners] will start to be a bit smarter about prequalification. So, I think you’ll start to, sort of, say what are, you know, what are the, sort of, assumptions within which a contractual framework would be awarded? So, you would start to set out there, so for example, as you’re, kind of, working out and system’s developed, what elements of the statutory responsibility that CCGs currently have would be assumed by departments? And I think that kind of understanding of it all before you get into a contractual process will start to say which partners want to take on a level of that risk and will be part of it and which might then sit in as part of a, sort of, secondary supply chain. So, I think that people will start to use prequalification._
both formal processes and dialogue, as a way of testing that. (Provider 2, NHS, acute, CCG4, June 2017)

Applying procurement rules in a creative way, through the use of pre-qualification stage of competitive procurement or by ‘procuring collaboration’, was posited as a way out of the “problematic” situation created by the misalignment between the procurement rules and imperatives of commissioning practice (Provider 2, NHS, CHS and/or MH, CCG1, June 2017).

The STP is not eliminating competition per se, but is, in essence, if you like, either ignoring it or saying actually, the – what has primacy, but without the legislation, is collaboration. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

Impact of the NMC programme

The NMC programme initiated in the 5YFV published in October 2014 resulted in a number of small-scale, pilot service initiatives. According to providers, the NMC programme had no effect on their understanding of the rules around competition. Some respondents noted that the NMC programme enabled a local system response without the need to resort to competition by encouraging local providers to innovate and experiment in service delivery. However others commented that the programme had not been successful in removing any of the existing divisions between primary, CHS and secondary care providers, which would have increased the flexibility within local systems.

Impact of the PCR 2015

The level of awareness of the provisions of the PCR 2015 and their impact on the procurement of clinical services within the NHS was generally low among interviewed providers. Only a small number of interviewed providers were aware of the provisions of the PCR 2015. One interviewee found out about the new regulations by chance, by attending a webinar on contracting. Many interviewees remarked that someone else in their organisations ought to know more about the PCR 2015. Alternatively, they stipulated that they would seek the information on the regulations when they feel that these may be relevant.

I think I’m in the space where I know a bit about how they might work, and if I thought they were going to be applied, I’d probably go and mug up and make sure I knew the detail, because that doesn’t seem to be where we are at the moment. I haven’t expended any more time in thinking about it than that really. (Provider 1, NHS, acute, CCG4, June 2017)

The CCG1 acute provider linked the PCR 2015 with the requirement to follow EU regulations on procurement. As an acute trust, they experienced the PCR 2015 in practice when the NHS England put out an expression of interest for a number of specialist services, which the trust provided.

In terms of the new Public Contract Regulations (...) NHS England had to put out for expressions of interest in terms of lots, lots as in procurement type lots I mean, of specialised
services. (...) It’s probably about eight, nine months ago they did that ahead of this current contracting round. So, what they did was they put out to the open market, you know. So, for example, we have a range of specialised services that we provide here. They put those out to the market to see if anybody else was interested in tendering for those. (...) so basically, we had to submit for our own contracts, for our own services if you like, an expression of interest to continue to provide that. There was nobody else who put forward an expression of interest so we went straight into contract negotiations with NHS England. (Provider 1, NHS, acute, CCG1, May 2017)

One interviewee commented on the Department of Health’s guidance accompanying the regulations (DH 2016). They found the guidance rather useful but would have liked more case studies to accompany it.

I think there are always questions about individual circumstances and situations, and what would apply in some ways, until they’ve worked through particular situations and you can see the outcome of that. Probably helpful to have more case studies, I suppose, I’m saying, rather than just the, sort of, you know, the rules as such. (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

Impact of the ‘Next Steps on the NHS Five Year Forward View’

According to some interviewees, the rolling out of an ACS might affect competition, as it could undermine some of the tenets of the NHS quasi-market such as the purchaser-provider split.

What do we think [ACS] means? Probably, if you ask ten people, you’d get ten different answers. (...) But for quite a lot of them, it would be commissioning and providing in some way coming together. ‘Sharing a pot of money’, is a phrase often used. The end of Payment by Results, maybe. Where does that sit with competition? I don’t know the answer. (Provider 1, NHS, acute, CCG4, June 2017)

[There is] a lack of understanding about the impact of tender processes on stability within an accountable care system. (Provider 4, NHS, CHS and/or MH, CCG4, Sep 2017)

CCG4 acute provider 2 noted that the publication of the ‘Next Steps on the NHS Five Year Forward View’ was unlikely to spur a change in the legislation, as there was no political will to revisit the HSCA 2012 in the present political context.

I don’t think we’ll see much [of the Next Steps] translated into statute books, simply because the statute books are going to be full of Brexit. You know, we won’t see any changes to the Health and Social Care Act. It’ll all be done by executive letter, it’ll all come out of the
department at DH – NHS England. But (...) the health policy direction is going in the right direction. The legal framework isn’t. (Provider 2, NHS, acute, CCG4, June 2017)

Some providers noted that the fact that the providers were asked to deliver new ways of working involving ACSs/ACOs without legislative changes presented a challenge.

One of the biggest challenges is the fact that the legislation isn’t changing, so we’re being asked to do all of this at the same time as the Government is saying, “We’re not going to put any legislative changes through the NH – through Parliament, while Brexit is ongoing.” So, they want us to work – you know, they want Trusts to work together, but we’ve still technically, got the legislation that exists in relation to Foundation Trusts, which are only meant to be concerned with their own wellbeing. (...) And the Government just won’t take that legislation through so, increasingly, we’re working to a different set of rules to that than the Government has approved. And personally, I don’t see that as a problem, but I can see us getting caught out by that, at some point. (Provider 2, NHS, CHS and/or MH, CCG2, Sep 2017)

According to some providers, working around the rules without changing the legislative framework might prove an inadequate approach, when it came to the ability of local organisations to establish accountable care systems and organisations.

But it remains to be seen what will happen (...) in relation to the implications of the current competition legislation around that, because I think what people are saying, actually, not sure you can necessarily move to accountable care organisations with the current framework that there is in place. Which is why people are, kind of, pursuing the first instance accountable care organisation – sorry, systems, because that’s a simpler and easier way to actually get the collaboration you need to actually affect that change in model of care, take a population-based capitated approach and do it in that way. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

**Impact of the regulators**

Health sector regulators, such as NHSI, played a crucial role in interpreting and enforcing the existing legislative framework in respect of competition in commissioning clinical services. Thus their behaviour and decision making impacted providers’ and commissioners’ understanding of the rules around the use of competition and cooperation, as health care actors stayed closely attuned to the messages from the regulators.

Interviewed providers postulated that the regulators had a big role to play in supporting a smooth implementation of new organisational structures such as ACS and ACOs, in particular in clearing the legal and bureaucratic obstacles in the path of commissioners and providers.
Regulators, as a group, are setting this as an aspiration, ACSs, another part of them needs to bring the regulations along to support that aspiration, don’t they? (...) I don’t see any sign of them doing that at the moment. (Provider 1, NHS, acute, CCG4, June 2017)

As the fieldwork was conducted during the early stages of the ACO/ACS programme, providers were not yet clear how the regulators would react to the NHS commissioning large contracts without competitive procurement.

Interestingly, if you start to put multi-million pound long-term contracts, accountable care contracts out, I think that they will think again. (...) It’s a – [city] one coming through. So, I think that’ll be – that’s the next big everyone’s waiting to see, you know, is an [MCPov], most capable provider type exercise going to be sufficient, or will that be seen as anticompetitive? (Provider 2, NHS, acute, CCG4, June 2017)

Another issue related to handling provider mergers by the regulators. One of the interviewed CCG4 acute providers recently went through a merger with another trust. They thought that NHSI were helpful in clarifying the concerns about the merger raised by the Competition and Markets Authority (CMA). The CMA was satisfied that the majority of patient flows did not overlap between the two hospitals that were merging, but became concerned about a small group of patients requiring highly specialised care. The trust argued that such patients required tertiary care offered in one of the few existing specialist units, which rendered any concern about diminishing competition obsolete. CCG4 acute provider 2 noted that the CMA did not display much understanding of particularities of health care provision. NHSI assisted the provider in presenting their arguments regarding a small group of patients requiring specialist care that the CMA raised.

The CCG4 acute provider noticed a change in approach by the CMA in the more recent merger cases compared with their own trust’s experiences. They commented that the CMA had begun to acknowledge the limitations of the quasi-market and competition in health care services.

It was a very commercial process and I don’t think that the CMA demonstrated a huge level of maturity in terms of the way health systems operate. But we were, only as I understood it at that point, either the second or third that went formally through the CMA process. We were approved at stage one. There was no need for us to go to the stage two. They were satisfied that our merger, effectively our M&A, would not materially affect competition and access for patients. (Provider 2, NHS, acute, CCG4, June 2017)

I think [CMA], they’ve backed off that now. My understanding is the CMA have recognised the, kind of, limitations of normal competition processes. The CMA are choosing not to intervene in some of these areas and I think (...) that’s quite a mature decision. (Provider 2, NHS, acute, CCG4, June 2017)
CCG4 acute provider 2 called for better guidance from NHSI on fulfilling the integration condition of the provider’s licence. The interviewee noted that the guidance, which would allow the organisations to fulfil a duty of integration and cooperation effectively with respect to sharing data, information and resources between organisations without falling foul of the competition law, was lacking.

CCG3 CHS trust respondent noted the regulators still had a tendency to view and assess provider organisations in isolation and not as a system, which was not conducive to fostering collaboration between providers exposed to forces pulling them in different directions.

*Individual regulators require different things from individual organisations, actually pulled against that in a way that’s not helpful or not conducive to collaborative working. So, it’s quite hard sometimes, in terms of — so, in very, very broad terms, you could describe, when working together, a win in total for the system, but actually, within individual organisations, there might be just these winners or losers, and I don’t like that terminology, but bear with me, and particularly financially. And at the moment, some of the way that regulators behave wouldn’t be conducive to supporting that answer, even if it was a better answer in overall terms.* (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

The interviewee noted that although the regulators did not openly discourage or prevent collaboration between providers, the regulatory system assessed providers as separate organisations, which might prevent some cross-organisational collaboration ideas. CCG4 CHS provider also remarked that the NHSI’s attitude towards an innovative local contracting arrangement, enabling inter-organisational working, was both encouraging and discouraging at the same time, resulting in a “mixed picture.”

*So, in one respect [NHSI is] saying, “Just get on with it,” and then, the other respect then going, “Oh, hang on a minute, we’ve had a chat to our Lawyers and maybe we ought to have some oversight of it.”* (Provider 4, NHS, CHS and/or MH, CCG4, Sep 2017)

**Impact of organisational restructuring of commissioning**

Some providers also mentioned the impact of an ongoing organisational change affecting both provider and commissioning organisations within the NHS. In particular, on a commissioning side a trend towards merging management and commissioning functions of different CCGs distracted commissioners from focussing on long-term service planning and reconfiguration.

*Organisational change inevitably just distracts some senior leaders from the more important job of just focussing on some of the care pathways and accountable care arrangements.* (Provider 2, NHS, CHS and/or MH, CCG2, Sep 2017)

The drive towards integrating management and commissioning functions might have affected commissioners’ capacity to commission services via competitive tendering and changed their appetite
for tendering due to having to reconcile different commissioning cultures between a number of different organisations. According to one provider, the continuous reorganisation of CCGs diluted the power of individual CCGs, tilted the power towards providers and enabled partnership working.

Two years ago (...) there were seven trusts in [area] and there were four CCGs. As of today, there’s only four trusts and there’s only three Chief Executives not seven. (...) There’s only one large [CCG] and a small bit of [another CCG]. So, we’ve gone from having eleven chief executives to just five and the number of organisations has halved as well. And all that, has enabled some very different conversations to take place. So, (...) it’s got the potential to be so much more joined up now. (Provider 2, NHS, CHS and/or MH, CCG2, Sep 2017)

With regards to organisational boundaries and structures, the CCG2 MH provider noted an emerging gap between the legal framework and reality, similar to the one characterising the procurement rules. In particular, with the advent of STPs, the individual clinical commissioning groups as the statutory organisations with the ultimate responsibility for local commissioning, as set out in the HSCA 2012, might have embarked on a path of gradual loss of sovereignty.

None of the CCG boundaries have changed and they can’t get rid of CCGs, but the rhetoric is now, strong commissioning voice needs to be based on the STP place. So, technically, there is still an organisation called [CCG2], but effectively, it’s giving up it’s [commissioning for part of the area]. It will still insist on having a separate board meeting and all the rest of it, but all the – not just the mental health, but all the commissioning arrangements will now have to be centralised and go into the [joint commissioning for the area]. So, on paper, you’ll still have a separate CCG, on the ground they – it’s joined up. (Provider 2, NHS, CHS and/or MH, CCG2, Sep 2017)

Personal views on the use of competition as a commissioning mechanism

Providers held a variety of views on the role of competition in commissioning clinical services. Some emphasised that they did not object to competition in principle or as a last resort measure, in cases where the service was poor or there was no adequate provider, but many noted that the NHS could not afford additional costs associated with operating competitive markets and dealing with for profit providers.

I don’t think I have a philosophical antipathy to competition. I can see where it might drive up quality, or drive out inventiveness, actually. I’ve done some really big procurements for buildings and services in my time, and I’ve seen it really add to the process. But I do think, where we are in really tight financial circumstances, we have to understand, if we are working with the private sector, there has to be a cost for the management of risk and the operation of
the private sector, which the public sector doesn’t carry. And we have to understand that if we’re going to go through full legal procurement, you know, there are a whole load of legal requirements, which of themselves, need to be satisfied. (...) Which, if you step away from that, into collaboration agreements, are potentially managed in a different way. (Provider 1, NHS, acute, CCG4, June 2017)

I think that some of the competitive processes around contracting have been really useful in driving things forward. But in this current – in the Health Service’s current stage of its evolution I think it’s outdated. And I – one of the reasons I think it’s outdated is because it’s, as I said earlier, it overly focuses on the financial and transactional elements and it doesn’t focus sufficiently on the responsive and dialogic elements with patients. (...) my view of the Health Service is we have a lifelong social contract with our population. That’s what I believe our statutory goal is and I think if you then continue to have to procure, tender, compete for services for that population in the name of efficiency, you drive another gap elsewhere. You – I think you drive a care and quality gap and you drive a relationship gap. And the current vogue is for occupational health and for, sort of, lifelong or long-term benefit, thinking about prevention, prevention into practice. I just don’t think that sits very well with an overly competitive, overly transactional regime. (Provider 2, NHS, acute, CCG4, June 2017)

However, the majority of interviewees noted that competition as a commissioning mechanism has become less acceptable in the NHS overall, with a move to ACSs and whole population based planning.

With such a significant social contract I don’t see a value of [competition] – I think it’s counterintuitive. I think the value to the population is less (...) than the benefit you get out of a holistic service, even if that holistic service is marginally less efficient than a transactive one. (Provider 2, NHS, acute, CCG4, June 2017)

CCG2 CHS provider noted that competition worked in perfect market conditions, where suppliers could easily enter and exit the market, the market conditions were fluid, there was a clear service offer, flexible supply chain and relatively low complexity. The NHS quasi-market did not fulfil such conditions, hence having to compete in it presented a challenge for providers.

So what you're trying to do is apply a competitive principle to an organisation that's hugely restricted and has to be all things to all people. (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

CCG1 acute provider, which was in a challenging financial position, argued that deploying competitive mechanisms in such circumstances became unhelpful. Competition might only be viable, if all trusts were delivering surpluses.
There’s two ways you can do the income efficiencies, the efficiency, you can either generate a bit more income or you can reduce your costs accordingly. But if the competition is taking the potential for income away from us then you’re just stuffing us from the first, you know, we’ve got to have the ability to do both, and that’s where I feel that at the moment it’s like I’m not sure the two go hand in hand. (…) If we were in a position where NHS Trusts were actually making a surplus and actually, and you’ve got to be careful here because we’ve been given the sustainability and transformation funds at the end of the year that make everything look positive, but actually the underlying run rate isn’t that at all. But actually, if you were to look at it objectively, say, we were making, in other words making a surplus, then I can see how the competition might be much more open to question. But at this time if you’re asking the question about, how does the competition aid it, I’m not sure. I can’t see how it does because right now this has to be about giving NHS Trusts the best opportunity to actually survive and reconfigure services so that they are sustainable going forward or be on a different footing. (Provider 1, NHS, acute, CCG1, May 2017)

Some providers were against competition in health services even in principle.

My personal view is that largely it is not the way to get the best outcome for a population. I think with the procurement route, unless the specification is right, well, I’m probably coloured by the fact most of the procurements we’ve seen have done by the local authority, and the driving factor behind them has been reduction in costs, a significant reduction in costs, up to 50%. So I suppose, yes, I’m coloured by that in terms of then the outcome has not been good for the people that we’re serving. (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

They offered a counter-argument to competition as driving innovation by stating that it was collaboration that led to more innovative solutions, whereas competition led to fragmentation and responding to rigid specifications for specific services. They admitted that their views may have been tainted by the fact that most of tendering that they responded to was for individual services rather than the ‘procuring collaboration’ type. The view that collaboration rather than competition was more conducive to fostering innovation was also echoed by CCG2 MH provider.

Collaboration, I think you’re more likely to harness different views, ways of doing things and come up with a better solution. I think the danger of just going straight down a procurement approach, and I suppose it depends what sort of procurement process, but largely you end up with a predefined specification and that’s it, but there might have been a better way of delivering that service, you know, that would produce a better outcome, be a better-quality service. (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)
Similarly, CCG4 CHS provider noted that collaboration between commissioners and providers might be more beneficial for both parties than resorting to simplistic competitive mechanisms. The participant emphasised that collaboration was widely relied on in the commercial sector.

In the commercial sector, is work with your suppliers to get the product you want at the price you can afford. And if you do that well, you will get high-quality and (...) you’ll drive market satisfaction. So, somebody like Tesco’s, which is known to be a pretty awful buyer and an awful payer, (...) when they build a good relationship with an agricultural supplier for lettuce and they’ve got the quality of the product they want, of course they will pin them down on money. But actually, they will also work with them to say, you know, “Tell us what you know about the market in lettuces,” you know, and a good provider will say, “Well, I think you should be using radicchio, or we can get a new way of growing rocket that’ll be cheaper for you.” And that’s where you should, you know, you should work collaboratively, because you can continue to develop the product and it becomes a mutual benefit for both organisations. (Provider 4, NHS, CHS and/or MH, CCG4, Sep 2017)

According to CCG1 acute provider the money, which over the last 15 years had been diverted to private providers, had to be ‘repatriated’ to the NHS providers to enable service reconfiguration. CCG1 acute provider was very critical of private sector involvement in provision of NHS funded services. They noted a lack of a “level playing field” between acute NHS providers delivering acute services and private providers, in that the latter were able to cherry pick profitable elective services and were not obliged to deal with urgent and emergency care demand, post-elective surgery complications, delayed discharges of care and had no overall responsibility for the health of the individuals that they treated (Provider 1, NHS, acute, CCG1, May 2017). As a result of prioritising the most urgent cases, which stretched capacity, the NHS providers were not able to take advantage of the most profitable elective work.

In terms of the competition the overriding theme through all of that is, if you’re going to do it in this really tight environment where you’re actually asking organisations to also collaborate across the NHS you’ve got to do it on a level playing field and I’m not quite sure how you do that when things like the private, you know, organisations in the private sector don’t have to deal with the acute work, don’t have the impact on beds and other things besides where, you know, they can literally pick which cases they want to do. Well, we can’t because under the NHS constitution if a patient is referred to us we have a legal obligation to see and treat them. (Provider 1, NHS, acute, CCG1, May 2017)

CCG3 CHS provider noted that competition could still be used as a last resort option in cases where providers failed to come up with a viable solution based on cooperation.
In terms of things like competition law etc., around wanting and needing to demonstrate increase in value, you don’t need to go through a tender process to do that, but if we can’t sort ourselves out then maybe it’s inevitable that that happens. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

CCG4 acute provider 1 noted that although commissioning skills are still lacking, over time commissioners had become a bit better at judging whether, when and how to use competition in commissioning.

CCG2 MH provider noted that “the experiment” with using competition to procure large, core services “has failed” (Provider 2, NHS, CHS and/or MH, CCG2, Sep 2017), especially following the Cambridgeshire and Peterborough contract collapse (NAO 2016). According to this provider, the use of competitive commissioning mechanisms for large scale service reconfigurations felt more like an “exception” nowadays and described such an approach as “old fashioned” (Provider 2, NHS, CHS and/or MH, CCG2, Sep 2017). They also branded using simplistic competitive tendering processes to address complex service challenges, or “blind tendering”, a disaster.

Blind tendering NHS services has been an unmitigated disaster. (...) if there’s a service where you genuinely can’t get providers to change or, you know, you want to get providers working together, there is something called a dialogue tendering process, where you put all the partners in the room together and you work with them until you end up with the right model. That sometimes, is very appropriate. But blind tendering and just putting it all out to tender, I look at and think, you don’t get the best available [provider]. (Provider 2, NHS, CHS and/or MH, CCG2, Sep 2017)

Views of independent providers

During this stage of the fieldwork we interviewed two independent providers of CHS operating in CCG3 and CCG4. The independent providers were wary of the policy turn to collaboration, but at the same time saw some opportunities that came with it.

Neither of the two interviewed providers was aware of the provisions of the PRC 2015. The CCG3 independent provider had positive experience of regulators, but would have liked to see more robust enforcement of the rules in respect of competition. In the case of this provider, a simplified qualification process alongside due diligence on the part of commissioners rather than a competitive tendering route could open doors to provision of their services in more areas based on patient choice. Yet commissioners were unwilling to contemplate such a possibility.

[NHSI] interpretation (...) was that commissioners did not have to go through a competitive tender, they just had to go through a qualifying criteria, because the competitive element was coming, the fact that [patients] would have multiple providers to choose from. Commissioners
have completely ignored that. They don’t want to do that. So, NHS Improvement have not been able to go into these areas and say well, you must do that, you know what I’m saying? [Commissioners] are still able to interpret the regulations the way they want to. (Provider 2, independent, CCG3, June 2017)

Thus, somewhat counterintuitively, due to a particular business model that the CCG3 independent provider adopted, they were not enthusiastic about competitive procurement processes, seeing them as unnecessary and expensive bureaucratic hurdles, “disproportionate to what we’re trying to achieve” (Provider 2, independent, CCG3, June 2017). This was reflected in their views on competition, seeing it as potentially useful but used inappropriately by the commissioners.

In theory, it is and I actually think it’s very positive to bring competition into the market. In practice, it’s under-utilised, they won’t use it, or it’s used inappropriately. So, for example, why would a CCG go through a competitive tender process to commission the same service they already had? It doesn’t make sense. So, they don’t – they either use it too much or not enough. In other areas we can’t enter, but very few competitive tenders come out for [the services that we provide]. But (...) if I look at the [city] area, they’ve just put out a massive tender and awarded it to the same providers. I just don’t get that. It just doesn’t – you know, that’s taxpayers’ money and it just seems inappropriate use of taxpayers’ money to tick a box to say they’ve met the regulations around competition and procurement, ‘cause I believe that’s what that would’ve been to do. So, (...) personally, I think it’s a flawed system. (Provider 2, independent, CCG3, June 2017)

CCG3 independent provider referred to the NHSI guidance (NHSI 2016), stating that commissioners were not required to put elective services to tender because of the presumed patients’ right to choose a provider. According to the independent provider, this guidance supported their argument about the superfluous nature of the competitive tendering.

NHS Improvement very clearly stipulates that as long as there is competition in the right to choose, CCGs don’t have to go through a competitive tendering process in order to bring competition into the market. (Provider 2, independent, CCG3, June 2017)

In contrast, CCG4 independent provider was in favour of competition in clinical services as a principle that promoted innovation. CCG4 independent provider thought that using competition as a commissioning lever became generally more acceptable in the NHS, whereas CCG3 independent provider thought that it was becoming less acceptable.

I think the basis of competition is to compare, basically, providers and – meaning that they will innovate, they will change what they need to do to deliver outcomes. I think without competition, you could end up having a monopoly, or even a duopoly in certain areas with only two providers, who could just deliver the same standards of care, which could be deemed to be
deficient. And only the addition of competition would add new providers to the area and hopefully improve care. (Provider 3, independent, CCG4, May 2017)

Summary of providers’ views

Similar to commissioners, interviewed providers found current rules unhelpful, as they did not reflect policy developments. Providers noted a lack of alignment between the legislative framework stipulating formal procurement processes and policy developments such as STPs based on collaboration between providers. The regulatory regime which was built around individual organisations rather than the whole local health systems was also misaligned with the policy direction.

The majority of interviewed providers found competition unsuitable in the current climate. Although some providers were not objecting to competition in principle, almost all found the way competitive tendering was being used in health services problematic. This included one independent provider who argued that competitive tendering was an unnecessary hurdle to service provision and that competition in the market ought to be assured by the provider qualification process and based on patient choice. Providers were expecting a turn away from the full competitive tendering of standalone, specified services to quasi-tendering processes of the ‘procuring collaboration’ type, where the interested parties would be asked to work together to propose a whole system, population based solutions.
Commissioners’ experiences of competition and cooperation

As well as gauging commissioners’ and providers’ understanding of the rules 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. We begin by discussing the main service delivery challenges listed by the interviewed commissioners and the use of competitive or collaborative approaches to tackle them.

Service delivery challenges

Commissioners in the four case study sites grappled with financial challenges and the implementation of cost saving measures. Two out of four CCGs representing our case study sites (CCG3 and CCG4) reported being in deficit in the financial year 2016/17. Both CCGs in question were implementing financial recovery plans at the time of the fieldwork. CCG4 was implementing a two-year turnaround programme and decommissioning agenda, “stopping doing things” (Commissioner 1, CCG4, Feb 2017). In this context, all commissioning decisions were influenced by the need to reduce the deficit in CCG4’s budget. According to the interviewed CCG4 commissioner, the driving factors behind the deficit were acute spend, lack of Quality, Innovation, Productivity and Prevention programme (QIPP) delivery and continuing healthcare overspend, alongside some other factors.

The CCG4 pursued two ambitious CHS services integration programmes around physical and mental health, utilising an outcomes based approach. The commissioners used a blend of cooperative and competitive mechanisms, characteristic of ‘procuring collaboration’, to identify local providers interested in participating in the CHS services transformation programme. Identified providers were asked to come up with the service delivery and organisational models for reconfigured services.

_We’ve done both [competition and cooperation]. So, the CCG before my time on physical health and we’ve done the same for mental health now, we followed a competitive approach to start with, to get to the point of appointing our Most Capable Providers group. And then, when the MCP group was agreed and confirmed, after due diligence that those providers were the most capable providers, following their expressions of interest. Then we then went through a collaborative route. But there was still the same due diligence around responding to an invitation to tender (...). And they still had to go through an evaluation and then a contract award process. So, it’s absolutely a blend of both [competition and cooperation]. (...) And the mental health providers, there’s actually eight of those in total. It’s a very large MCP group. And it’s all been done through the Supply to Health portal, the competitive process and we’re now in a collaborative process. And (...) we’re in the process of evaluating their tender at the moment._ (Commissioner 1, CCG4, Feb 2017)
At the time of the interview, the whole health economy of CCG3 had significant financial challenges, including the CCG itself. CCG3 commissioners were preoccupied with reconfiguring existing services in order to identify efficiencies in areas such as preventing hospital admissions. They had also moved the acute provider contract from the national tariff onto a block arrangement. This was done in order “to help those organisations (...) reconfigure the services in a way that means that they’re not trying to pull money off each other” (Commissioner 1, CCG3, March 2017).

At the time of the fieldwork, CCG1 was in relative financial balance. The commissioners were working on an idea of establishing an ACS. The approach they took was through the incremental redesign of services by utilising the NMC programme and putting in place services for people with long-term health conditions requiring complex care.

For our CCG our vision is to have an accountable-care system by 2019/20. So, what we're doing is... you can't just put everything all in one go. It's baby steps. So, what we've been doing is we have the new models of care, which targeted patients with complex care needs. We then have started working on the diabetes procurement, which was running a little bit later than the complex care, which was bringing all diabetic services together under one umbrella to get the best patient care because it was really fragmented. So, it was just... so, that's what we're doing. (Commissioner 1, CCG1, June 2017).

In contrast, CCG2 was in a healthy financial position. The CCG2 commissioner mentioned challenges in respect of the deployment of the specialist workforce, rolling out primary care led services, merger of MH trusts and stroke services as their main service delivery challenges.

What's really pushing service configuration change is the need to make sure that we organise and deploy specialist workforce as efficiently as possible. So, you know, how many vascular on-call rotas can a particular system sustain? How many doctors have we got to cover a particular function, or how many specialist staff are there? And what that... you know, if you’ve got to be able to deliver a service on a seven day a week basis with a certain level of clinical expertise and there are only so many of those types of people around, then it means obviously you have to think about how you organise those people into a smaller number of more specialised locations. (Commissioner 1, CCG2, June 2017)

CCG2 commissioner noted that financial concerns were of lesser importance than the workforce, when it came to service reconfigurations. In the case of CCG2, financial concerns tended to drive the streamlining of the back office functions, sharing payroll, HR or finance functions.

**STP related service reconfigurations**

We asked commissioners about the service reconfiguration plans included in the STPs and how they proposed to achieve them. At the time of the fieldwork the service reconfiguration plans discussed under
the STP umbrella were still in their infancy and the commissioners could not provide much detail about the ways that they planned to achieve those and, in particular, whether and to what extent the competitive or collaborative mechanisms would be used. The CCG4 commissioner mentioned that so far their local STP used competitive tendering to procure some consultancy and public engagement work around producing the STP itself, rather than thinking about implementing its aims. They also noted that at that time there was no intention to procure clinical services as part of the plan, but they did not exclude such a possibility either, stating that commissioners might resort to using both competition and cooperation to achieve the STP’s aims.

CCG2 commissioner 1 noted that commissioners did not feel supported by the current legislation, when it came to deciding on a method of commissioning as part of the STP plans.

*One of the things we’re struggling to understand really is how best to mobilise or procure these services [as part of STP], because it’s not always clear and... I think, you know, I think it certainly doesn’t feel like a straightforward thing to just say, well, we’ll write a specification, stick a notification out in the various magazines and Supply to NHS, and then just go out to a classic procurement. Increasingly, we seem less likely to do that to me, but there is a dissonance between what the rules officially say and what the practice seems to be in fact.* (Commissioner 1, CCG2, June 2017)

Another CCG2 commissioner noted that procuring services as part of STP was likely to involve a mix of competitive and collaborative mechanisms, “because the rules require it”, yet increasingly “the mood is towards removing the commissioner provider split as such and thinking about creating a kind of, a single public service in each STP area” (Commissioner 2, CCG2, May 2017). The same commissioner also drew attention to the fact that different CCGs within the same STP footprint did not have to follow the same approach to commissioning services. In fact, in the current framework CCGs were treated as independent commissioning units and were at liberty to take whichever approach they deemed appropriate after assessing the risks of being challenged by a provider. This might change in the light of the increasing number of CCG mergers and joint commissioning arrangements, which would require a greater synergy of the commissioning approaches.

*The reality of it is CCGs can and do what they want in terms of procurement. It’s more about your appetite for risk and, you know, how much risk the CCG wants to take. (...) Now, the level of risk that you’re taking there is that no one else is going to object to your awarding of that contract.* (Commissioner 2, CCG2, May 2017)

Both CCG1 and CCG3 were developing ACSs as part of their STP work. CCG1 chose to focus on complex care and diabetes care services in the first instance. They were building on the recent diabetes services procurement, which was meant to bring disparate diabetes services under one umbrella. CCG3 was also developing an ACO as part of the STP, but at the time of the fieldwork the project was “in its
infancy” (Commissioner 1, CCG3, March 2017). Interviewed CCG3 commissioner was concerned about the discrepancy between the procurement rules and plans for setting up the ACO and called for the risks of challenge to be appraised. They noted that despite the rules not supporting a move to ACOs/ACSs, there was a widespread assumption and considerable policy pressure to move quickly with the implementation of the ACO plans on the ground, “there’s an assumption that you can just do things” (Commissioner 1, CCG3, March 2017).

Some of these providers that might be looking at having their services removed and put into an accountable care organisation, are not going to willingly just kind of roll over and let that happen. (...) I feel like I do have sometimes, have quite a challenge convincing some of my colleagues that they need to kind of slow down, consider the risk and then formalise the fact that if they still want to go on in that way, they’ve got to advise what the risks are and make sure that it’s signed off in a document that says, this is our way that we’re going to kind of move to an accountable care organisation. These are the risks, but we’re comfortable with that and that’s the conversation that I seem to have had about three times in the last two weeks. (Commissioner 1, CCG3, March 2017)

We noticed that more junior commissioners advocated a cautious approach and adherence to the procurement rules, whilst some senior interviewed commissioners postulated a ‘bolder’ approach to commissioning. Senior commissioners were more confident in sensing a change of policy direction and hence diminished reputational and litigation risks that came with the turn to collaboration.

NMC related service reconfigurations

We also inquired about commissioners’ experiences of applying procurement rules in setting up services under the NMC programme.

We repeated the question about the planned mechanisms of commissioning for any NMC related services. Some commissioners found this issue “tricky” (Commissioner 1, CCG2, June 2017).

The rules say that you can’t mobilise new care models without a procurement process and of course they involve a very different type of contractual process with much longer-term contracts, very different types of outcome frameworks, you know, those, then those processes in themselves aren’t yet mature. So, you know, the exact form of the contract, exact form of the risk share, the exact position regarding the tax implications, particularly for VAT, all of that stuff is still not clear and so there are significant uncertainties still in my view around those processes. (Commissioner 1, CCG2, June 2017)

CCG2 was in the middle of conducting an evaluation of their local vanguard care model based on integrating CHS with primary care. The vanguard was set up and led by local providers without much
of a steer from the commissioners. At the time of the fieldwork, CCG2 commissioners were considering whether and how to procure this model on a larger scale.

[Local providers] collaborated informally, you know, put forward a proposal to NHS England in terms of this is what we want to do, these are the people we’re planning to work with. (...) I’m sure they have partnership agreements that sit underneath that for themselves. (...) Well, it certainly wasn’t a procurement and we certainly didn't say go out... come back to us as an alliance. (Commissioner 1, CCG2, June 2017)

CCG2 commissioner 2 saw the potential for procuring the local vanguard model as an alliance of providers, building on the CCG2 experience of procuring another alliance for the provision of urgent and emergency care service.

CCG3 commissioner noted that although the CCG had a vanguard scheme initially, it did not manage to secure the funding for it to continue. So the vanguard was scaled back and the CCG3 applied for a much smaller pot of funding to continue this programme in some form. The idea was to provide more CHS based around GP practices provided by multidisciplinary teams including health and social care. As a result, the CCG3 commissioners planned to work with existing providers for a scaled down vanguard project, rather than go out to procurement.

The scale of it, it’s small. It’s not very big now, so we wouldn’t be able to go up to market ‘cause it’s non-recurrent funding as well. Commissioner 1, CCG3, March 2017

The CCG4 had no local vanguard initiative and CCG1’s vanguard was driven by the acute trust and established without recourse to competitive procurement.

**How commissioners decided on the use of commissioning mechanisms**

Given the ambiguous rules and regulatory context, commissioners considered different options for procuring services carefully. To reach a decision, commissioners relied on formalised decision-making processes and option appraisals.

We have a decision tree in relation to procurement that we follow, and if we decide to waive the competitive position, then we’d need to do that through our SFI it goes to. It has to have to have multiple signatures, depending on the level, and it also has to go to our Audit Committee for signoff. (Commissioner 1, CCG4, Feb 2017)

The formal processes were needed in order to appraise the risks of potential challenges from interested providers and assess the cost of competitive procurement against the value of the service. CCG1 was considering whether or not put their MCP model out to tender.
It depends on what the service spec is. And we will get full procurement advice, around how we do it, which we always do. We buy our procurement legal support from our CSU and they give us the legal advice. (Commissioner 1, CCG1, June 2017)

Similarly, CCG3 after a long pause in using competitive procurement was deliberating whether to tender the wellbeing service. They engaged in talks with procurement specialists from their CSU, gathering information for service specification and costs. Previously, the service was provided by voluntary sector provider on a small scale and commissioners were looking to extend it to a wider footprint. The contract for the service breached the threshold above which commissioners deemed it susceptible to competitive tendering. There were also many different potential providers available locally.

The service is likely to be somewhere in the region of, well, clearly over £300,000, so we know that the legislation would kind of force us to kind of open that up, so that any – there’ll be a – potentially be a number of interested parties that could provide this service as well, and so because of that, you know, I think we’re – the legislation says that we’re expected to go out to market on it. But they obviously believe that they can probably get better value if we were to kind of open it up and stimulate the market to see who’s out there. (Commissioner 1, CCG3, March 2017)

In the cases where commissioners decided to go ahead with competitive tendering, the prevailing rationale included availability of different providers within the market, including independent sector ones, interested in providing the service and fear of falling foul of the rules by not running a competitive process. For instance, CCG4 commissioner noted that in the case of learning disabilities service, there was a strong rationale to go out to tender.

There’s private providers; there’s NHS providers and it was absolutely right for that service to be procured, because there isn’t – you know, there’s a very competitive marketplace and it wasn’t a position where there’s just one provider that could deliver that service. (Commissioner 1, CCG4, Feb 2017)

Similarly, CCG2 commissioner justified putting urgent and emergency care service to tender due to multiple interested potential providers.

I think for that one it was clear that the most likely... the marketplace we were working with was made up very substantially of private providers rather than public sector providers. It was also a marketplace in which we wanted a very different type of result, so it wasn’t as though we had someone who was an existing public sector supplier who was delivering the service, and the barriers to entry into that market were relatively low. (...) There were lots of people who could’ve conceivably delivered it and so it felt like a genuine competition in which we might secure better value through a competitive procurement. Of course that differs in other
circumstances, but those were the kind of characteristics that led us to believe, and I think correctly, that that procurement was the right thing to do there. (Commissioner 1, CCG2, June 2017)

The aim of the commissioners in this case was to instigate collaboration between emergency and urgent care providers by designing the procurement process to “procure collaboration” (Commissioner 1, CCG2, June 2017)

We created something called the Alliance which all successful bidders have to give an undertaking to be part of. The Alliance creates a network of providers, all of whom of course have been successful through this process, and that alliance requires all providers to share their staff, to share all of their information and performance data, to cost cover one another. So it basically takes all the competitors and says, if you win, you will become a partner with the other competitors so you have to suspend competition and act collectively. It was quite an unusual and relatively controversial thing to do, but it’s probably the key characteristic of, one of the key characteristics of the process. (Commissioner 1, CCG2, June 2017)

CCG2 had also put their community ultrasound diagnostics service out to tender because there was a market for these services.

I think because we knew from our experience elsewhere that there was sufficient competition in the market for us going out for competitive procurement. So, we knew that acute trusts were not the only players in town. We knew there were other providers of services. I think that that was one of the reasons. I think the scope of the services that we were looking to procure meant that it’s... there was less risk around it, if that makes sense. So, you know, there wasn’t... You know, we’re talking about diagnostics here. So, there wasn’t a need... There wasn’t a clinical need to have a base at an acute hospital, you know, because ultimately you’re... they give pictures and imaging people. So, it lent itself very nicely to doing a procurement and so the specification was right in terms of the requirements of the... any potential provider. And, equally, we knew that there was enough competition out there to warrant going out to procurement. (Commissioner 2, CCG2, June 2017)

CCG2 was in the process of deciding whether to follow a cooperative or a collaborative approach to roll out their primary care vanguard.

We’re also I think trying to think about how we mobilise primary care led services, you know, kind of MCP vanguards and whether we do that through some sort of collaboration or procurement. (...) [neighbouring CCG] I think want a clear pathway towards a procurement, but I don’t think it’s quite so clear-cut in the other areas and perhaps even in [neighbouring CCG] ultimately it may not be quite so clear-cut. (Commissioner 1, CCG2, June 2017)
The CCG2 commissioner 2 added that expansion of the local acute trust and the need to reconfigure services between different hospital sites, deciding which site will have downgraded emergency services, posed a challenge for commissioner. Related to this issue was a need to decide how to procure an urgent care centre. This commissioner was concerned about a potential challenge from interested providers, if the CCG decided to award the urgent care centre services to the acute trust without a tender.

*Everyone here is going along the lines of the assumption that the acute trust will deliver [urgent care centre]. They see it as part and parcel of the new hospital development. They don't see it as something that's going to be procured. And I'm not necessarily reflecting a side that says, yes, it must, but I think we do need to... There doesn't seem to be very much consideration to the fact that we might [procure].* (Commissioner 2, CCG2, May 2017)

The CCG2 commissioner 2 also mentioned a general challenge of estimating the price of a service accurately, especially CHS services, which thwarted commissioners’ ability to issue realistic service specifications and financial envelopes in respect of the services they put out to tender. They foresaw that isolating and identifying the value of the urgent care centre would be difficult to achieve as well as fearing the destabilising effect of a potential loss of urgent care activity on other hospital services and hospital’s ability to meet the Private Finance Initiative (PFI) repayment commitments.

*What we really want to be paying for is outcomes. Nobody wants to be paying for people. (...) I don't want to commission a service, I want to commission outcomes and it's very difficult to draw a line. A) outcomes are hard, both in development and in delivery and it's very difficult then to align enough of a proportion of the value to the outcome and make it... to give the incentive that you want because of the people that are involved [in delivering the service].* (Commissioner 2, CCG2, May 2017)

CCG2 commissioner 2 compared the rationale behind the commissioning decisions to go out to tender to switching a utility supplier.

*Obviously, what you’d like to do in most cases with regards to procurement is save some money but I very often sort of make the comparison to switching your electrical services or your utility bills, if you like. You're trying to get the same service for the same price but better quality or the better quality for less money or at least the same quality for less money. That's the thing you're trying to do here.* (Commissioner 2, CCG2, June 2017)

In some instances, the option of competitive procurement was found to be unsuitable. This was the conclusion reached by the CCG2 in terms of LES delivered by the GPs.

*Whilst [LES] didn't form part of the core GP contract, they were a very fundamental funding stream for primary care and what we didn't want to do is destabilise any of the core services by removing some of that funding stream. Now, we've changed the mechanism by which they...*
get paid for that in terms of what we expect them to do (...) the majority [of CCGs] have come up with some sort of primary care framework or scheme that pays [GPs] for delivering services that benefit both primary care and commissioning. (...) There were a bunch of requirements that they had to fulfil in order to sign to the scheme but it wasn't a bidding process. (Commissioner 2, CCG2, May 2017)

Commissioners hoped that they had made the right decision each time, regardless of whether they ultimately decided to use competitive tendering or not. However, the implications of their decisions could not be fully appraised in advance. In a number of cases the commissioners admitted that they encountered problems down the line. For instance, in the case of a community diagnostics service tendered by the CCG2, mistakes were made in the original service specification and there were problems with service over performance against projected activity.

**How commissioners applied the rules in their CCGs**

Whilst trying to interpret national policy messages, the commissioners still had considerable discretion in the way they chose to apply the rules on procurement in their CCGs.

CCG2 commissioner acknowledged that the policy priorities had shifted away from competition in the last two years and local commissioning refocussed on fostering collaboration and contract monitoring mechanisms. Yet they also noted that competitive procurement as a commissioning tool was “still really useful in some circumstances” (Commissioner 1, CCG2, June 2017) and ought to be kept as an option for commissioners. CCG1 commissioner thought that competition could increase value for money.

*That's where you get the best value. (...) I always think if you put the competition you get people to strive to do a little bit better.* (Commissioner 1, CCG1, June 2017)

Since January 2015 all four CCGs in the case study sites had issued new invitations to tender for clinical services as sole or lead commissioners (see Table 3). In addition, CCG3 and CCG2 were finalising competitive procurement for some clinical services, which had commenced in 2014.

The services identified in the Table 3 do not constitute an exhaustive list of competitive tenders due to persisting difficulties in collating such information flagged up in our earlier publications (Allen et al. 2016). We came across difficulties in determining both when the tendering process begun and how or when it ended. In addition, it became increasingly difficult to distinguish ‘genuine’ competitive tendering from other hybrid forms of tendering, some of which might be advertised as ‘Expressions of Interest’ on the various contracting portals. Consequently, the tenders identified in Table 3 exclude the quasi-competitive tendering processes, such as outcome based contracting for MH services run by CCG4 or the complex care service set up by CCG1. In the case of these two services, the opportunities were advertised on the Contracts Finder website, but did not seem to progress to the formal competitive
process, utilising instead the MCProv process. The table also excludes joint commissioning arrangements for tendering due to the difficulties of identifying such arrangements. This includes the competitive tenders which the CCGs in the four case study sites participated in, but for which they were not lead commissioners, for example the NHS 111 service procurement, which CCG4 took part in but did not lead.

Table 3 Indicative list of services put out to competitive tender in the four case study sites (2015-2017) (year of issue of the Invitation to Tender)

<table>
<thead>
<tr>
<th>CCG1</th>
<th>CCG2</th>
<th>CCG3</th>
<th>CCG4</th>
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<tbody>
<tr>
<td></td>
<td>Community Ultrasound Diagnostics (2015)</td>
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<tr>
<td></td>
<td>Community Lymphoedema service (2016)</td>
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<td></td>
<td>Community Intermediate Beds (2016)</td>
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Source: Interview data; Contracts Finder.

The new tendering processes instigated by the CCGs were in respect of small-scale services and affected only a small share of the commissioning budgets. When compared with the previous period (2009-2014), for which we gathered comparative data, the frequency of putting services out to tender had diminished considerably in all case study sites with an exception of CCG2 (see Table 3 and Allen et al. 2016: 84-85)).

According to their own assessment, CCG2 commissioners used a mix of competitive and collaborative approaches to commission services, whilst the rest of the interviewed commissioners emphasised collaborative approach to commissioning as dominating their day to day practice.

*I think probably in truth we’ve got a fairly equal mixture of both [competition and cooperation]. We’ve used procurement a fair bit for quite a variety of things, so I think it’s probably fairly distributed in terms of our specific initiatives. So I suppose if you looked at where the money flows out of the organisation, then the vast majority of it flows out through standard NHS contracts renewed annually without a competitive process, so through the normal contracting route and that would account for, by far in a way, the lion’s share of the money. But in terms of new services we’ve brought into existence, then I think we probably use procurement a lot actually more, probably more than half the time, probably most of the time. (Commissioner 1, CCG2, June 2017)*

The small scale use of competitive procurement mechanisms was due to a number of external and internal factors. The nature of the market for certain services, such as acute care, made them difficult to procure on an open market as there was only one potential provider. The CCG3 commissioner reflected
on “a fairly static market within [the CCG]” (Commissioner 1, CCG3, March 2017). Also CCGs were constrained in their capacity to run procurements, which were resource intensive exercises. For instance, CCG2 used procurement support from their CSU and also external consultants. Commissioner 2 noted that CCG2 compiled a list of services which should be awarded contracts without procurement, with only community based elective care was considered suitable for competitive procurement.

Under the regulations, realistically we should be looking to procure all services. So, services from our acute providers, I think we should be procuring... Well, under the regulations we should be procuring those. (...) The reality of it is once you’ve got into specifying that, it would be very difficult for anybody else to be able to deliver it because there’s only your host provider. (Commissioner 2, CCG2, May 2017)

**Experiences of competitive tendering processes**

We asked commissioners to share their experiences of the recent competitive tendering processes that they managed and any associated challenges.

Since January 2015 CCG4 had conducted a competitive procurement process for learning disabilities service (see Table 3). In the case of the learning disabilities procurement, CCG4 used the LA team to run procurement and relied on the LA’s in-house expertise. The incumbent provider was a community interest company (i.e. a social enterprise). The learning disabilities service was an integrated service provided jointly by the CCG and LA.

There’s three [providers] that have expressed an interest. The ITT has been prepared to be issued. So, we aim to make that contract award in the summer. (Commissioner 1, CCG4, Feb 2017)

In autumn 2016 CCG2 concluded a long and complex competitive procurement process on behalf of 16 CCGs for integrated GP out of hours, NHS 111 and urgent care services, which was instigated in 2014. The process was time consuming and expensive. It can be classified as ‘procuring collaboration’ as the specification required eventual providers to collaborate by sharing information and coming together in an alliance arrangement. The CCG2 purchased procurement support from a dedicated procurement team on a consultancy basis in addition to relying on the support from the CSU. The service was awarded to a number of providers, the biggest of which was a private provider.

We did it as a classic kind of open competition procurement with a lotting strategy and multi-partner evaluations and awarded a series of contract awards, the biggest of which was to [a private provider]. So, you know, that was very much a kind of full-on formal procurement. (Commissioner 1, CCG2, June 2017)
Integrated urgent care required us to write a very different type of specification from the original 111 specification that also combined out-of-hour services and required all of the eventual suppliers to collaborate with one another by sharing information and staffing and that kind of stuff. So it effectively, in order to bid you had to agree effectively to be a partner with the other organisations so that was kind of interesting. It’s almost like procuring collaboration. (...) That exercise took years and we… it’s cost millions of pounds. It took three years to do, plus [large number of] CCGs, very complicated governance and it’s taken us… and we’re still working on, you know, six-month post mobilisation, but it on the whole has been pretty successful. It’s just a very complicated, expensive and time-consuming process, but I think probably has served a purpose. I’m not sure we could’ve arisen at that result without going through those kinds of processes, really. (Commissioner 1, CCG2, June 2017)

The commissioners followed a complex and rigorous assessment process to procure an alliance of providers.

The providers were evaluated against both quality and financial criteria. Those criteria were extensive and had been developed in advance in consultation with all of the CCGs that were party to the procurement, and then the bids were subject to a quite complex but very comprehensive scoring assessment which was all done blind and then moderated independently so that we had a very objective evaluation of the bids, and by a tremendous amount of detail. And I think 60, 70 individuals involved in the evaluation of bids altogether in various combinations, including 20 or 30 members of the public. So really a very, very kind of comprehensive and time-consuming but nevertheless very effective process of evaluation. And then the whole thing was kind of ranked and scored, followed up with a mixture of written responses and assessment interviews, as well as tests. We did readiness tests and capability tests, so it was a pretty rigorous process, really. (Commissioner 1, CCG2, May 2017)

CCG2 also tendered a community ultrasound diagnostic service (see Table 3). The service offered a direct access ultrasound services to GPs. The CCG2 commissioner 2 admitted that this procurement process was challenging as the CCG made a mistake in the service specification by omitting a group of housebound patients. The tender was awarded to a private provider, whilst the services provided hitherto by the incumbent acute provider were decommissioned. Yet as a result of a mistake on the part of commissioners, this had a negative knock-on effect on the group of housebound patients.

The problems we had with that service was that we hadn’t actually specified everything that was coming out. So, we very quickly became aware of a group of patients who would be classed as housebound. So, we decommissioned the service from the acute provider in order to be able to go out to procurement. The specification that we went out to didn’t include patients who were housebound who needed ultrasound diagnostics but was included in the activity that
would be commissioned. This wasn't identified in our way. But we then... Once we got the
mobilisation of the new provider, we very quickly became aware of this group of patients. The
private provider was not able to deliver that service and they... Even if it had been [in] a
specification, they would have said they couldn't deliver that service. So, we then had to go
back to the acute and agree a mechanism where they would deliver it. (Commissioner 2, CCG2,
June 2017)

The mistake was attributed to the break in continuity of commissioning staff working on the
specification and service mobilisation. The situation was remedied by the acute trust agreeing to take
back the activity associated with provision of the ultrasound services for the housebound patients.
However, it is worth noting that the private provider would not have been willing or able to provide this
part of the service, presumably most complex and costly, even if it had been included in the original
specification, echoing the concerns about a lack of level playing field between the NHS and private
providers.

In 2016 CCG1 instigated a procurement process for diabetes service (see Table 3). This was in order to
reduce fragmentation in the existing diabetes services.

In the initial stages, when we had the stakeholder-engagement sessions, we had quite an interest
with [two large private providers], I think, and some other people alongside the primary care
and the GPs and the hospitals. (…) when we did actually receive bids in, we only had one bid
which was from a collaboration between the acute trust, primary care, and the mental health
provider. (Commissioner 1, CCG1, June 2017)

CCG1 bought procurement support and legal advice from the CSU and had a dedicated project manager
who oversaw the process with senior CCG contract and finance managers feeding into the process. The
CCG also had diabetes experts sitting on the scoring panel. The only bid was assessed on how the
collaboration between the acute trust, GPs and MH provider could achieve specified outcomes within
the set block budget. The winning providers already provided large parts of diabetes services but in a
more fragmented way.

According to the Contracts Finder website, CCG3 issued a new invitation to tender for wellbeing service
in July 2017. However, at the time of the interview with the CCG3 commissioner, the CCG3 was still
deliberating whether to put this service out to tender. Thus, we were unable to gather data on the
experiences of this particular procurement process at that point. The interviewed CCG3 commissioner
noted that lessons learned from the past tenders indicated that competitive tendering was not “always
the best way to (…) choose the end result.” The CCG3 instead focused on greater integration between
existing providers.

We haven’t had the best of track records in the past, so we’re going back maybe five years
when the PCT were here, and we tried to do an AQP procurement, and no one ended up going
for it. So, it’s not always that you – we believe that you do get, you know, a better position from the market. Quite a lot of the services that we’ve been providing, the landscape hasn’t changed significantly. When we talk about the projects that we were working on last year, it’s more around integration than adding additional players into the market. (Commissioner 1, CCG3, March 2017)

Effects of tendering the service

Commissioners hoped that the services that they tendered would result in improved quality or lower costs. This was not always the case.

For instance, CCG2 commissioner admitted that the CHS diagnostic service provided by the private provider turned out to be more expensive than originally assumed. In addition, the tendering impacted financially on the acute provider which lost this activity, and had to look elsewhere for business in order to keep the existing workforce.

Similarly, CCG3 commissioner observed a knock-on effect on the local acute provider of the tendered service, which was awarded to a private provider.

I think that certainly we’ve been able financially to see the shift from our main provider, and then the growth in the new provider, so you can see one’s grown, the other one has shrunk down. It’s very difficult to comment on the actual quality. I think the CHS based service, just because of the nature of the way it’s set-up, it does rate very highly with [patients], (...) so the [acute and private provider] models were different and you can see the [private provider] model was much welcomed. (Commissioner 1, CCG3, March 2017)

Yet the commissioner also talked about having to devote considerable staff resources to “almost man mark that contract” on a few occasions (Commissioner 1, CCG3, March 2017). The costs of monitoring and managing the contract and relationships between providers ought to be taken into account.

So, although you can see financially it’s actually working, it’s saving the organisation money, you can see the benefits of it from a quality perspective, it has been quite a high maintenance contract to keep going. (Commissioner 1, CCG3, March 2017)

Another aim that commissioners tried to achieve through tendering was fostering greater collaboration and service integration between providers. In some cases this was successful. Despite early days in mobilisation of the urgent care service, CCG2 commissioner 2 noted that this aim has been achieved.

That’s part of a wider strategy to have all those types of... all urgent care providers be a party to the alliance. So, our next course of action with that alliance is to try and bring on board [local ambulance service provider] as the deliverer of ambulance services into the alliance and
then a sort of progressive move throughout the other urgent care system elements, hopefully to the point where we get all acute providers, all urgent care providers included in the alliance. (Commissioner 2, CCG2, May 2017)

Whereas some tenders specifically aimed at ‘procuring collaboration’, facilitating cooperation between providers following classic competitive tendering proved more challenging to commissioners, especially if the providers were in direct competition with each other for patient flows. This was the case of two providers delivering the same type of service – private and the NHS one – in CCG3.

Integration is quite a big thing, and there is like a [service area] network, so what it has done is that kind of having two providers sitting around the table, it certainly stimulated debate, so you kind of see the level of rivalry between the organisations there. And I suppose, I don’t know directly. I’d assume that that would manifest itself in, kind of, you know, keeping an eye on the good things that each organisation have, and trying to replicate that internally. But managing relationships is another tricky thing in there, with regard to kind of when we try and bring these companies in the same room. (Commissioner 1, CCG3, March 2017)

CCG3 had similar difficulties in terms of fostering dialogue between competing providers in another case of a previously tendered community based service, which was awarded to a private provider.

It’s been the same with the (CHS based) service, in that when we try and create, you know, networks, so you know, we’re really trying to bring all the providers around the table so that we can make sure that the pathways work and that they are integrating fully. But it was very difficult having the (...) service, because we had, in effect, the hospital providers sitting around the table who were potentially losing work, and we had the new providers that were taking the work from them. And then we also had our local [clinical service] committee around the table, (...), they’d actually applied for the procurement as well, and they weren’t successful. So the dynamics of that, at those meetings were – have been very, very tricky. You’ve got one organisation that didn’t get it, one organisation that did get it, and another organisation that were losing the work. So, you know, individually, competition might work, but when you’re trying to integrate and bring people together, it’s an absolute nightmare. (Commissioner 1, CCG3, March 2017)

In some cases, competitive tendering was used as a commissioning tool to reduce fragmentation in contracts and services with existing providers. For instance, this rationale seemed to have accompanied the diabetes services tender in CCG1. Following a competitive tendering process, the CCG ended up with the same providers of diabetes service but reduced fragmentation in contracts and reduced service variation in different localities.

Commissioners were also considering their options with respect to renewal of contracts for services awarded on the basis of competitive tendering. Once the contract was awarded on a competitive basis
to a private sector provider, recommissioning the service without tendering or ‘repatriating’ it back to the NHS exposed commissioners to a high risk of legal challenge. In such circumstances the commissioning options were heavily skewed towards having to repeat competitive tendering exercise. Thus, arguably, using competition in commissioning creates path-dependency to some extent.

*For the same reasons that we went out to procurement in the first place, just awarding it back to the NHS provider would leave us in a very, very substantial risk of challenge from the providers and the market.* (Commissioner 2, CCG2, May 2017)

**Experiences of using cost per case payment structures and Any Qualified Provider (AQP)**

During the previous stages of this study, commissioners found using cost per case payments for competitively tendered services where competition in the market (rather than for the market) was the result problematic (Allen et al. 2016). The AQP policy was seen by commissioners as enforced top down and they were struggling to control expenditure on contracts with multiple qualified providers.

Commissioners tried to address some unintended consequences of this type of competitive tendering where providers were paid on a cost per case basis, such as financial over performance, through contract management mechanisms.

*The contract management try to identify the trends. Are there some practices that are referring more than others? You know, what are the referrals that are coming through for, the services that we commission from them? Are they...? You know, are they just taking advantage of the fact and they're just doing everything that's coming through the door or, you know, is it...? Are they really, really the right referrals? And that's how we've managed that over performance.* (Commissioner 2, CCG2, May 2017)

However, contract management mechanisms might be too weak to control the rising activity in the cost per case services. This was especially difficult for commissioners to achieve if patients could self-refer to the service and private providers actively promoted their services, such as in the case of the AQP adult hearing service commissioned by CCG2.

*Activity has gone up. And, again, through the contract management process we very much looked at that and said, right, okay why is that happening, you know, there aren't... proportionately there aren't any... there aren't more people who wear hearing aids than there were when we went out to procurement. We did an analysis of what we thought the change in demographic would be. Why are more people than we anticipated buying hearing aids? And we've been doing that analysis for a few years now and trying to work through that.*

*And what was the reason?*

*There isn't... I think, again... again, we're down to the promotion of it, if I'm being honest.* (Commissioner 2, CCG2, May 2017)
In the case of this CCG2 an AQP adult hearing service the non- NHS providers of this service, having presence on the high street, were driving over performance. However, as the quality of the service was good, there were no immediate plans to decommission it. However, CCG2 did not plan to use AQP in the future.

I think it’s difficult to justify letting non-cash limited, open-ended activity contracts when you’ve got a tight financial budget and quality standards to achieve. So it’s a perfectly valid form of contract, it’s just one that we haven’t had cause to use much recently because generally speaking we’re trying to put in place greater levels of control than you can get from an AQP process, really. (Commissioner 1, CCG2, June 2017)

The financial over performance of the community diagnostic service had a knock-on effect on CCG’s ability to deliver money saving QIPP targets. CCG2 commissioners identified some savings in the diagnostic spend which they hoped could be achieved through competitively procuring the community diagnostic service with a reduced financial envelope. However, the assumption that the new provider will be able to deliver savings turned out to be false.

We had a financial envelope which is, you know, which was the totality of that diagnostic spend. There would have been a QIPP agenda attached to that. So, we’d have identified some sort of reduction in cost that we’d have anticipated in that envelope. And we then go out to procurement. (...) there’s more expenditure that’s required which we haven’t accounted for and the knock-on to that is of course that there is now more QIPP to be delivered. (Commissioner 2, CCG2, June 2017)

Other commissioners also struggled with cost containment of services procured on an AQP model. For instance, CCG4 found AQP Podiatry and Musculoskeletal (MSK) contracts expensive and implemented a number of contractual mechanisms to contain the costs. There were also plans to integrate these services within the outcome based contract framework, thus removing them from payment on a cost per case basis. At the time of the fieldwork CCG4 was considering the future of this arrangement.

We’re slowing the activity at the moment. We’ve made some contractual efficiency changes (...) in relation to pricing, in relation to activities that they see, referral thresholds, that type of stuff, just normal business as usual that you would do. (...) We may not re-procure them at all and let the contracts close and decide to do it in a different way, but we haven’t decided yet. (Commissioner 1, CCG4, Feb 2017)

CCG1 commissioner called the AQP model “expensive and ridiculous” (Commissioner 1, CCG1, June 2017). In a similar move to CCG4, CCG1 was likely to move away from the AQP model of commissioning towards a weighted capitated budget. Contracts for services currently commissioned under AQP would be moved to an organisation responsible for the ACS budget.
Finally, CCG3 had previously a complicated AQP arrangement across a wider geographical footprint, being responsible for a lead provider contract for a larger area in orthopaedics rather than holding AQP contracts with a number of providers. These contracts were moved to a standard NHS contract. CCG3 considered the AQP for community endoscopy diagnostics, but the model was not attractive to providers, who faced high upfront set up costs with no guaranteed activity. CCG3 did not plan to use AQP contracts in the future.

**Summary of commissioners’ experiences of competition and cooperation**

Commissioners considered carefully the consequences of using competitive tendering on the local health system. The use of ‘classic’ form of competitive tendering for the market decreased in three out of four case study sites in the last two years compared with the previous period of fieldwork. However, the use of quasi-competitive tendering processes which encouraged collaboration between identified ‘capable’ providers seemed to be on the increase. In a number of instances, commissioners utilised the procurement process, or some aspects of it, to procure collaboration between providers rather than pitch providers against each other in a straightforward competitive tendering process. Providers responded by increasing forms of cooperation ranging from formal mergers to less formal alliancing or collaboration arrangements. This self-organisation by providers offered some protection from the risks of competition, whilst allowing the providers to take advantage of the turn to collaboration in commissioning. The commissioners’ experiences of the recent competitive tendering processes indicated that high transaction costs associated with competitive procurement factored against greater utilisation of this commissioning method.
Providers’ experiences of competition and cooperation

In addition to commissioners’ practices, we also gauged providers’ experiences of competition and cooperation. Providers were facing different commissioning bodies within and outside of the NHS sector. We begin by outlining the experiences of NHS providers and discuss the experiences of non-NHS providers separately in order to highlight any differences and similarities.

When asked about their main service delivery challenge many interviewed providers mentioned local authorities’ approach to commissioning and fragmentation of commissioning and contracting amongst other challenges that they faced. These two challenges had direct implications for the utilisation of competition and cooperation in commissioning and are discussed below.

LAs’ approach to commissioning

LAs’ approach to commissioning was mentioned as a major challenge by a number of CHS and acute providers. A number of interviewed providers noted that LAs tended to apply competitive tendering to services as a default option and they did not invest in ensuring the sustainability of their suppliers.

The boroughs are much more disposed to the use of competition as a means of establishing contractual framework and that is true. They are coming together to do these things, pan London contracts, obviously borough contracts, sharing of specifications, all of which is helpful. That kind of scale is very helpful for us as a big provider. However, there is no market stewardship, to use that phrase I used earlier, you know. They absolutely do not appear interested in the sustainability element. So, that is a, from my perspective a major flaw in an over use of pricing or particular performance elements in any contract. I think you’ve always got to have wider population health indicators and measures in your contract award. I don’t think we see enough of that, despite it being a public health led process. (Provider 2, NHS, acute, CCG4, June 2017)

CCG2 CHS provider 1 noted that LAs often used procurement exercises as a way of cutting budgets for services.

[Local authority] put out children services to tender about, probably a year ago (...). But what they’ve done is they’ve taken the health services budget, which is ours, and they’ve added on the children's services budget around children centres which was provided by a variety of organisations. That combined budget was £43 million and they put it out to tender for £34 million. So they slashed £9 million off it. So if we’re successful we’ll expand the turnover because we’ll provide all of that from just our physical bits but we’ve got to do it for nine million less. (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)

And that’s what I mean about, you know, councillors and council commissioning is arbitrary. I mean there is very little science behind their approaches to putting stuff out to tender and there
are some that they chip off the budget. We've seen examples right across the piece really where we're actually not able to bid because, you know, the bid sum doesn't even cover direct cost, the cost of providing the service let alone the cost of overheads, IT, estate and, it's not even worth a conversation about profit. (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)

Similar point was made by CCG3 CHS provider.

[Main challenge is] rising demand and pressures on our services, but with an ever-reducing envelope of resource (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

CCG1 acute provider noted that in order to deal with the problem of delayed discharges, one-off non-recurring funding was allocated to pay for some intermediate care beds in the community by a LA. However, continuation of this arrangement would depend on the LA, as budget holders, choosing to continue to invest in the beds infrastructure that enabled better flow of patients through the hospital. This, given various other LA priorities, might not be the case. On the other hand, the interviewee remarked that there were limits to expanding provision of beds in acute settings due to strict rules on staff ratios as well as bank and agency staff use. The participant hoped that some of extra social care funding would be used by the LA to facilitate the hospital-to-community patient flow. However, the interviewee remarked that it was ultimately the LA’s independent decision how they chose to spend that money.

Just throwing money at hospitals is not going to actually do the trick here. What you have to do is look at the system and get the money out in social care. (...) you have to do that through relationship management technically because they are, you remember the local authorities are a completely separate entity. We can’t hold them to account in the way that we can hold others to account and that is a really difficult dynamic because it’s quite right if the money isn’t coming to us to direct because we don’t, in some respects we don’t want the money if it’s going to be ringfenced for putting beds in here because that’s the wrong place, there’s a limit to how much we can actually do. But we must have assurance from the local authority that they’re going to put, use that money, put the right type of infrastructure in the right place to support the flow. (Provider 1, NHS, acute, CCG1, May 2017)

**Fragmentation of commissioning**

The CCG4 acute provider 2 mentioned the fragmentation of contracting and commissioning in respect of a particular service, for which the trust was a major provider, as a major challenge. The CCG4 acute provider 2 noted that despite high fragmentation in commissioning, these services were largely delivered by the same clinical teams on the ground.

*Most of our professionals work in both [acute] and more routine CHS (...) Services, but also support our specialist [services]. Now, those are separate contracts,
separate payers, separate businesses, and yet, actually, in terms of delivering a service it’s – you know, you might as well take your left arm off. (Provider 2, NHS, acute, CCG4, June 2017)

A similar point was made by the CCG1 CHS provider who noted that some services such as children services were affected by the fragmentation of commissioning, with some services in the same pathway subject to competitive tendering, whilst others were commissioned via collaborative mechanisms. This posed a challenge to the providers who were ultimately responsible for provision of a seamless service.

So, for example, children services for us are largely commissioned by the local authority, so health visiting, school nursing, safeguarding, those sorts of services, youth offending, and so on. Our local authority commissioned services are likely to be tendered, whereas some of the other services, like child and adolescent mental health are commissioned by the CCGs, much more likely to be in a collaborative process and, actually, that might not be in the best interest of the children in this area to have a different approach, you know, depending on which service it is, rather than looking at children per se and what they actually need and how to develop an overall service. (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

Dealing with a multiplicity of commissioners and contracts was becoming a challenge for some providers. For instance, CCG4 acute provider 2, which served a number of different CCGs, LAs and NHS England, was exploring the use of alliance and lead commissioner contracts to address the issue of fragmentation of commissioning.

CCG1 CHS provider also mentioned that having to deal with multiple commissioning bodies and approaches, especially at the interface between health and social care, whilst trying to deliver a seamless service to the public, posed a challenge.

Again, it’s probably more on some of the interfaces with a local authority services, you know, particularly services where the local authority would charge and the health service wouldn’t, you know, when you’re providing an overall integrated service across the whole health and social care economy, those differences in approaches are probably the most challenging things. (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

**Expectations of commissioning the STPs**

NHS providers were engaged in different work streams as part of the local STPs. Although at the time of the fieldwork any service reconfiguration initiatives were still at very early stages, there was a lot of hope and aspiration on the part of providers that the STPs would address some of the pressing and complex issues that they were facing. For instance, CCG4 acute provider 2 hoped that the STP process would reduce fragmentation of commissioning and contracting and refocus commissioning towards more long-term thinking and incentivising outcomes.
I think, is the goal of the STP, to close the care and quality gap by better linking these kinds of things, not being so short-termist, both in terms of the costings and the length of the contract, but also in the way in which we measure these things. (Provider 2, NHS, acute, CCG4, June 2017)

However, the participant admitted that STPs might not be a ‘silver bullet’ to solve the problem of fragmentation of commissioning, as they introduced their own boundary issues. For instance, CCG4 acute provider 2 worked across two different STP footprints, whilst being formally engaged in just one of them.

Citing the lack of a level playing field between NHS and non-NHS providers in terms of responsibility for provision of complex and comprehensive care, the CCG1 acute provider thought that competition should not be applied as a mechanism to reconfigure local services as part of the STP.

Somebody would have to explain to me how that competition, if it could be ever set up on a level playing field, would then drive that improvement because at the moment what we’ve, I think if you took a step back and looked at the macroeconomics of it what you would say is over the last 15 years a lot of planned care work which is highly productive in terms of, highly beneficial in terms of the funding streams going into the private sector has left a massive problem for the public sector NHS in terms of dealing with the urgent care demand where the tariff is not as attractive, whether there’re some mechanics around that that can change that dynamic I don’t know. (Provider 1, NHS, acute, CCG1, May 2017)

Many interviewed providers hoped that the collaborative STP process would enable greater harmonisation of commissioning and contracting and address other complex service delivery challenges.

Certainly locally we have lots of different work streams taking place in order to deliver integrated services. So that’s everything from, you know, the actual delivery and the staffing associated with that and the patient pathways, through to payment mechanisms and, you know, outcome indicators and so on, so, yes, there’s loads of stuff, actually, because it’s really complex. (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

NMC related service reconfigurations

We asked providers about the NMC programme and the way competition and cooperation principles were applied to various initiatives. Providers who were not directly involved in any of the vanguards could not comment on the way the commissioning mechanisms were used. On the other hand, some providers had been directly involved in vanguard schemes. For instance, CCG2 CHS provider 1 participated in both provider led and commissioner led local NMC schemes. These schemes followed
different commissioning paths, with the provider led one using collaborative mechanisms, whereas the commissioner led one opted for competitive tendering.

As an organisation we've got, if you like, substantial new model pieces going on, both [X] and [Y], and they're very different beasts in that [X] is very much provider led as a new model offer whereas [Y], although it's still in the tender phase, but it's very much commissioner driven. And so you've got very different dynamics and different ways of developing the offer and developing the model, and there are benefits of both. But it's quite a thing to see it from both sides as it were. I sit on the [X] board on behalf of [the trust], so I can see the really good stuff as well as the pitfalls shall we say with regard to a provider led vanguard. (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)

This provider observed that the fact that the vanguard was led by a provider put the commissioners in a tricky position.

The CCG find themselves conflicted on occasions because they want to be involved to get the learnings from the exercise but they also realise that at some point in the future if they put out a whole system offering procurement terms to, you know, equivalent of a MCP or an ACO, they don't want to be seen to be, you know, favouritism to be suggested with regard to the [vanguard]. So they struggle a little bit with the whole arrangement. (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)

As the NHSE central funding for vanguard schemes was likely to be time limited for three financial years from 2015/16 to 2017/18 (see e.g. (NHSE 2015)), the local commissioners would have to decide whether to support the schemes with local funding and if so, whether to use competitive tendering to roll out and embed the services that vanguards had established.

The CCG2 CHS provider 1 was also bidding for another local vanguard scheme which was recently put to out tender by commissioners. The tendering process for this vanguard was another example of commissioners using competitive procurement in a non-traditional way. In the case of vanguard Y, local GPs were in a strong position in deciding on the preferred bidder, because the successful bidder was required to “work hand in glove together” with the GPs (Provider 1, NHS, CHS and/or MH, CCG2, June 2017).

The CCG Y have said the GPs will support the preferred bidder. So effectively the preferred bidder needs to have GP primary care support to enable them to put in a successful bid. (...) And so we've been going through this very bizarre pre-tender, pre-procurement exercise, almost a beauty parade, with the GPs. (...) We are optimistic, (...) that we will be that preferred partner of primary care. (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)
The participant reflected that using “an unofficial element of the procurement” to inform “the official bit of the procurement” was a particularly risky strategy that was open to legal challenge, especially as private providers were also interested in this procurement (Provider 1, NHS, CHS and/or MH, CCG2, June 2017). However, at the same time the participant admitted that a legal challenge was unlikely.

*I don't think there'll be a [challenge], no, because these are big companies, they understand the way of the world and the truth is that, you know, we've already been through a substantial exercise. So, just because it happened at the informal stage, we could have done it at the formal stage and arguably the same outcome would have occurred. But you just don't know. (...) Well, it's not a traditional procurement process, let's put it that way. (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)*

This procurement process set in motion an interesting four-way dynamic between the GPs, acute, CHS and private providers. There were three private providers interested in bidding for this vanguard, yet only one of the private bidders and the CCG2 CHS provider went as far as having conversations with the GPs. The stakes in this procurement were high as the contract value was substantial and long-term. The CCG2 CHS trust paired up with an acute trust to strengthen their position, yet they realised that the GPs were not keen on the acute trust steering the bid. On the other hand, the acute trust realised that they were in a losing position and decided to collaborate with the CHS trust rather than make an alliance with a private provider. Finally, the GPs were finding the option of NHS providers preferable to having to deal with the private provider which could endanger the GPs’ own contractual arrangements.

*So you've got this mix of the GPs being fed up with the acute and saying to us you need to run the CHS services and manage the acute. And then you've got the acute kind of, you know, cowering in the corner and realising that they're on a loser but they're choosing the, sort of, the best of the not good options which is for us to be the lead and be their partner. It's very interesting. (...) And I think the GPs were, you know, scared of the potential that [private provider] would come in and basically say we want a salary for GPs, so you need to give up your PMS and GMS contracts and come and work for us. (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)*

Furthermore, the winning bidder would have to operate a service model which effectively controlled primary care. This was likely to add another element to the complex partnership dynamics. The tender process was still ongoing at the time of the fieldwork.

In the case of the CCG3, the funding for one of its vanguard schemes ceased but the work initiated by the vanguard continued on a smaller scale with CCG3 CHS provider staying involved. The CCG3 CHS provider was also involved in another local vanguard scheme. There was no competitive tendering process, but the trust had to bid for central funding to set up specialist services as part of this vanguard.
CCG1 had an enhanced health in care homes vanguard in place. The CCG1 acute provider was involved in implementing innovative solutions to provide care in the care homes settings. The acute trust built on its expertise accumulated over the years in this area of service provision, including by winning a number of competitive tendering processes to run such services in a number of local CCGs and further afield. However, the CCG1 vanguard was not competitively tendered, but CCG1 acute provider had won some funding to support this work.

**Providers’ experiences of commissioning practices**

CCG4 acute provider 2 noted that commissioners were obliged to consider the legal framework and best value when commissioning services. This interviewee noted that CCG4 utilised the MCPProv guidance to avoid going through an expensive competitive procurement process for their CHS. This was an example of a non-competitive, yet transparent procurement process carried out by CCG4.

> And they've started to use the most capable provider guidance as a mains of demonstrating that a procurement exercise would be pointless and (...) expensive, because you’re going to end up with a provider, or group of providers, who, kind of, are the best fit anyway. (Provider 2, NHS, acute, CCG4, June 2017)

> This was partly a market stewardship exercise, in that they were trying to create a, sort of, a level of sustainability in the system, as well as testing the new models of care. So, (...) they were keen to find a way that we would support the most capable provider guidance. So, they were clearly mindful of the law, they took advice about (...) the extent to which it applied and whether or not the MCP guidance, which should be established by the department, would allow them to potentially go down that single tender wave ratio. (Provider 2, NHS, acute, CCG4, June 2017)

CCG4 acute provider 2 noted that the shift towards hybrid forms of competitive procurement was accomplished by CCG4 through utilisation of quasi-competitive methods of commissioning such as competitive dialogue, whereby commissioners encouraged a group of providers to work together and propose a solution to a particular commissioning challenge.

> You’ll start to have that kind of dialogue. Effectively, on a prequalification process, it starts to say, you know, this is what we want, how can groups of providers come together to demonstrate this? It’s almost like a perfect competition process, you encourage the providers to have a dialogue. I mean, it’s – is it perfect competition or anti-competition? I don’t know that. (Provider 2, NHS, acute, CCG4, June 2017)

CCG1 CHS provider 2 offered another paradoxical example of commissioners using rules that were designed to stimulate greater competition to foster collaboration.
I think commissioners wrestle with it. I think they clearly have an eye to what the rules are, but at the same time are trying to balance that with the need, really, for the only way to deliver what needs to be delivered is to provide, to work together and to jointly come up with solutions. Certainly, locally, what that’s meant is we’ve had collaborative processes in place around either whole populations or disease groups. So, for example, diabetes, commissioners have published a prior information notice as sort of the first stage in a process. And then the actual collaborative process has taken place with identified providers. So that’s sort of you using the rules, but making sure that it's collaboration and cooperation is what’s actually happening.

(Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

Providers were encouraged by commissioners to collaborate with each other rather than respond to tenders in silos.

The kind of direction of travel is much more about how do you get a set change through collaboration and encouraging providers to collaborate together to form new models of care, rather than just saying, I’m just going to write a new spec, put it out into the market and see who can respond to it. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

CCG2 commissioner 1 labelled this shift in commissioning practice “procuring collaboration” (Commissioner 1, CCG2, June 2017).

A number of providers noted a level of discretion that CCG commissioners continued to have concerning the commissioning method used. Yet they also observed that the collaborative route now prevailed.

I think [CCGs] set a framework and expectations and they could go either way, they could just decide to put everything out to competition, or they could go down entirely the collaborative route, and ultimately that is their decision. I would say CCGs are definitely going down a more collaborative route. (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

According to these providers, the existence of a gap between the rules and the current policy direction was sometimes reflected in the difference in approach to commissioning between the senior and junior commissioning managers. CCG3 CHS provider noted that there was a disconnect between senior and junior managers within an organisation, with the latter more likely to stick to their view of the rulebook.

According to CCG2 CHS provider, CCGs in their local area favoured collaborative approach to commissioning which was exemplified by the STP work streams, some of which were led by the CHS trust. However, they also noted that as a result of proposed CCG mergers, yet another distracting reorganisation, the voice of single CCGs might become weaker in the STP initiative, whereas the acute providers would gain leverage.
I have to say the risk in part is that the CCGs are going through a process of change at the moment in [the local area]; they’ve been looking to merge for a long time now and as a result their focus has, you know, been taken away from the STP to an extent. They’re kind of staring back at themselves. (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)

Providers noted that there were differences between CCG commissioners in terms of their frequency of resorting to competitive tendering in the past. However, such individual differences in the approach between different CCGs might diminish in the future, as more CCGs merged and shared posts.

We’ve got three local CCGs, and of the three, one has been more likely to go through a competitive process in the past, and the other two are more inclined to a cooperative approach. However, those three CCGs have recently been coming together and aligning, you know, shared posts and so on, so I think, overall, the approach is much more moving to cooperation. (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

In one case the providers had difficulty in pinpointing the overall approach of their local CCG to commissioning. According to CCG4 acute provider 1, CCG4 showed no consistency in favouring either a collaborative or a competitive approach to commissioning services as the CCG suffered from “a very severe change in leadership” adversely affecting their commissioning capabilities (Provider 1, NHS, acute, CCG4, June 2017). During the fieldwork for this study, between 2014 and 2017, CCG4 went through numerous senior management changes.

It’s a small CCG. It’s short of capability and capacity and now it’s short of corporate knowledge and awareness. (Provider 1, NHS, acute, CCG4, June 2017)

On the whole, providers noted that CCGs tended to have a collaborative approach to commissioning, mindful of the importance of continuous provider engagement and avoiding the dangers of destabilising key providers. The CCG1 acute provider described their relationship with CCG1 commissioners as good.

I think it’s been more about constructive relationship management because what people have done is they’ve been mindful of what everybody else is doing all the time, and if there’s ever been any inkling of something that would be destabilising. People have been pretty good at getting around the table and having an argument about it, but at least getting around the table. I don’t think the competition in that respect has caused mass scale destabilisation. (Provider 1, NHS, acute, CCG1, May 2017)

Providers noted that in contrast to CCG commissioning, where the use of full competitive tendering was waning, competition remained the dominant mode of commissioning services by the LAs.

Local authorities are much more into tendering and much more clear about here is the cycle of what — how we need to test and, you know, they’re much more willing to go out to tender, you
know, look at who can lead us back at the lowest cost and then, to revert tenders. And so, the biggest change in provision has been through local authority tendering, certainly in our world, as opposed to NHS tendering, and as you know, a lot of services provided by community and mental health trusts have — were transferred over to local authority purchasing, with the demise of – or the ending of PCTs. So, then, that’s a different dynamic. So, it’s different for different services that providers are providing, based on different commissioners. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

According to the CCG3 CHS provider, as LAs faced even greater financial pressures, their approach to commissioning was akin to “reverse engineering” services against available resources. In contrast, health commissioners’ approach tended to be more open ended and focused on the needs of the population rather than on the available resources.

*The local authorities, I suppose that their requirements and maybe it’s why they’ve been able to tender things, certainly from their perspective, a lot more effectively. I wouldn’t necessarily agree with that in totality, but is actually, their criteria is a lot simpler in so many respects, as in, we have a resource that’s available, perhaps what we want people to come back with and we will almost reverse engineer what we’re able to provide against that resource.* (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

In the experience of the CCG3 CHS provider, CCG3 commissioners “don’t have a huge appetite for tendering” (Provider 1, NHS, CHS and/or MH, CCG3, June 2017). The CCG3 CHS provider noted that competition was a “very harsh tool” as profit margins in healthcare were low. In their opinion, providers preferred collaboration to the “blunt” instrument of competition (Provider 1, NHS, CHS and/or MH, CCG3, June 2017). However, the same provider noted that the downside of a collaborative approach to commissioning was being bogged down in the details of contracting arrangements at the expense of strategic thinking about the bigger picture.

*My hope would be that as we move forward into more of an accountable care type of system, that we would have more time spent by our combined teams on commissioning than they would be spent on the mechanics of contracting.* (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

**How providers decided which services to bid for**

Given the high transaction costs of participating in competitive tendering, squeezed financial envelopes for tendered services and the salience of this income stream for some providers, all of the interviewed providers had internal processes in place for appraising the costs and benefits of participating in particular bids.
We have a very, very small team who supports competitive tendering, if it happens. So, we have two people who have a whole load of other things they have to do as well, and if there is a service that’s put out to tender, (...) the service line will decide if they want to tender for it, how they would tender and then one of the two people will support them. It will go through our Investment Committee, in effect, to make sure that it’s satisfying our, kind of, return on investment margin, kind of, requirement. If it’s marginal, or there are some big issues, it will then come up through to the Executive Management Committee, which I chair. It is a real drain on how we do stuff, so you know, the service line has to put a lot of time into it, which clearly takes them away from doing other things, and you split those opportunities really, into two. One is where it’s current business, and you can’t afford to lose it, and the second is, opportunity where maybe we can grow on things we do well. (Provider 1, NHS, acute, CCG4, June 2017)

We go through an assessment of each opportunity that comes out. So we have a template that then considers different factors from our reputation and the competition and the financial returns, the risks and so on, and in effect we end up with a score and that determines whether or not it’s one that we would pursue or not. (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

What would happen in simple terms is our business development team would identify a potential tender for winning, and they will put it to the respective service lead, and then usually through our executive group a quick proposal will be put together to say X service has been put out for tender. This is what’s on offer. We do or do not think we should make a bid. And it’s a quick fire run through of, you know, what’s the ask, what’s the funding for it, what’s the expectations in terms of outcomes, can we deliver it? (Provider 1, NHS, acute, CCG1, May 2017)

CCG4 acute provider 2 had similar arrangements in place. Some providers, such as the CCG1 acute provider and CCG4 acute provider 2, were starting to develop niche specialisms in certain services, “things we do well” (Provider 1, NHS, acute, CCG4, June 2017), which they were more likely to bid for.

We’ve got a very specific process within the Strategy Team, which allows us to effectively rate the opportunity associated with the bid. Does it fit our strategy? Is there – what benefits are there? How easy is it to implement? And (...) we’ve got nine questions, basically, which we armed and we score. And depending on that scoring you’d have – make a recommendation as to whether you were going to go forward and bid. (Provider 2, NHS, acute, CCG4, June 2017)

For [service X] we know that this is still part of the environment and we will continue to put resource into procurement and complying with (...) procurement programmes. It’s absolutely part of our strategy and we also recognised that, as I said earlier, the local authorities are much more advanced, more sophisticated in their tendering processes anyway. But for almost
Everything else we’ve got a bit of a, sort of, gateways really, sort of go through an assessment process that starts with say, how aligned to our existing strategy is this, what’s the ease of implementation and what’s the return? (...) we are being a bit more mindful about the resources we’re putting into this. And that’s partly a reflection of, you know, a focus on our core business, the way the operating plan is looking and partly a reflection on actually the procurement exercises tend to tighten margin all the time (...) And partly, actually, our learnt experience is that (...) almost 50% of these tenders now end up getting protracted and you end up doing it again. (Provider 2, NHS, acute, CCG4, June 2017)

Some providers such as CCG1 CHS provider tended to participate in tenders when the services advertised related to the services they were already providing, in order to ensure financial viability of the organisation. In contrast, CCG4 provider 2 acute noted that they had changed their tactics in respect of competitive procurement by becoming more selective. Previously, the trust would have bid for the services, where they had been an incumbent, regardless of how small the service was, just to maintain their market share, but they were moving away from that position. CCG2 CHS provider 1 stated explicitly that they were prepared to lose their existing business, if tender was not priced correctly, as they could not commit to delivering services at a loss. This participant noted that some LA tendering calls attracted no bids as the budgets were cut beyond what providers could deliver.

[Local council] are re-tendering their children’s services and a few years ago we won the tender for school nursing. So the reality is that based on the envelope that they put out, again we can’t bid within the number so we then don’t put in a bid. It didn’t even cover direct costs. So our contribution on that piece at the moment is £400,000, so we’d end up having to effectively giving that contract away and covering off the £400,000 somewhere else. It’s probable that the existing provider of the health visiting services, which is [another trust], would probably bid and lose money on it but they’d, because their chunk is so much bigger they’d probably bid and make a loss. But we can’t, we’re just not in the business of bidding and making a loss. (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)

The CCG3 CHS provider gave an example of a decision not to bid, despite being an incumbent provider, as the financial envelope was too tight for the service tendered by a local CCG.

One where we decided not to tender, because what we did is, we looked at the size of the financial envelope, the specification that was being issued by the health organisation and decided that – you know, we did look at whether there was a redesign possible etc., whether we could effectively provide the level of service and the quality of service (...), in relation to the standards that we set ourselves as a provider, within the financial envelope that was available and we decided we couldn’t, so we didn’t tender, we didn’t submit a tender. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)
In contrast, CCG3 CHS provider decided to bid for the same type of service in another area, in partnership with another provider.

*The reason why we decided to bid for it was because we felt that we wanted to develop the skills of working in partnership with the other provider we went together to do that with, and part of our learning about, you know, responding to bids and tenders with other organisations, so it was a bit about learning about that. It was also about wanting to expand our geographical footprint into other areas, which might have strategic opportunities for us.* (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

**Experiences of competitive tendering processes**

We asked providers discuss their experiences of recent competitive tendering processes in which they had participated. Providers shared many examples of successful and unsuccessful bids, invitations to tender which they decided not to pursue and tendering processes that were halted by commissioners and re-tendered or abandoned.

All providers that we interviewed had recent experiences of taking part in competitive tendering, usually initiated by other commissioning bodies than the four CCGs under study. Providers noted a difference in propensity of commissioners to put services out to tender, with LA commissioners and, to some extent, NHSE using competitive mechanisms far more frequently than CCG commissioners, when contracts come up for renewal.

*For nearly all the local authority, council commissioned services, they will all be coming up for renewal, and some of the NHS England commissioned services, so flu vaccinations, for example, are just about to go out to tender. (...) [CCGs] tended not to have a cycle of procurement, so they tend to look at individually at services or groups of services. The others tend to have, you have a three-year contract that expires on a particular date and it will go out to procurement. (...) There’s quite a real disparity between the services that are commissioned by a council, by local authority, versus those commissioned particularly by CCGs and then probably the NHS England commissioned services, or specialist services are somewhere in between those two.* (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

CCG4 acute provider 2 noted a significant decrease in tendered opportunities, which resulted in them removing a post that was specifically dedicated to monitoring procurement portals.

*In the last 12 months it’s significantly reduced. So, the numbers of procurements have significantly reduced. (...) Because CCGs have moved away from using the formal competitive process (...) and are moving into the, kind of, prequalification dialogue and partnership models. (...) they haven’t specifically said, oh, that’s why we’re doing it, but you know, this*
time a year ago, 15 months ago, we would’ve had three or four tenders every three months, and out with of [service X], we’ve only had two in the last 12 months. (Provider 2, NHS, acute, CCG4, June 2017)

Similar to our previous findings, acute providers were generally less exposed to competitive tendering than CHS and MH providers (see Allen et al. 2016). The scale of the services that were subject to tendering were not material to some of the acute trusts that we interviewed. For instance, the CCG1 acute provider noted that so far, they had not had to face a situation where a service which they ‘historically’ provided went to a different provider as a result of a procurement.

*It doesn’t feel massive at the moment. It feels like it’s a growing thing but it doesn’t feel like it’s massive at the moment. I mean what would be massive, you know, if the CCG put our main contract out to full-blown tendering that would be a huge issue for us, yes. (Provider 1, NHS, acute, CCG1, May 2017)*

Many interviewed providers reflected on the experience of competitive tendering as a learning process. Participating in many successful and unsuccessful bids made the CCG3 CHS provider better at taking part in the competition.

*Every single tender we’ve done, we’ve learnt from. Ones that we’ve been successful in and ones that we haven’t been successful in and what we’ve been able to do is to then identify what skills and knowledge do we need in our organisation and how do we develop them? We’ve also had to learn what skills and knowledge we need to, not necessarily have in our organisation all the time, but we buy it in for, you know, that particular thing that needs to be done. We’ve also had to learn how to actually ensure that we think about the costings and how, you know, how we might do the service redesign. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)*

Providers listed a number of challenges associated with procurement process, which we discuss below.

**Reasons behind unsuccessful bidding**

Some providers acknowledged that in some cases their bid was not good enough resulting in unsuccessful attempt to win a contract. One such example was shared by the CCG4 CHS provider whose bid for the CCG4 health visiting service was unsuccessful. This was attributed by the CHS provider to insufficient attention of senior management having been dedicated to preparing a bid. The CCG4 CHS provider admitted that their bid was not good enough.

CCG4 acute provider 2 noted that sometimes providers did not put adequate resources into preparing a bid, especially when the economic case for providing a service was not clear-cut. This was the case of
the MSK service for which CCG4 acute provider 2 initially submitted a bid, but which was eventually awarded to an independent provider. CCG4 acute provider 2 reflected that the independent provider won the MSK contract because they were prepared to put more frontline staff resources into providing the service to make sure they met the waiting times target, which gave them a competitive advantage over the acute trust. In this case price was not an issue, as both bidders’ price offers were similar.

However, there were also many examples, especially in services commissioned by LAs, where there was competition based on price, not quality of the service. For instance, the CCG1 CHS provider was unsuccessful in bidding for substance misuse services commissioned by the LA because of the price. The contract was awarded to the third sector provider.

**Protracted, iterative and abandoned procurement processes**

Some commissioners terminated the tendering processes unilaterally. This was an experience of the CCG1 CHS provider which submitted a joint bid with other neighbouring providers for the unscheduled dental care service in the region, but the NHSE stopped the procurement exercise to reconsider it. This type of experience was particularly frustrating for the providers. For example, CCG4 acute provider 1 submitted bids for a number of services, which were underspecified, as commissioners did not budget for the level of expertise required to run these services. According to the providers, the commissioners were using the competitive procurement process as an opportunity to learn how to specify and price the services. Providers offered many examples of such “stop start” procurements (Provider 1, NHS, acute, CCG4, June 2017).

So, we’ve had a stop start, stop start around [a particular service], which I think is [local authority] running that, ‘cause it’s a public health commissioned service. (…) Which has been unhelpful. They tendered, we bid, but bid a non-compliant bid because it couldn’t be achieved for the rate of money they had. They then stopped and went out again. I can’t remember where we are with that one, but I think we might’ve had two goes at that.

There was one for [service X led by another CCG on behalf of a group of CCGs], which we provided part of, but not all, so we decided we needed to bid, which we did bid. Again, that didn’t proceed, because they only wanted to spend less, significantly less than we believed was the absolute minimum that you needed to do it safely. (Provider 1, NHS, acute, CCG4, June 2017)

In the case of the above mentioned service which CCG4 acute provider 1 was interested in providing, the commissioners decided to revert to the status quo and go out to tender again.

Which is one of the most frustrating outcomes, to be honest. (…) ‘Cause it means you’ve got to do it again, at some point, and we’ve had a number of those, and they are just – they really are
just a consuming of time for absolutely no benefit. (...) a learning process for them, using a competitive tendering process as a way of honing and developing the specification, and maybe understanding the true cost, but a very expensive way of doing it. (Provider 1, NHS, acute, CCG4, June 2017)

CCG4 acute provider 2 also noted that some procurement processes were protracted and characterised by commissioners changing their mind and direction of travel. This was the case of a community based rehabilitation service. Initially, the interviewed provider joined a consortium led by another major acute trust as a supporting partner and the consortium won the tender to run this service. However, about a year into the contract, the commissioners decided to activate an exit clause and retender the service. A different consortium of providers won the second tender, but the commissioners were still not happy with the service.

It’s now the third lead in four years. It’s the third contract offer in four years. Incredibly disruptive for everybody, not the least of which are the people in care homes or the staff on the wards who are now getting used to their third model. (Provider 2, NHS, acute, CCG4, June 2017)

**High transaction costs of tendering**

The CCG3 CHS and MH provider’s experiences of competitive tendering related almost entirely to the services that had been put to tender by the LA commissioners. Participating in tendering incurred considerable transaction costs for the trust. Equally, the income from tendered services constituted around ten to fifteen per cent of the overall CHS trust budget, so the loss of this funding stream would impact the trust materially and the high costs of tendering had to be incurred.

It’s not only the team that we’ve got that work on tenders, but all of us get involved, in one shape or another, within tendering process. So yeah, a lot of our resource goes onto responding to tenders and, you know, and it’s a lot of our income that’s impacted on by tenders as well. (...) It is tens of thousands of pounds per tender. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

The CCG3 CHS provider estimated that they prepared around ten tender responses or other substantive pieces of work involving competition per year. This included formal tenders, but also requests to prepare specific bids or joint proposals within a “closed club” of pre-selected providers.

Many providers procured ad hoc support for preparing particular bids, such as the services of a bid writer or legal advice on the contract, in addition to relying on their internal teams responsible for procurements. The CCG1 acute provider noted that having a dedicated business development team that oversaw potential new tenders and was in charge of protecting existing work was a considerable cost
pressure on the hospital. The team was supported by the expertise from legal, contracts and business intelligence functions.

*It can become quite time consuming some of this stuff in terms of dealing with it, assessing it, doing the actual bids and then presentations, winning the awards, doing the contract, you know, there can be quite a bit involved with it and so there is definitely an administrative burden.*

(Provider 1, NHS, acute, CCG1, May 2017)

**Dealing with tight financial envelopes**

The CCG1 CHS provider recently won a tender for health visiting services advertised by a LA. There were a number of challenges in preparing the bid and adjusting the service to the tight financial envelope.

*The time input is very high, it’s very time intensive, it's usually a very short response period. You know, there's huge amounts of detail usually we have to pull together. (...) there are always challenges. The overall cost envelope is always a challenge, and the need to redesign services in order to deliver within that cost envelope. The TUPE list that you would then receive, you know, the list of staff with TUPE to the successful provider, you know, the cost of that can often exceed the overall financial envelope. So then you need to make an assessment about how quickly you could redesign and release some of those costs and would there be any redundancy impact and so there’s always loads of challenges. There certainly were in this one.*

(Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

**Inadequate service specifications**

CCG4 acute provider 2 questioned commissioners’ skills in writing accurate, outcomes oriented service specifications.

*I do not believe that colleagues in the commissioning environment, it’s a very difficult environment to be, are putting enough into the specification to really get the outcomes that they want. (...) And there’s a bit of a common theme coming through. We’ve had a major sexual health contract where we were the only bidder, we were the only shortlisted bidder to meet the specification. This is a pan London, (...) so it was a multi-CCG, a multi-borough contract. We’re the only bidder to meet the spec and yet, they asked us – you know, they said they weren’t happy with the spec. They’ve asked us, you know, just to go back and re – effectively rebid. (...) and we’re considering now whether we challenge that.*

(Provider 2, NHS, acute, CCG4, June 2017)

**Lack of uniformity of tendering processes**
Providers also found that tendering processes were not uniform and rarely followed a predictable trajectory. As the CCG4 CHS provider remarked “the thing that we find with the tender processes is, they are all so different” (Provider 4, NHS, CHS and/or MH, CCG4, Sep 2017). This meant that providers could not rely on a bank of answers nor could they replicate the approach they applied in the last tender, even if the tender was for the same type of service.

The CCG3 CHS provider found it more difficult to respond to less formal competitive procurement processes, as there were no clear rules on which such exercises were based.

Although it’s not a tender in the sense, it follows all the regulations, it’s still a competitive process. It’s made it for us difficult, on occasion, and we have had an example recently over, “Well, were the rules on which we were putting the bid against?” I think a competitive tender, in some respects, is clearer because people have got to set out a scoring system and all of those sorts of things. (…) Whereas, some of the bidding processes, actually, either they’ve already made their mind up or actually, they don’t really know what they’re going to get. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

Organisational implications of managing tendered services

Successful bidders encountered many challenges in the post-award stage of service mobilisation, especially if the service was new, in a new geographical area or based on a different service model.

For instance, the CCG3 CHS provider in partnership with an independent provider was successful in bidding for a service commissioned by a CCG in a different area but found the mobilisation stage challenging.

[It was] a very intensive experience and took up a lot of resource to do and it’s not just the, kind of, not just the responding and tendering, but it was new business for us, so you’ve got all the, kind of, setting it up, making sure it’s working properly and all of that. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

CCG4 acute provider 2 recalled their experience of managing a post-discharge CHS service when being part of a supply chain with the major acute trust leading the service.

So, we were part of the supply chain, effectively, (…) what we tried to do was align some of the dynamics with this with our core operating plan requirements, you know, can it support streaming in A&E, can it support rapid discharge? You know, we know who the vulnerable care homes are, can we align them with those? (…) we didn’t make much progress in significant service change. But yeah, no, I mean, I think fundamentally that’s what caused local commissioners to get anxious quickly, which was that we didn’t change the model sufficiently, we didn’t really move to an out of hospital model, which is what they want. (Provider 2, NHS, acute, CCG4, June 2017)
The CCG3 CHS trust reflected that a big part of learning how to compete was learning how to deal with HR issues such as Transfer of undertakings protection of employment regulations (TUPE) after winning the contracts.

"The biggest challenge that we have and in particular, because it was a service that’s outside our patch, was one of, if you like, that successful transition for staff. So, if you like, for any feelings that they were being pushed from pillar to post, but at the same time, also wanting them to, you know, be part of a different service model or a clinical model. So, that required possibly, more effort as in face-to-effort – face effort than we possibly would have envisaged" (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

Similarly, the CCG4 CHS provider found inducting the staff transferred to their organisation a challenge.

"It’s been a lesson for us, in terms of mobilisation generally, and we’re pretty good at mobilising, that’s one of the things we are very pleased about, we put a very formal structure in place when we mobilise services. But we missed some issues around, how do you induct current staff into your service? So, you know, in services where there were staff already employed, actually, getting them trained in what our policies and procedures are, what our standards of care are, how you report incidents, what our expectations would be of them. I think we had a couple of incidents, which we – have taught us that actually, you know, you can’t just assume that because somebody’s a qualified nurse and that they’ve been immunising children for the last 20 years, that they’re doing it to the standard that (...) we would expect. (...) So, you know, a greater emphasis on proper induction for the staff we’re TUPEing over and making sure that they feel part of our organisation, even if they’re operating at a distance, those sorts of things." (Provider 4, NHS, CHS and/or MH, CCG4, Sep 2017)

On the other hand, the TUPE process also presented challenges for those organisations which were losing contracts to another provider. This was the case when CCG4 acute provider 2 lost its MSK service to an independent provider and had to transfer some of the staff. The acute provider felt a negative impact on staff morale.

"So, it was relatively marginal, ‘cause, as I said, it was a small contract. The main impact is a human one, staff who were employed by us, who were part of our rotas, who spent, the majority of their time on this community contract, but also rota-ed through our inpatient services, they were TUPE’d across. So, it’s quite disruptive, you know, workforce is our single biggest resource in the system. (...) it’s not good for the staff and it’s not good for the service." (Provider 2, NHS, acute, CCG4, June 2017)

Some participants mentioned positive effects of tendering. CCG3 CHS trust noted that winning services through tenders did not have a big financial impact on their organisation as profit margins were very
small, but it was a platform for practicing and developing collaborations with other providers – both NHS and non-NHS ones - and thinking about service delivery in a more innovative way through service redesign.

**Experiences of providing AQP services**

Throughout this study, we traced closely commissioners’ and providers’ experiences of the AQP contractual framework (Allen et al. 2016). Initially, the policy mandated putting a number of CHS based services to AQP process and broadening competition within the market driven by patient choice of provider (Jones and Mays 2013). However, a number of difficulties beset the policy, including commissioners’ inability to control the costs. Many commissioners decided to stop AQP arrangements and move the activity back to block contracts. Unsurprisingly, the AQP policy was viewed more positively by providers, especially the independent providers, who saw it as an income-generating stream. However, the CCG1 CHS provider complained about the administrative burden that recording AQP activity introduced.

> It was very time consuming in recording, because within the podiatry service, part of it was AQP and part of it wasn’t. The specialist element was still in our core contract, so it meant the podiatrist had to record differently. We then had to extract that activity to say which was core and which was AQP and which was specialist under the block, and have a charging mechanism for the AQP element of it, so there were huge transactional costs to that. From a service delivery perspective, it didn’t really make any sense, someone could come along and have part of their input from a podiatrist under AQP and part of it was under the specialist part of the contract. So it didn’t make any sense from an operational delivery point of view and it just caused huge transactional costs, both for us and for the CCGs I think. (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

The CCG1 acute provider had a more positive opinion about AQP contracts as they ensured an extra revenue stream and did not require a huge investment in staff. The contracts for the AQP services they provided, such as pathology and radiology, were coming up for renewal and they hoped that these arrangements will continue.

> My experience of [AQP], touch wood, has been very positive. I think our CCGs have been very pragmatic in terms of not overburdening us on that sense with the commissioning structure around that. So, you know, they put out a service spec, people bid for it. We put a service model in and a service offer, we’ve won it and the contract around it wasn’t too onerous, touch wood, it seems to work quite well that one. (Provider 1, NHS, acute, CCG1, May 2017)

**General implications of competition for providers**
Providers also reflected on the more long-term consequences of the use of competitive commissioning mechanisms for the sustainability of the NHS providers. There was a concern about the use of quick gains tactics by the commissioners.

*We are very anxious about the salami slicing of bits of service and bits of it being hived off for competition, for transactional gain. ‘Cause we think that that kind of transactional gain (...) is a long-term threat to sustainability. You know, we cannot be left with just either those expensive bits of the service left and exposures to a lot of fixed costs. (...) so the CQC, our regulator (...) a lot of guidance is being applied about what’s the right rota that you need to have, how do you comply with seven day services? Those are not volume specific indicators and if we lose elements of volume to, yeah, an uncontrolled competitive process, that causes a long-term threat for us.* (Provider 2, NHS, acute CCG4, June 2017)

The CCG1 acute provider pointed to the negative impact on the hospital’s ability to cross-subsidise certain expensive services, if the most profitable service lines were put out to competition and lost.

*The way the tariff is structured, the way it’s worked out is based on averages. So, if you provide 100 services within your hospital, you know, service number one may make you £2 million a year, by the time you get to service number 100 that’s losing you £2 million a year. The balance of some of the parts might allow you on a fair win to get to a financial balance by the end of the year. If you start picking individual services off, not only do you leave a massive hole in there for the individual organisation but actually, depending on whether it’s service one that makes a positive contribution or service 100 that makes a negative contribution, it may or may not make it appealing to prospective bidders.* (Provider 1, NHS, acute, CCG1, May 2017)

*I have seen this whereby, you know, something’s put out there with the desire for it to be a different model but then the money is like, you know, like 20% less and actually what quite often happens is it can completely unravel. It can unravel very quickly and then you end up going back to the default position, which is back to the NHS provider* (Provider 1, NHS, acute, CCG1, May 2017)

In particular, a number of interviewed NHS providers were concerned about the impact of the independent providers on the local health economies. The CCG1 acute provider gave some examples of cherry picking by private providers, such as in the case of the hip replacement elective procedures, whereby the NHS provider was burdened with more expensive and complex revision surgeries.

*What [private provider] were able to do is look at the national tariff and say, well, hip, primary hip replacements, primary knee replacements make a contribution of £1,000 each and did a lot of those. Revision joint replacement surgery they weren’t so keen to do because they only got £9,000 for something that cost 15 to do, but that’s the market they’re in.* (Provider 1, NHS, acute, CCG1, May 2017)
CCG1 acute provider noted that running NHS hospitals might not be appealing to private businesses oriented towards profit.

When I talk to my friends about how it works and they always talk about, you know, the private sector this and the private sector that, I always ask them one question which is, if it’s so appealing or if it’s so easy to do then ask yourself this question, why have huge private sector entrepreneurs like, you know, Lord Sugar or Richard Branson or Virgin or these top companies, why have they not come in en-masse when they’ve had the opportunity and taken over, bought and taken over the running of these NHS organisations? And I suspect that, I don’t know about individuals, but you would look at it and you would say because when you look at the cost incurred in running it and you look at the tariff structure in terms of what you get, I suspect the, it’s not very appealing, I don’t know. I’m just guessing there, but I suspect it’s not very appealing. (Provider 1, NHS, acute, CCG1, May 2017)

CCG4 acute provider 2 noted that there was a fundamental difference between the outlook of NHS and non-NHS providers, as the latter “don’t see themselves taking on any (...) statutory responsibility for the care of the population” (Provider 2, NHS, acute CCG4, June 2017). Competitive procurement was also described as an “antithesis” of a health community for wasting precious resources:

I understand why [commissioners] feel they need to get things right [for fear of challenge], but it makes things move very slowly and again, it just seems to me to be the antithesis of the health community. You know, it’s trying to use its resources as well as it can and I just think the competition as it currently stands is too blunt an instrument for where we’re at. (Provider 2, NHS, acute CCG4, June 2017)

Similarly, the CCG2 MH provider reported having lost two large tenders for local MH services to two different third sector organisations, only for commissioners to realise down the line that the non-NHS providers did not have the capacity or capability of dealing with the most complex cases that were coming to their services. As a result, the NHS trust had to step in to provide cover for complex cases, whilst commissioners had to spend more resources on expensive private acute beds.

By tendering [a mental health service], the Commissioners ended up spending even more money on private beds than they did in the first place. So, in reality, they haven’t even saved money. So, they fragmented the service, not saved money and now we’re being asked to put it back together again, and I think that’s dawned on people that that’s just silly. (Provider 2, NHS, CHS and/or MH, CCG2, Sep 2017)

Relationships between providers
We asked the providers about the characteristics of their relationships with other providers, both the NHS and non-NHS ones. The turn towards relationships based on collaboration was evident in the interviews in this third wave of fieldwork. The interviewed providers perceived other providers less as competitors and more as potential collaborators. This change in perception constituted a marked difference from the findings cited in the previous report (Allen et al. 2016), where providers were generally more wary of other providers as competitors.

CCG4 acute provider 1 observed that the general wariness about collaborating with competitors had diminished in the current policy climate, which was more conducive to cooperation, albeit that the legal framework remained “deeply ambiguous” (Provider 1, NHS, acute, CCG4, June 2017).

*People scream ‘cartels’, don’t they, if you get too close to each other, versus, you know, raw competition. We’re trying to, kind of, dance round each other I think, if I’m honest, about not wanting to do – so just occasionally, at the edge of things, we might compete, but yeah. But we’re not in raw competition with each other, no.* (Provider 1, NHS, acute, CCG4, June 2017)

It seemed that for the interviewed acute providers, having to cooperate and compete simultaneously became less of an issue, because of a diminished focus on competition. CCG4 acute provider 2 was finding themselves increasingly cooperating with their former competitors.

*We’re finding increasingly collaborating with [acute trust A], interestingly, having spent years competing with them. We’re increasingly collaborating, because we recognise that our – you know, on [our] side of the patch they see patients in the North (...) and we see patients in the South. (...) With the [CCG4] population specifically, we spent a long time competing with [acute trust B]. They see about half of the [CCG4] patients, we see the other half. And we’re finding ourselves increasingly collaborating, because actually, what’s important to the Commissioner is equity of service, equity of access. So, where we are then actually – so, instead of saying oh, we want to do 20 and we only want them to do ten, it’s like well, actually, let’s see where it goes, actually. The important thing is that we provide the right things, service and we’re thinking about trying to streamline our models, consolidate our single operating model.* (Provider 2, NHS, acute, CCG4, June 2017)

There were a number of initiatives in place aiming to increase cooperation between providers, which were both commissioner- and provider-led. Commissioners often resorted to the strategy of “procuring collaboration”, whilst provider-led initiatives tried to find ways to collaborate with other providers both in terms clinical and non-clinical functions. One such example was a partnership between three hospitals in the CCG2 area.

*[The partnership] is something quite different. That’s a device created by three NHS trusts to collaborate, so that brings together [acute trust A, acute trust B and acute trust C] in a kind of provider collaboration to share back office functions and that sort of thing. That’s not
commissioner inspired. (...) What they're doing is they're collaborating together to see how they can best use the back-office functions they have but also to try and ensure that they're not competing against each other for services, which one of them is the better at. (Commissioner 1, CCG2, June 2017)

Similarly, CCG4 acute provider 1 gave a number of examples of clinical and non-clinical collaboration with other acute providers in the area.

We’re currently part of two big clinical collaborations. One is for Orthopaedics, which is based at [acute trust A], and the other is Pathology, which is based at [acute trust B]. Yeah, they’re quite hefty, but we’re then doing a number of, sort of, smaller things where we share scarce resources in particular services, often through joint appointments, and we do a number of back office and semi-back office collaborations as well. (Provider 1, NHS, acute, CCG4, June 2017)

The CCG1 acute provider collaborated with another acute provider both in terms of shared clinical services, submitting joint bids for new work and forming joint ventures to attract more work. The trust also cooperated with another trust by sharing a supply department function.

Our stroke service is one that recently is under the joint agreement with the [acute trust A]. Historically, we’ve always had a joint service across the two trusts in terms of medical oncology and haematology. And in terms of some of our surgical specialties our head and neck services, our surgical, so that’s ENT, ophthalmology, orthodontics and oral surgery is where we have what’s called a visiting service. So, the consultants from [the acute trust A] come over here and do agreed sessions, outpatients and some theatre work per week every week for which we pay [the acute trust A] for their time to come and do that service and those are the historic agreements. And we also have agreements with [the acute trust A] on pathology. (Provider 1, NHS, acute, CCG1, May 2017)

Having recently gone through a formal merger process, CCG4 acute provider 2 was exploring different ways of collaborating with other acute providers, which were short of formal mergers. One such model, which CCG4 acute provider 2 was interested in, was a hospital chain model, introduced in the NMC programme. They were looking to set up their own hospital chain with the neighbouring hospital trust.

You don’t go down the full merger and acquisition process, but you potentially get some of the synergies out of that without actually doing the organisational change. So, basically, what they are saying is that they get their commissions in on patient groups or disease basis to issue effectively a common specification, a common way of working across multiple sites. And they basically have this, sort of, single operating model and they use a very clinical audit driven types of – clinical audit type approach, which is to, sort of, say so, where are the areas of variation, can they drive out the areas of variation as a means of mana – improving outcomes,
but also managing down ineffective resource? So – and you basically, kind of, just continue to scale up the number of hospitals who use this model. And you get to a certain scale where you can say actually a certain amount of finance or HR, other types of support that you need and then you can expand that across. (Provider 2, NHS, acute, CCG4, June 2017)

CCG4 acute provider 2, apart from collaboration with other NHS providers, had established a collaboration with a private provider to deliver different parts of the service on the same pathway.

We have one contract, which was just one in [type of service], which is about home testing, with a private provider (...). We’ve got quite an innovative, effectively, resource and an income share agreement. (...) so there’s a lead and (...) they subcontract us in to do that. But it is almost a 50/50 type agreement. (Provider 2, NHS, acute, CCG4, June 2017)

In contrast to acute providers’ experience, CHS trusts were forced to continue having to compete for the market and to cooperate simultaneously. CCG2 CHS provider mentioned collaboration with other providers in terms of putting in joint bids for services. The provider noted that in their experience commissioners preferred to receive bids from organisations that offered the right skill mix and, at the same time, had one organisation taking the lead to reduce fragmentation in the supply chain. This commissioning preference incentivised the CHS provider to collaborate with other providers. At the same time, the CCG2 CHS provider was also mindful of keeping track of opportunities to compete for services, whilst being preoccupied with acquisition of two smaller CHS providers in order to strengthen its dominant position in the area. This meant that the trust simultaneously competed and collaborated with the same providers.

We’re collaborating [with a number of providers] and moving towards a single organisation for October. But we, you know, competed on a few items over the last year or so, appreciating that perhaps [provider A] and [provider B] and [provider C] haven’t got the strength to be able to be successful on bids. But that’s an example where we’ve, you know, we’ve felt that we need to maintain that balance between moving towards collaboration but having to make sure that we do keep a firewall in place until we’re the single entity. So we do need to separately bid for new stuff. (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)

The CCG1 CHS provider noted that there was still a lot of competition between CHS providers locally for LA commissioned services such as school nursing or health visiting, whilst there was less competition for the NHS commissioned services. Thus CHS services providers found themselves more often in a position of both competing and collaborating with other providers, maintaining “a delicate balance” (Provider 2, NHS, CHS and/or MH, CCG1, June 2017).

It’s a really fine balance. So, yes, we do, I think in particular at STP level, we are then cooperating, you know, across patient pathways of mental health, whilst at the same time potentially competing against an organisation for a council commissioned service that’s gone
out to tender, so yes, we do both. So we’d be competing, yes, we’d be competing with an organisation at the same time as collaborating with them. (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

The interviewee found the STP governance arrangements in respect of collaboration and setting up ‘whole system’ contracts particularly challenging.

*I think on some of the larger contracts around collaboration, particularly where you’re talking accountable care systems, whole population based sort of specifications, actually deciding what your outcomes are going to be when they’re going to be long term, and how you incentivise providers to deliver those, I think, is hugely challenging.* (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

The CCG1 CHS provider had a number of collaborations with acute and GP providers. The goal of those collaborations was to improve quality and outcomes and reduce costs of the services. One collaboration was in respect of providing complex care for people with multiple long-term conditions, led by the local acute trust with the CHS trust and GP federation in a role of subcontractors. The second example was in respect of putting a new model of diabetes care between two other CCGs, GP federations, local acute trusts and voluntary sector organisations. The CCG1 CHS provider noted that so far their collaborations were service or disease specific and did not extend to a whole population care model. Equally, the CCG1 acute provider noted that although they had a number of longstanding collaborations with other providers, these initiatives appeared small scale, when compared to the ambition of the STPs.

**Resource implications of cooperation**

Whilst the transaction costs of competitive tendering were well recognised, the cooperative behaviour reported here did also incur some direct and indirect costs. For instance, the CCG1 acute provider mentioned that collaborations and partnerships resulted in additional administrative costs.

*There’s a lot of administrative stuff that needs to be sorted out between the two sites. There’s a lot of relationship management. I mean there’s a lot of it in some cases is about building resilience, but there’s still a huge administrative burden centred around it whether that be systems, patient administration, letters, management of waiting lists and referrals, you know, there’s a huge amount of administrative stuff that has to be done, processing and actually, of course, you know, the costs of running the actual service itself. So it’s not straightforward.* (Provider 1, NHS, acute, CCG1, May 2017)

The CCG3 CHS provider concurred that collaboration was “hard work” for providers and had its costs.

*Whilst competition is a very overtly costly process, collaboration, in terms of some of the softer skills and, you know, one-to-one meetings and all those sorts of things, particularly if you’re
talking about collaborations across multiple organisations, not just one-to-one, actually, is very time intensive and because it’s time intensive, then of course, it’s – there’s a cost attached to that ‘cause it’s just something that you’re not doing then, elsewhere. So, for us, in particular, because we operate across a number of health systems, that’s actually quite challenging. (Provider 1, NHS, CHS and/or MH, CCG3, June 2017)

There were many challenges associated with partnership working, which could be slow and could stall, even if there were no formal ongoing disputes between partners. Partnership working required diversion of precious staff time and other resources to a particular project and was particularly costly (in relation to the benefit produced), when the project in question was small scale. Furthermore, collaboration between providers might result in doubling up of management efforts and often suffered from a lack of alignment with similar initiatives running in parallel.

Some participants also identified limits to collaboration with other providers, not least the logistical limits associated with service delivery.

There’s a logistical limit [to collaboration] ‘Cause a lot of the services, the health services are delivered to patients in a physical way. So, it doesn’t matter if I collaborate with anybody, if I need a person to do a thing to a patient, and they have to be here to do it, I need my person here. And if equally, my colleague somewhere else also needs a person there, you can’t share the person and have them in two places at once. So, the, you know, the hands-on delivery nature of healthcare, means that there’s quite a lot of things where you need people in all the places you’re trying to do it. (…) Where knowledge can be delivered down a digital line, so an example of that might be really clever reading of diagnostics in Radiology, you don’t need the person physically next to the patient. (…) You can share that. But where you’re talking to the patient about what it means and what you’re going to do, you’ve got to be with them. (Provider 1, NHS, acute, CCG4, June 2017)

Some participants pointed out that the costs of collaboration sometimes included taking on debts of the weaker providers. This was an experience of the CCG2 CHS provider, which made some projections aiming to reduce the deficit accumulated by another provider that it was looking to acquire.

The trouble with collaboration now is that you almost feel as though you’re doing a virtuous thing as opposed to a financially beneficial thing because there are so many organisations out there in financial trouble that you’re partnering with organisations that have got big deficits, big holes, and any benefit that you get out of collaboration is effectively to close off their black hole. (…) And it’s the same with the acquisitions; we’re closing a big hole in [partnership between providers] with the corporate synergies that we’re looking to deliver. So there's potentially about £7 million worth of back office synergy, most of which is going to go into the deficit position at [another CHS trust]. So there is some strategic benefits of us doing it, as in
a bigger organisation, a wider footprint reduces the risk of, you know, cherry-picking at a local level, destabilising it, all of that stuff. But from a bottom line financial point of view, all the immediate gains disappear and sort out the deficit of one of the partners. (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)

The CCG2 CHS trust planned to reduce the costs of one of the providers by streamlining back office functions, but was wary of unexpected costs that could take them into deficit as a result of the merger. At the same time the interviewee was convinced that from the taxpayer’s point of view such a merger would be more beneficial than abandoning a financially struggling provider.

The combined business, yes, hopefully, hopefully we’ll get it back to a surplus. But it’s a tough ask at the moment because the analysis we’ve been doing on the other two businesses has unearthed a few gremlins. So maybe. If the numbers suggest not, then our board, you know, would be unwise to sign off a business case that takes [our trust] from a pretty healthy surplus position to a far worse position with parts of the business that we don’t know. (…) The truth is though, for the taxpayer that’s a far better outcome than it would be without merging because, you know, you save £7 million a year on back office costs that wouldn’t occur if you didn’t merge. So it’s a difficult one. (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)

Similarly, the CCG2 MH services provider stressed a sense of responsibility for the local services provision, even if some services were being delivered at a loss to the organisation. In the spirit of localism and aligned with the STP the provider noted that they delivered some services such as primary care for homeless people which were not viable financially but were vital to the local vulnerable populations. Thus according to this interviewee, working in partnership between commissioners and providers entailed not only commissioners not putting services to tender (which would undermine the providers), but also put responsibility on the providers to continue offering services which were vital despite being unprofitable.

The CCG1 CHS provider cooperated with a voluntary sector provider in the provision of MH services, amongst other things by sharing posts. This provider reflected on the costs of cooperation.

Certainly legal costs, if you need to put agreements in place, you might have some memorandum of understanding and that might need to be a more formal document, so yes, definitely would be legal costs. (…) so far we’ve largely used reallocated time of existing members of staff rather than recruiting new. There are some posts at STP level, for example, the mental health work stream, certainly the providers involved in that have got two or three shared posts to lead that work, so I suppose there is a cost to that, yes. (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

The CCG1 CHS provider mentioned the recognisable high costs of competition such as additional staff time, legal advice and costs of bid writing. This also extended to the ‘procuring collaboration’ type of
competition. The latter type was especially resource-intensive as it seemed to combine the costs associated with both competition and collaboration.

*I think [it] gets more complicated where, I'm just thinking where NHS England have put services out to tender across a wider geography, so they, for example, unscheduled dental care. We’ve then needed to collaborate with other providers within a procurement in order to then respond as a, you know, whatever, as a partnership of providers or as a lead provider or whatever. And then there are more costs associated, and you need to bring together the different providers in order to form a single bid for that, that becomes more complex and, you know, takes more time.* (Provider 2, NHS, CHS and/or MH, CCG1, June 2017)

Although both competition and cooperation incurred costs, some providers noted that these costs could be viewed in terms of investment. The CCG2 CHS services provider noted that although taking part in competition had its initial costs in terms of setting up a commercial business development team, this investment brought sizeable benefits to the trust by enabling a number of successful bids for tenders.

*So I suppose we invested early on in those corporate teams to make sure that we were fit for the future, you know when it came to an increase in competition and market testing. So yes, there was an implication initially but actually we've reaped, you know, huge rewards from that investment since we've won, I think we've won nine out of nine tenders, something silly like that.* (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)

Some providers either went through mergers recently or were preparing to merge with other providers, which presented a challenge and strained their staff resources. The CCG1 CHS provider also mentioned difficulties in aligning IT services in instances of collaboration across care pathways and providers.

*The biggest challenge we've got at the moment really is we're going through an acquisition of two other organisations. One is a foundation trust, (...), and the other is an arguably sustainable but pretty small mental health trust and they're a non-FT, so technically we acquired both.* (Provider 1, NHS, CHS and/or MH, CCG2, June 2017)

Overall, cooperation compared with competition was viewed as less costly, as by cooperating providers produced many efficiencies (for instance in back office functions) and interviewees stressed huge savings on transaction costs due to eschewing expensive competitive tendering processes.

**Independent providers’ experiences and relationships**

We decided to provide a brief outline of the independent providers’ experiences separately, because of their unique position in the NHS system. It was important to analyse independent providers’ experiences in-depth to highlight any similarities and differences with the NHS providers. During this third wave of interviews, we interviewed two private providers – a CCG4 CHS services provider and a CCG3 community based maternity services provider. Both interviewed providers represented mid-sized home
grown private companies owned by the individuals with ex-NHS backgrounds offering community based services. A CCG2 private provider declined to be re-interviewed on this occasion and we had no response from a CCG1 private provider, despite attempts to contact them.

Despite being wary about the turn away from competition in the NHS, the two independent providers noted that some tendering opportunities still existed in their areas of work across the country. The independent providers also complained of the confusing overload of different approaches to commissioning in the NHS, which was hard to keep up with for an organisation that sat outside the NHS culture and communication channels.

*If we roll back and we see what’s happened in the last year, we have STPs, we have Vanguards, we have MCPs, we have ACOs and ACSs, and you’re kind of going, well – and then you could argue you have your normal block contracts, AQP contracts, cap and collar, (...) volume driven, PbR, I mean, it’s a bit of a joke, to be quite honest. (...) what happens is – well, let’s address the issues by confusing it even more.* (Provider 3, independent, CCG4, May 2017)

Although a policy turn away from competition was generally not good news for private providers as it decreased their opportunities for market entry by this route, some were exploring other ways of achieving market entry, in particular by closer alignment with the STP work. This was the strategy of the CCG3 independent provider, which engaged with one of the local STP work streams.

*The ACO or ACS frameworks, there will not be a need to have competitive tenders or competitive dialogue going forward, that’s our understanding. It’s more about investing in a partner, having a discussion, forming a relationship, agreeing with how it should be done and then delivering. So, in some respect, you could argue, it’s taking some competition out of the market.* (Provider 3, independent, CCG4, May 2017)

The CCG4 independent provider expressed a wish to be part of the STP process and complained about the lack of engagement of non-NHS providers in this work, seeing it as an exclusionary process.

*R1: I think realistically, the STPs are there for one reason, is because the NHS is failing, from a financial standpoint, let alone delivering outcomes. So they’re trying to find another way in working in partnership and actually reconfiguring services. And if the reconfiguration means that they need to jettison procurement frameworks and procurement basically, regulations and law to deliver what they need to deliver, that’s what they will do. (...) R2: I think the financial priorities and the STP priorities will probably mean that they’ll do whatever they want.* (Provider 3, independent, CCG4, May 2017)

Similar to the NHS providers, the CCG4 private provider noted the stretched financial situation of the NHS that had implications for the way services were being commissioned and represented a major service delivery challenge from their perspective.
The challenges would be that there’s less money in the system to pay for delivery, so therefore, the CCGs are asking more and paying less because they don’t have it either. (...) And we’re looking at a rise in the estate costs and inflation rising at 2.6%, but not getting any uplifts in tariffs. So, you’re, kind of getting a disconnect between what the NHS can afford and pay you and what our outgoings would be to try and deliver that service. So I think you could say it’s becoming very, very stretched. (Provider 3, independent, CCG4, May 2017)

The CCG3 private provider had recently won a competitive tender for provision of community-based services in CCG3, expanding their presence as a provider in the area. However, their business and service delivery model created a number of difficulties for their relationships with the commissioners and other providers. Apart from relying on expanding their portfolio of contracts, the provider also used a provision on non-contracted activity to gain entry into the market and offer their services directly to patients outside of areas where they held a contract with commissioners. The independent provider argued that as an accredited provider of clinical services, they could offer services to patients based on the patient choice. At one point, this created many challenges and the provider was instructed by NHSE and Monitor/NHSI to stop this practice. However, the independent provider argued that their practice was legal within the current NHS competition framework. The regulators claimed that although the standard NHS contract allowed for non-contracted activity to be charged in certain circumstances, the services in question were excluded from this arrangement.

We took legal advice (...), and [their] opinion was that we should take NHS England to court because the regulations were so – the policy to meet those regulations was vague and it didn’t seem that they were meeting the regulations under the Competition and Cooperation Regulations. We obviously couldn’t take NHS England to court. We didn’t have the motivation or the resource to do that (Provider 2, independent, CCG3, June 2017)

The dispute intensified as some CCGs interpreted this provision differently and were accepting the independent provider’s invoices based on non-contracted activity, whilst other CCGs did not. Interestingly, despite relying on the non-contracted activity provision to gain market entry, the private provider commented that they would prefer the CCG in question to formalise their relationship with them into contract rather than basing it on non-contractual activity.

The CCG3 private provider also mentioned commissioners’ unwillingness to support patients’ choice of a provider as a challenge to their business model. Ideally, this private provider would have liked to become a choice option for provision of particular type of services on the basis of the accreditation process, in order to create a level playing field between them and the NHS providers.

I think a single commissioning framework with qualifying criteria should give providers the ability to be able to accept [patients] into the service regardless of where they come from. (...) And I would argue that NHS Trusts, Acute Trusts, don’t have those restrictions, because they
can accept [patients] under their non-contracted activity clause, but we can’t. (Provider 2, independent, CCG3, June 2017)

The CCG3 private provider also grappled with challenges of inadequate national tariff for the type of services they offered. Due to a particular business model that the independent provider adopted and the way financial incentives were structured along the care pathway, the consequences of the inadequate tariff were severe, including potentially impacting patient safety. Unlike a large NHS hospital, the private provider could not rely on a cross-subsidisation strategy to cover the shortfall.

In the light of such challenges, the CCG3 private provider was looking for ways to scale up the services and to learn from other private providers’ business models. It also attempted to diversify its means of market entry by engaging, where possible, with commissioners and providers in partnership work, for instance as part of the STP processes.

Although operating a much more sustainable business model than the CCG3 private provider, the CCG4 private provider was less successful in their attempts to engage with the STP process, despite expressing a wish to do so.

At no point have we been engaged by the authors [of the STP plans], the CCG or maybe the lead, basically, GP Federations or lead Acute Trust that they’re written around. Again, there’s an issue here around the engagement, seems to be for a selective few who decide on the STP the way forward without any consideration or consultation with other providers in the market. (Provider 3, independent, CCG4, May 2017)

Apart from exploring new routes to market entry, private providers were pursuing traditional opportunities to expand their services through bidding for contracts. The CCG4 private provider noted that in their line of service there were still opportunities available via competitive tendering, albeit with an exception of CCG4. Similarly to the interviewed NHS CHS services providers, the private provider noted tightening of financial envelopes for services.

There’s still opportunities there and we’re bidding for them, yeah. (...) we’re in the part of the market where, yeah, there’s probably 70% that’s relating to our specialists here and we would consider to write up and chase. Some we wouldn’t, because although it’s something we can deliver, the financial framework that the CCG can pay for is undeliverable, so we won’t write up. (Provider 3, independent, CCG4, May 2017)

The CCG4 private provider became more selective with regards to services they bid for. In particular, AQP services fell out of favour and they preferred contracts based on block payments.

First of all, there’s not many [AQP] coming onto the market, everything seems to be going back to block. Secondly, we just don’t think a lot of them are viable with what they want to pay, you’re not guaranteed activity. So we’d rather focus our efforts and our time in block contracts,
where we’re secure in the knowledge that we’re going to see the activity, get a certain payment, and that means we can commit to taking facilities and staff on, which we would not be prepared to do in AQP anymore. (Provider 3, independent, CCG4, May 2017)

In contrast, the CCG3 independent provider complained that they did not have enough information about existing tender opportunities and, as a result, they might have missed some potential tenders. Their strategy involved approaching commissioners informally to enquire about opportunities in terms of tendering and of being accepted as a service provider based on accreditation. In the latter case, the provider referred to the guidance from NHSI stating that there was no requirement to put elective services to tender because of the presumed patient’s right to choose between a number of accredited providers (NHSI 2016). They also advertised and promoted their services directly to patients.

We’re a small independent provider. We’re not on the same circuit. I don’t even know how to sign up to some of these ’cause – so I rely, for example, I rely on maybe a Commissioner saying to me do you know there’s a tender coming up in that area – or – and I rely on hearing it through those routes really. I have informally contacted CCGs to say would you consider commissioning us? (…) by approaching them directly, informally and most of them come back with, “We’re not interested in going through a competitive tender process at this stage. We’re working with our own providers to deliver the model,” etc., etc., and then when I provide them with the statement from NHS Improvement on that, they still don’t want to go through a qualifying criteria process either. (Provider 2, independent, CCG3, June 2017)

Although the CCG4 private provider had a lot of recent experiences in bidding for tenders, these services were not commissioned by CCG4. For instance, the CCG4 private provider won a few large, long-term block contracts, which had improved a financial standing of the company.

The CCG3 private provider won a number of contracts to deliver services via competitive tendering, including from CCG3. The CCG3 private provider found the bidding process for the CCG3 tender time consuming and expensive. They did not employ any external help to prepare the bid. They were successful as they were already providing a similar service model that the service specification called for.

Winning large, long-term contracts for provision of services had a dramatic, positive impact on financial stability of both private providers.

Financially, we were delighted to have it ’cause it increased turnover and profit for the company. Now, delivery wise, it meant that the company grew about 25% overnight. (Provider 3, independent, CCG4, May 2017)

However, winning the contracts did not shield the private providers from post-tender mobilisation challenges, mentioned also by the NHS participants. The private providers faced additional challenges...
having to bridge the relationship between the NHS and private sectors. They had a varied experience in this regard, with some collaborations proving much easier to establish than others. For instance, after winning a competitive tender process, the CCG3 maternity provider noted a tense relationship with an incumbent acute provider and commissioners’ limited ability to foster cooperation between them.

We have a very challenging relationship with the incumbent provider. (…) Once the commissioning process had taken place, everybody sat back and we just were left then to find our own pathways, make our own relationships, etc. [Commissioners] then realised that more work had to be done, particularly with the secondary care provider on shared clinical pathways, but unfortunately, they have no enforcement power to force providers to do it. So, we have struggled for four years to get any formal shared pathways in place to support shared care. (Provider 2, independent, CCG3, June 2017)

The private provider made efforts to formalise their relationship with the acute trust though creating clinical pathways and a cooperation service level agreement. However, this had not been signed yet by the CCG3 acute trust at the time of the fieldwork. According to the private provider, commissioners were not in a position to enforce the signing of this agreement by the acute trust. Notwithstanding the challenges, the private provider had noticed some improvement in their relationship with the acute trust recently.

We still haven’t got formal pathways [with the acute trust]. But the relationship’s improving, ’cause we’ve been there a while now. They’ve just got used to us really. But it’s not going to be easy for new providers to come into these landscapes. (Provider 2, independent, CCG3, June 2017)

The CCG3 independent provider hoped that the ACO work would allow them to find a way to improve collaboration with the acute trusts rather than pitch them against each other and duplicate the services, as in the current set up. So effectively, the CCG3 private provider was hoping, at least in part, for the elimination of competition from the current system.

What we’re looking at now in the [local service system] is that there’s a single commissioning body. Whether that will sit under a lead provider model, an ACO model I think they’re still looking at. But what that will potentially do is remove competition. (…) ’Cause (…) most Trusts do struggle to provide CHS services as well as acute. Acute services will always take precedence. CHS(…) So, we come in and say actually, let us do that for you then, ’cause we can do that and some Trusts are very interested in that, some Trusts aren’t. But I think this type of (…) model will help those conversations more. (Provider 2, independent, CCG3, June 2017)

The CCG4 private provider reported a difficult relationship with CCG4 commissioners with regards to the AQP commissioned services, which they provided. CCG4 commissioners were pursuing a
programme of consolidating their CHS services under an outcomes based contract. As a result of this work, there were plans to move the AQP contracts previously held by the CCG4 private provider to a new lead provider for the whole outcomes based contract, which was the local NHS CHS trust. According to the private provider, the CCG4 commissioners did not handle the process of transition of contracts well.

Our contract is technically being delivered or being overseen by the CHS provider, which is the local CHS Trust. (...) Well, we had a letter telling us it happened and that was it, we weren’t consulted on whether we wanted to have our contract overseen by another body. So, again, there was no consultation. (Provider 3, independent, CCG4, May 2017)

During the fieldwork we were not able to establish with certainty whether the AQP contracts had already been transferred, as the interviewed CCG4 CHS provider denied that this was the case. However, it was clear that CCG4 commissioners amended the AQP arrangement by capping the amount they were prepared to pay for the activity. This move had not been consulted on with the private provider and resulted in a breakdown of trust between the provider and the commissioners.

It’s been a complete and utter farce... Literally, overnight, they decided to cut our activity by 70%. We had staff and facilities and patients in the system. (...) So there was no consideration for that whatsoever. (...) All they were interested in was basically saving as much as they could before yearend 16/17 approach. (Provider 3, independent, CCG4, May 2017)

Capping the AQP services activity resulted in longer waiting times for CCG4 patients. Given that this independent provider delivered services to 18 different CCGs, they described the behaviour of CCG4 as “a complete outlier” (Provider 3, independent, CCG4, May 2017). In the experience of this private provider, CCGs generally tended to adopt a partnership approach, where difficulties were resolved in a dialogue with the providers. According to the provider, the challenges with the CCG4 AQP contract would have no impact on their viability as a provider, as the contract constituted only a small part of their business.

The CCG4 private provider collaborated with the NHS providers which provided services complementary to their own, but did not collaborate with the providers with whom they were in direct competition such as the CHS services providers.

We collaborate in some of our, basically, contracts with the Acute Trusts who provided the diagnostics and the surgery for us. (...) So we’re very open to collaboration. We have contracts with [acute trust A] and [acute trust B] for some of their Consultant’s time, who come out and work with us. So, again, we’re a very open and collaborative organisation and where possible, we work with other partners and providers to make sure the pathway is effective. (Provider 3, independent, CCG4, May 2017)
Similar to the experiences of the NHS providers, the private providers noted significant costs of both cooperation and competition. For instance, cooperation with other providers on a patient pathway had direct costs to the CCG3 private provider, due to the way the payment tariff was structured. The private provider was in direct competition with the acute trust and had no control over costs that acute trust charged them for the care on part of the pathway. Thus the payment structure was also potentially a real obstacle to collaboration on the joint patient pathway.

It requires resource from us in that we have to pay the other providers for the care that they’re providing [to] our [patients]. So, it’s not like acute provider to acute provider cooperation when they can either share services or share, you know, quid pro quo type of things that happens. We, as a CHS based (...) provider, we’re always the one that pays out, but we don’t get any money back in, so it’s a one-way process from that perspective. (...) We have found that when money doesn’t become a barrier, Clinicians are more open to sitting around the table and collaborating on pathway work, etc. (Provider 2, independent, CCG3, June 2017)

**Summary of providers’ experiences**

Interviewed providers had to adapt their strategies to the proliferation of hybrid forms of competitive tendering, whereby commissioners used only some aspects of the process (such as an initial advert) rather than carrying out a full formal procurement. The ‘procuring collaboration’ approach to commissioning reflected the ingenuity of commissioners who had to accommodate a systemic imperative for cooperation within the existing legal procurement framework. Whilst there might be some benefits to this type of approach to commissioning, the interviews with providers suggest that collaboration also incurred costs. As a consequence, the commissioning practices that combine collaboration with competition risked increasing transaction costs associated with each of these strategies.

We found that the importance of services commissioned via competitive tenders had diminished substantially for the interviewed acute providers as, compared to the CHS providers, they were less exposed to the competition for the market in the first place (Allen et al. 2016). Some interviewed acute providers were scaling back their internal resources dedicated to scanning the market for opportunities. On the other hand, for the CHS and MH services providers competitive tendering was still an important focus of their business models ensuring their long-term sustainability. Yet the providers noted that it was the LA and not NHS commissioners who were the most prolific users of competitive tendering in their line of services.

Private providers faced extra challenges of bridging the gap between the NHS and private sector in a tight financial environment. They were also actively looking beyond competition for other routes to the healthcare services market entry such as exploring opportunities for deepening collaborations with the
NHS providers as part of the STP framework in order to become more tightly interwoven into the fabric of the providers of the healthcare services to the NHS.
Discussion and conclusions

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 community health services. We focused our investigation on three main research questions:

- 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?

The findings presented in this report stem from interviews with senior commissioner and provider managers conducted in four CCG areas in 2017. These interviews constituted a third wave of a longitudinal study of four CCGs in England initiated in 2013. The longitudinal design allowed us to compare the findings from this stage of the fieldwork with the findings from the previous two rounds of interviews. This alerted us to some new trends or changes in commissioning practices, which we discuss below.

Summary of findings

Both commissioner and provider managers reported that the formal rules governing the use of competitive and cooperative mechanisms in commissioning clinical services had not changed since the HSCA 2012. The rules stipulated the need for the commissioners to follow transparent procurement processes, which encouraged the use of competitive mechanisms. In addition, in April 2016 the PCR 2015 had come into force (although not all commissioners were clear about their effect on the NHS), The PCR 2015 could be deemed to be another pro-competitive legal measure. Despite these pro-competitive rules, we found that both national policy and commissioning reality on the ground had changed substantially by turning in favour of the use of the cooperative mechanisms and organisational solutions.

Interviewed commissioners and providers found that the existing rules did not support the national policy direction. Participants also moved on from a preoccupation with the lack of clarity in the existing rules, noted in the previous stages of the fieldwork. Since the introduction of STPs and ACOs/ACSs, local commissioners and providers were being asked to come together in search of the locally agreed solutions to address various service delivery pressures in the context of deteriorating financial resources. The energy of commissioners and providers was directed towards searching for such solutions, rather than on the interpretation of rules. On the whole, the participants found that the use of competitive
methods of commissioning clinical services in the current financial context of the NHS was unhelpful and inappropriate. This was due mainly to the high transaction costs associated with tendering. Yet, some commissioners also commented that the possibility of using competitive mechanisms in commissioning ought to be retained in order for commissioners to be able to discipline and incentivise the providers to change.

Despite acknowledging (and in many cases embracing) the turn to cooperation, interviewed commissioner and provider managers could not ignore the rules entirely, partly for the fear of legal challenge and partly as the sector regulators still appraised the financial and clinical performance of their organisations individually.. The regulatory system set up to uphold and enforce the rules of the internal market in health care was still in place. We found that whilst many senior managers were ready to bypass the rules stipulating competitive tendering of clinical services and focused on development of bold cooperative solutions, their more junior colleagues were wary about breaking the existing rules. Some commissioners noted that the disjuncture between the rules and the policy could become a stumbling block on the road to STP and ACO implementation. In particular, it was not clear to some commissioners and providers whether the NMC and budding ACOs could be commissioned outside of the competitive procurement framework. Commissioners and providers closely observed developing practices in this respect.

In all but one case study site commissioners used competitive tendering less frequently than during earlier waves of the fieldwork. However, despite the turn to cooperative thinking, all four CCGs under study had issued at least one new invitation to tender since January 2015. The services put out to tender in the four case study sites did not amount to a major procurement by value of the service. Often the services were put out to tender following a market appraisal, suggesting interest from a number of potential providers.

Previously, we found that the acute providers were less affected by the competition for the market compared with the community providers (Allen et al. 2016). This finding was confirmed this time round. Furthermore, some interviewed acute providers had begun to scale back internal resources dedicated to scanning the internet and other sources for tendering opportunities and had become more selective about the type of tenders that they were prepared to respond to, developing niche specialisms. The acute providers perceived other acute providers more as collaborators than competitors and turned their focus to exploring new governance and clinical cooperation arrangements, including mergers and acquisitions, alliances and hospital chains. This marked a change from the findings from the earlier waves of fieldwork. The trend towards greater selectivity when bidding for contracts and exploring merger and collaboration arrangements was also visible in respect of some interviewed CHS and MH services providers. At the same time, CHS providers were still mindful of keeping track of opportunities to compete for services in order to retain their dominant position in their area. This meant that the CHS
trusts simultaneously competed and collaborated with the same providers, even when going through mergers or preparing joint responses to bids.

The CHS trusts and other providers noted that the bulk of competitive tendering they responded to was instigated by the LA commissioners, in charge of public health functions, as opposed to CCG commissioners. This was a new finding offering another indication of diminishing use of competitive tendering by the CCG commissioners.

Although the frequency of putting services out to tender by NHS commissioners in the four case study sites decreased, where procurement was used, it was usually because of the perceived availability of a number of potential providers and for the fear of falling foul of the procurement rules. The high transaction costs associated with tendering continued to accompany traditional competitive tendering processes, with both commissioners and providers devoting substantial resources to preparing tenders and responding to the bids. Some commissioners reflected on the existing path dependency in the system, in that services that had been competitively tendered in the past were likely to require a repeat tendering following the expiry of the current contractual arrangement.

In addition to traditional competitive tendering, commissioners and providers reported the increasing use of hybrid forms of competitive tendering. This referred to the open procurement processes which were conducted on the basis of existing competitive procurement guidance and infrastructure but which explicitly aimed at putting in place a collaborative arrangement between identified providers for provision of a particular type of service. This type of procurement utilised some elements of the competitive procurement process, such as open advertisments, but effectively required successful bidders to come together at some point in the process to propose a collaborative model of service delivery. Such hybrid procurement processes were highly complex and resource intensive, potentially surpassing the transaction costs of traditional competitive tendering.

The creative use of the procurement framework by commissioners to ‘procure collaboration’ had an impact on provider behaviour. Interviewed providers noted that some commissioners preferred to receive joint bids from a number of provider organisations offering the right skill mix and, at the same time, having one organisation taking the lead to reduce fragmentation in the supply chain. Such commissioners’ approach promoted collaboration between providers.

We also found evidence of commissioners using procurement processes as a learning process for specifying and pricing a particular service. Interviewed providers found such practices frustrating and counterproductive, often resulting in iterative, protracted, start-stop types of procurement processes, whereby commissioners used the learning from the previous stage of procurement to inform their next steps. Clearly such a learning strategy also incurred high transaction costs.

During this third stage of fieldwork we found that the use of AQP was on the wane, with both commissioners and providers turning away from the model. Commissioners were curtailing AQP
arrangements in order to bring back control over costs of such contracts, whilst some providers, including the independent providers, preferred to be commissioned on a block contract basis with a predictable income, which allowed them to undertake better planning of the workforce and other resources.

As mentioned above, some providers (both acute and community) became more selective in respect of services for which they were prepared to bid. Some admitted that they were prepared to lose existing business if the service was not priced correctly, as they could not commit to provide it at a loss. However, such attitudes, aligning with the logic of the market, was not compatible with the growing acceptance amongst some providers of the overall responsibility of the local NHS for provision of vital services to the population, even if such services were unprofitable. According to some interviewed providers, joint responsibility and accountability for local health systems not only entailed commissioners eschewing competitive tendering which could undermine key local providers, but also put responsibility on the providers to continue offering services which were vital to the population, despite those services being unprofitable.

The latter dilemma related to the direct costs of cooperation in the context of tight financial resources, for instance the costs associated with taking over the deficits of struggling providers. Thus although the ethos of the NHS as having cradle to grave responsibility for population health was posited by some participants as a factor differentiating the approach of NHS and independent providers, at the same time the NHS providers begun to feel the effects of the push towards collaboration by having to take on more financial risks.

Independent providers were wary of the turn towards cooperative mechanisms in commissioning services as it would decrease opportunities for market entry. Yet at the same time they had begun to explore working in partnership with NHS providers as another way of gaining market entry. Private providers continued to be critical of how competition has been applied in the NHS, in particular with regards to a lack of a level playing field with NHS organisations in some aspects, and with regards to attitudes of and relationships with NHS commissioners and providers.

**Limitations of the study**

The findings reported here are from the last phase of a longitudinal study which adopted a qualitative case study research design. The study has certain limitations.

Firstly, it should be noted that the study was not designed to assess the scale of the use of competitive and cooperative mechanisms in the NHS, nor the actual effects of competition and cooperation on service efficiency, quality or patient outcomes. The assessment of such impacts continues to be notoriously complex due to poor availability and consistency of data on tendering and other commissioning mechanisms, and difficulties of linking such data with clinical and financial performance data, as well as drawing definitive conclusions about the causal effects.
Secondly, during our study we followed four CCGs over a period of four years, between 2013 and 2017. A case study design enabled exploration of the context of local commissioning practices and relationships. The case study sites each represented a unique demographic and service configuration context, thus any trends uncovered here may not extend to the NHS as a whole. The unique setting of each case study site also made the straightforward cross-case study comparisons problematic. Utilising contextual knowledge gathered over the years of our presence in the sites, interview and documentary material as well as public notices published on tendering portals, we made an educated judgement that the frequency of the use of competitive tendering decreased in three out of four of our case study sites since 2015. In particular, there were no major tenders issued in three sites during the third phase of the study. However, this did not seem to apply to the CCG2 which continued to use competitive tendering and also led on a large joint tender of the urgent care services in its wider region. In addition, the specialist press titles such as the Health Service Journal has continued to report on the use of competitive methods for commissioning large packages of services, including NCM, in some areas of the country.

Thirdly, similar to our previous report (Allen et al, 2016), we encountered persisting difficulties in appraising the number and value of services put out to competitive tendering, both at national and local levels. Gathering such intelligence required triangulation of many data sources, as there was no one place that held comprehensive information on the issue. We found that such an aim was made even more complicated by the recent blurring of the distinction between the ‘traditional’ and ‘hybrid’ uses of competitive procurement process, which made it difficult to judge whether the process constituted competitive tendering or not.

**Implications for policy and practice**

Based on our study, we can draw a number of implications for policy and commissioning practice. Commissioners still wanted to be able to use competitive mechanisms of commissioning clinical services in some circumstances. Furthermore, some local commissioners were still concerned that procurement rules stipulating competition ought to be taken into account. These attitudes appeared to conflict with the recent statements by NHSE and DH which were anti-competition in tone, including those by Simon Stevens (Dunhill, 2016; Thomas and West, 2017) and Jeremy Hunt (Lintern, 2017). What is more, the national policy leaders’ rhetoric seemed to be at odds with the legal framework in place. It seems that the policy makers made a number of attempts to change the policy without changing the legislation. Interviewed commissioners alerted us that such an approach might prove to be extremely challenging to implement, especially with regards to ACOs.

Thus the study uncovered a pressing need for better alignment between the legal framework and the policy messages. Given the existing policy commitment to the collaboration and financial imperatives, the adjustment of the legal framework ought to follow, in order to facilitate the commissioning instruments necessary to deliver a policy turn towards collaboration in the NHS.
Implications for research

The study has also several implications for the research.

As it stands currently, the interplay between competition and cooperation in commissioning clinical services is tilting towards cooperation. It is important to monitor how this will play out in the future. We need to research what kind of commissioning mechanisms will be utilised to commission ACOs and ACSs, to what extent competition will be ruled out of the array of commissioning tools available to NHS commissioners, and how commissioners will navigate creatively around the legal framework, if there is no political will to align it with the policy direction.

As these were early days, the study indicated that there were a number of commissioners who considered utilising both competitive tendering and collaborative approaches to establish ACO/ACSs and NMC related services. It is important to monitor the effects of commissioners’ choices of commissioning methods both in terms of associated transaction costs and in terms of any potential legal implications or challenges.

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 aid the measurement of efficiency, this research should attempt to take account of the magnitude of transaction costs incurred in the tendering process by all parties.

Finally, 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. Researchers need to investigate the effects of a turn to cooperative methods of commissioning on the behaviour of independent providers. This study offered some early indication that private providers had begun to explore partnership working as a potential new route of market entry. The behaviour of different service providers in the changing policy landscape ought to remain at the forefront of the research into commissioning NHS services.
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## Appendix 1. Timeline of policies and regulatory decisions (November 2015 to October 2017)

<table>
<thead>
<tr>
<th>Date</th>
<th>Document Title</th>
<th>Type</th>
<th>Summary of information pertaining to competition and cooperation in the NHS</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2015</td>
<td>Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21</td>
<td>Guidance</td>
<td>Requires the NHS to produce a five year Sustainability and Transformation Plan (STP) that is place-based and will drive the implementation of the Five Year Forward View</td>
<td>NHS England</td>
</tr>
<tr>
<td>May 2016</td>
<td>Briefing for clinical commissioning groups: options for selecting providers and awarding contracts</td>
<td>Briefing</td>
<td>This note supports clinical commissioning groups (CCGs) to make good decisions by clarifying what they need to do when selecting providers and awarding contracts.</td>
<td>NHS Improvement</td>
</tr>
<tr>
<td>October 2016</td>
<td>Public Contracts Regulations 2015 for NHS commissioners</td>
<td>Guidance</td>
<td>Summarises the Public Contract Regulations 2015 (PCR 2015) requirements for NHS commissioners and those supporting them with their procurement of healthcare services.</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Date</td>
<td>Event Description</td>
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| December 2016 | The NHS Terms and Conditions for the Supply of Goods and the Provision of Services | Guidance: Supports NHS bodies when preparing terms and conditions for inclusion in tender documents and when drawing together contracts for the purchase of goods and services.  
Procurement Transparency Guidance. The Guidance included a number of commitments around the transparency of procurement information and was brought into effect under the 2014/15 NHS Standard Contract  
| March 2017  | Next steps on the NHS Five Year Forward View                                        | Policy: Recommends that commissioners and providers across the NHS and local government work closely together by means of New Care Models, Sustainability and Transformation Partnerships and Accountable Care Systems.  
| August 2017 | Central Manchester University Hospitals / University Hospital of South Manchester merger inquiry | CMA decision: Manchester hospitals merger cleared by CMA  
| August 2017 | University Hospitals Birmingham / Heart                                              | CMA decision: CMA cleared the anticipated merger between University Hospitals Birmingham NHS Foundation Trust (UHB) and  
Competition and Markets Authority: https://www.gov.uk/cma-cases/university-hospitals-birmingham-heart-of-england-merger-inquiry |
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