

Cooperation and Competition Panel

**REVIEW OF THE OPERATION OF 'ANY WILLING PROVIDER' FOR THE
PROVISION OF ROUTINE ELECTIVE CARE**

FINAL REPORT

28 July 2011

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REVIEW OF THE OPERATION OF 'ANY WILLING PROVIDER' FOR THE PROVISION OF ROUTINE ELECTIVE CARE

FINAL REPORT

EXECUTIVE SUMMARY

1. Since 2008, all patients needing routine elective care in England have been able to choose between any NHS or independent sector provider of routine elective care in England that is registered with the Care Quality Commission (CQC), has a PCT- or nationally-let contract, and is willing to provide services at the NHS tariff. This policy is referred to as the Any Willing Provider (AWP) policy for routine elective care.
2. On 17 December 2010, the Department of Health and Monitor requested that the CCP undertake a Review of the Operation of 'Any Willing Provider' for the Provision of Routine Elective Care. Our Interim Assessment was published on 25 February 2011 and this is the final report in this review.
3. We have found that patients, providers and commissioners are still adapting to the opportunities arising from choice and competition in routine elective care. But emerging evidence shows that patients and taxpayers are benefitting from higher quality care, greater accessibility, and more efficient delivery in services that represent around 15% of PCT expenditure on healthcare (ie approximately £12 billion in 2009-10). These benefits can be expected to grow as patients become more aware of their ability to choose, and providers respond to patient expectations by improving services.
4. At the same time, during our review we saw many examples of PCTs excessively constraining patients' ability to choose, and providers' ability to offer routine elective care services. While a number of commissioners appear to be performing well in facilitating patient choice and competition in routine elective care, and successfully balancing the tensions that can emerge between this and other objectives, there are significant variations in practices across PCTs.
5. Given this, the Panel's view is that there is a serious risk that unless practices that appear endemic among certain commissioners are addressed, the expected results from the policy of Any Willing Provider, including higher quality services and better value for money, are not going to be realised to their full potential.
6. This report provides guidance to commissioners on when restrictions on patient choice and competition can be justified because of their benefits to patients and taxpayers, and as a result, are consistent with the Principles and Rules of Cooperation and Competition (Principles

and Rules).¹ The recent shift from national- to PCT-led contracts for many independent sector providers, as well as the Government's recent release of operating guidance for the extension of patient choice into community and mental health services², has increased the importance of guidance in this area for commissioners. Our report also contains several recommendations to the Department of Health (set out in paragraph 23), which are aimed at improving the implementation of Any Willing Provider in routine elective care and the operation of patient choice and competition in these services.

7. PCTs that constrain patients' ability to choose their routine elective care provider most frequently do so through influencing GP referral decisions, and in some cases, directing GPs to refer patients to (or away from) certain providers. Patient choice of provider is also being limited or distorted through the referral processes used in a number of Referral Management Centres.
8. In terms of restrictions on providers' ability, or incentive, to offer routine elective care, this most frequently takes the form of PCTs imposing what are, in effect, caps on the number of patients a provider can treat or will be paid for treating. The Activity Planning provisions of the Standard Acute Contract are one of the vehicles for imposing these restrictions. The arrangements for paying for routine elective care are also being used by PCTs to control levels of routine elective care at providers, and hence, patients' ability to choose between providers and providers' ability to compete for patients.
9. These payment arrangements, which include block and capped contracts and implicit threats of non-payment, appear in many cases inconsistent with the Code of Conduct for Payment by Results. As such, they are also likely to be inconsistent with the Principles and Rules, which requires that payment regimes are transparent and fair. More broadly, they represent a move away from a rules-based system for paying providers through Payment by Results, and a return to a system where hospital funding is reliant on historic budgets and the negotiating skill of individual managers.
10. Further constraints by PCTs on providers' ability to offer routine elective care arise from requirements that providers apply uniform minimum waiting times before patients can access treatment. In a small number of cases, PCTs have also refused to enter contracts with certain providers for the provision of some, or all, routine elective care services.
11. The CCP's approach to assessing restrictions on patient choice and competition under the Principles and Rules is to balance the costs to patients and taxpayers of a restriction against any benefits that arise from that restriction. PCTs often told us that restrictions are needed to control demand for, and expenditure on, routine elective care, and thus allow PCTs to balance their budget (consistent with their statutory obligations).
12. We agree that PCTs need to meet their statutory obligation to balance their budget, and that patients and taxpayers benefit from effective financial control by PCTs. However, a range of

¹ Further guidance is also provided in the findings and recommendations that the CCP has made in relation to the complaint by Circle Health Limited regarding the actions of NHS Wiltshire and NHS Bath and North East Somerset. The CCP's report on this complaint is available at www.ccp-panel.org.uk.

² Department of Health, *Operational Guidance to the NHS: Extending Patient Choice of Provider*, July 2011.

instruments are available to commissioners to control demand for, and expenditure on, routine elective care. In managing demand for routine elective care, commissioners should, wherever possible, use mechanisms that target overall demand rather than the number of patients that can be treated by individual providers given the restrictions this places on patients' ability to choose between providers. In doing so, commissioners will ensure that they are acting consistently with the Principles and Rules.

13. PCTs also told us that restricting patient choice and competition had the potential, in certain circumstances, to benefit patients and taxpayers through:
 - achieving better value for money by directing patients to the lowest cost provider;³
 - ensuring service continuity; and
 - facilitating the training of clinical staff.
14. In assessing compliance with the Principles and Rules, the extent of these benefits need to be considered on a case-by-case basis and balanced against the extent of any restrictions that are involved. There are, however, some general points that can be made about these potential benefits to patients and taxpayers.
15. First, in relation to commissioners achieving better value for money by directing patients towards the lowest cost provider where a difference in cost arises from tariff variations, we note that it is a requirement under the Payment by Results Guidance for 2011-12 that "patients must be able to choose between providers regardless of price".⁴
16. Second, for a restriction on patient choice in routine elective care to deliver benefits in terms of service continuity, the potential loss of routine elective care volumes by a provider would need to result in a significant risk that other services – with critical access requirements for patients – could no longer be sustained. While this argument is frequently advanced, we have not yet seen persuasive evidence of this relationship, and we would expect commissioners to rely on robust evidence of this relationship before putting in place such a restriction. Moreover, to the extent that other regulatory arrangements are in place to protect essential services in the event of provider failure, restrictions on patient choice and competition as a means of ensuring service continuity are more difficult to justify.
17. Finally, for a restriction on patient choice and competition to be justifiable in terms of clinical staff training, commissioners need to have adequately explored, and be satisfied that there are no other options available for ensuring the training of clinical staff, including through cooperative arrangements between multiple providers.
18. In summary, the practices identified in this report which restrict patient choice and competition are, in many cases, likely to be inconsistent with the Principles and Rules because of limited offsetting benefits to patients and taxpayers. The Panel is not recommending a blanket prohibition on such practices because of the possibility that there may be offsetting

³ Differences between providers in the tariff payable for routine elective care, and thus value for money considerations for commissioners, arise as a result of several factors, including: the market forces factor, which adjusts the national tariff for each provider according to local costs; revenue caps, volume-based discounts and minimum income guarantees for providers each of which changes the effective tariff that is paid by the commissioner for routine elective care; and lower, locally negotiated tariffs that arise when routine elective care is shifted from an acute to a community setting.

⁴ Department of Health, *Payment by Results Guidance for 2011-12*, 18 February 2011, para 446.

benefits of sufficient magnitude in certain circumstances. But the Panel does expect commissioners to identify in a transparent manner why such restrictions, where adopted, should be allowed and for what period.

19. Commissioners imposing restrictions are exposed to challenge under the Principles and Rules, and we encourage commissioners to approach the CCP for informal advice when considering the appropriateness of any restrictions. Further, we recommend that commissioners be required to approve any such restrictions at Board level, and annually publish details of these restrictions (eg as part of their annual report or statement of commissioning intentions), including details of how the restriction operates, its underlying rationale, an assessment of its impact and a time-bound plan for its removal.
20. More broadly, it has become clear in this review that there are some external factors that are incentivising commissioners to restrict patient choice, such as ISTC contracts with minimum income guarantees and the application of the market forces factor to the national tariff. The scope for patient choice would increase in the absence of these influences on commissioner behaviour. However, efficiency and investment considerations also need to be taken into account in assessing these issues.
21. We believe that a key outcome from this review is the guidance it provides to commissioners on the consistency of restrictions on patient choice and competition with the Principles and Rules. We recommend that commissioners review their existing practices in this area and take steps to bring themselves into compliance with the Principles and Rules. Further, we recommend that Strategic Health Authorities (SHAs), and in future the National Commissioning Board, implement oversight arrangements to ensure that commissioners are not restricting patient choice and competition in routine elective care against patients' and taxpayers' interests.
22. At the outset of this review, the CCP made it clear that information provided during the course of this review would not be used to assess the compliance of individual PCTs with the Principles and Rules. However, having now provided guidance to commissioners, we encourage providers with concerns about restrictions on patient choice and competition to raise their concerns with the relevant PCT and SHA, and in the event of being unable to achieve a satisfactory resolution, to bring their concerns to the CCP.
23. In summary, we make the following recommendations to improve the operation of patient choice and competition in routine elective care.
 - i. We recommend that commissioners review their existing practices in relation to restrictions on patient choice and competition, and take steps to bring themselves into compliance with the Principles and Rules.
 - ii. We recommend that commissioners be required to approve any such restrictions at Board level, and annually publish (eg as part of their annual report or statement of commissioning intentions) details of any restrictions on patient choice they have adopted, the underlying rationale for the restriction, an analysis of its impact and terms of the restriction, including the period for which it will operate.

- iii. We recommend that commissioners also be required to:
 - a. publish the approach they have adopted to Activity Planning with providers in their locality; and
 - b. when imposing waiting time requirements on providers, publish on the home page of their website clear information about the minimum waiting time imposed by the PCT on each provider.
- iv. We recommend that Strategic Health Authorities (SHAs), and in future the National Commissioning Board, implement oversight arrangements to ensure that commissioners are not restricting patient choice and competition in routine elective care against patients' and taxpayers' interests.
- v. We recommend that the Department of Health:
 - a. requires commissioners to ensure that Referral Management Centres implement the Choose and Book system effectively and share with all local providers the scripts and any other communications used by Referral Management Centre staff when referring patients to a provider for routine elective care; and
 - b. requires commissioners to copy to all local providers any information they supply to GPs concerning providers.
- vi. We recommend that the Department of Health, in the light of our findings regarding payment arrangements takes action to ensure that SHAs and commissioners are implementing Payment by Results in accordance with the Code of Conduct for Payment by Results and national guidance, including ensuring that commissioners publish the details of any locally adopted variations to the national tariff.
- vii. We recommend that the Department of Health, in developing accreditation arrangements for future commissioners, requires that commissioners demonstrate to the National Commissioning Board an understanding of the policies and rules concerning patient choice and competition, and a commitment to complying with their obligations under these policies and rules. Compliance with the policies and rules concerning patient choice and competition should also be made a condition of continued accreditation.
- viii. We recommend that the Department of Health reviews the rationale for the Activity Planning provisions in the Standard Acute Contract, and if these provisions remain necessary assess whether amendments could be made to make these provisions less susceptible to being used to restrict patient choice and competition.
- ix. We recommend that the Department of Health reviews the way in which the Market Forces Factor is incorporated into the tariff for routine elective care, and assesses whether the incentives that the current arrangements create for PCTs to restrict patient choice are outweighed by other considerations.

INTRODUCTION

24. On 17 December 2010, the Department of Health and Monitor requested that the CCP undertake a Review of the Operation of 'Any Willing Provider' for the Provision of Routine Elective Care. This is our final report in this review.
25. In commissioning this review, the Department of Health and Monitor asked the CCP to:
- examine whether and how the policy of Any Willing Provider is being implemented across England; and in doing so,
 - identify any forms or patterns of behaviours that are inconsistent with the Principles and Rules; and
 - produce a report with any relevant recommendations to the Department of Health and Monitor or guidance for the sector.⁵
26. The CCP was also asked to assess the extent and materiality of any problem that currently exists and to what extent it is caused by:
- a. PCTs restricting choice and competition, for example, by constraining the services providers can provide, attempting to set 'caps' on expenditure with providers, or to dissuade GPs from referring to particular providers in ways that are inconsistent with the Principles and Rules; and
 - b. different contract and payment terms being offered which potentially discriminate between providers on the basis of ownership, for example arrangements concerning payment at national tariff and rules on follow-ups.
27. During the review, we received around 80 submissions from NHS providers, GPs, Primary Care Trusts, Strategic Health Authorities, independent and third sector providers, representative organisations and others. Non-confidential copies of these submissions are available on the CCP's website at www.ccp-panel.gsi.gov.uk.⁶ We also conducted a short survey of senior executives at NHS acute trusts. An Interim Assessment of the issues was published on 25 February 2011.⁷
28. The report is set out as follows:
- first, we review the development of Any Willing Provider in routine elective care (paragraphs 30 to 41);
 - second, we set out the broader context in which Any Willing Provider in routine elective care takes place and discuss the implications for our analysis (paragraphs 42 to 53);

⁵ The Terms of Reference for this study are available on the CCP's website at www.ccp-panel.org.uk.

⁶ We have not published a number of submissions by providers due to concerns that publication of these submissions would be likely to prejudice the commercial interests of the organisation which had made the submission.

⁷ During the study, providers of routine elective care raised concerns about restrictions PCTs were placing on patient choice, including in the Standard Acute Contracts being offered to ECN/FCN providers. Those PCTs identified as putting in place restrictions were asked to respond to the issues that had been raised. To address providers' concerns about the possible impact on their relationships with PCTs of making submissions to this review, the CCP asked PCTs to respond to a general description of the issue that had been raised. In some cases, PCTs felt that this general description did not provide a sufficient level of detail and in a number of other cases PCTs did not respond to the allegations that had been made. However, the CCP found that, overall, the information provided by PCTs was sufficient for the purpose of reaching general findings and recommendations for this review. We note that had the CCP needed to assess the compliance of individual PCTs with the Principles and Rules then the PCTs would have required a greater level of details regarding the concerns that had been raised with the CCP.

- third, we identify and discuss the main restrictions on patient choice and competition in routine elective care and discuss their effect on patients and taxpayers (paragraphs 54 to 137); and
 - finally, we summarise our guidance and recommendations in relation to the operation of patient choice and competition in routine elective care (paragraphs 138 to 144).
29. There are two annexes to this report. Annex A summarises the evidence regarding the effects of patient choice and competition in routine elective care. Annex B discusses issues arising out of the contractual arrangements for routine elective care.

THE DEVELOPMENT OF ANY WILLING PROVIDER AND PATIENT CHOICE IN ROUTINE ELECTIVE CARE

30. Patients needing routine elective care in England are able to choose between any NHS or independent sector provider of acute elective care in England that is registered with the Care Quality Commission (CQC), has a PCT- or nationally-let contract, and is willing to provide services at the NHS tariff. This policy is referred to as the Any Willing Provider (AWP) policy for routine elective care.
31. Patients' ability to choose their provider of routine elective care has been progressively expanded since the policy of patient choice was first announced in 2000. Following pilot programmes in 2002-04, choice on referral to hospital for routine elective care was introduced for all patients on 1 January 2006. Initially, patients were offered a choice of at least four hospitals (or suitable alternative providers), and a choice of date (and time) for their booked appointment. This was expanded in July 2007, when the choice available to patients requiring orthopaedic care was expanded to include providers on the newly established Extended Choice Network (ECN), and again in 2008, when all patients requiring routine elective care became able to choose between any NHS Trust, Foundation Trust, Independent Sector Treatment Centre (ISTC), and any provider registered on the ECN or Free Choice Network (FCN).⁸
32. In January 2009, patients' right to choose was enshrined in the NHS Constitution. The NHS Constitution states that patients "have the right to make choices about their NHS care and to information to support these choices". The Handbook to the NHS Constitution states that this right means that, subject to certain exceptions, patients "have the right to choose the organisation that provides your NHS care when you are referred for your first outpatient appointment with a service led by a consultant".⁹
33. By February 2011 patients could choose between approximately 165 NHS Acute Trusts (including Foundation Trusts) operating from approximately 300 sites as well as around 15 nationally-contracted independent sector providers of routine elective care operating from a further 175 sites. Patients in certain locations, for certain elective services, may also have the option of choosing additional locally contracted providers, such as former PCT community

⁸ The ECN and FCN are sets of contracts the Department of Health has with independent sector providers of routine elective care that allows these providers to offer services to NHS-funded patients. We refer to these two arrangements collectively as the ECN in the remainder of this report.

⁹ The source of this right is the Primary Care Trust (Choice of Secondary Care Provider) Directions 2009.

services provider arms, GPs and other private and voluntary sector providers. This is particularly the case for services that were previously provided only in an acute setting but are now available in a community setting.

34. Until recently, PCTs have contracted with NHS providers of routine elective care using the Standard Acute Contract, while independent sector providers have, in the main, been contracted nationally by the Department of Health through ECN and ISTC arrangements. Over the past year, the ECN arrangements have been brought to an end, and ECN contracted providers have entered into Standard Acute Contracts with PCTs. In our Interim Assessment, we concluded that there was a significant risk to patient choice as a result of the new PCT-based contracts not being in place by the time that the ECN arrangements were scheduled to end. As a result, the Government extended the ECN for 3 months, and we understand that the vast majority of new PCT contracts have now been entered into successfully.¹⁰
35. Patients' ability to choose between providers for routine elective care is underpinned by a range of supporting infrastructure. Key elements include:
 - the *Choose and Book* system, which allows patients (and GPs acting on patients' behalf) to select their provider of choice and book their first outpatient appointment with that provider;
 - *Payment by Results*, which – in principle – remunerates providers for routine elective care according to patient treatment volumes through a framework of fixed tariffs covering a range of procedures;¹¹ and
 - *NHS Choices*, which provides performance information on each provider to assist patients in selecting their preferred provider.
36. The underlying rationale of providing patients with the ability to choose between providers of routine elective care is that the need to attract patients (in order to earn revenue given the Payment by Results system of tariffs¹²) ensures providers have an ongoing incentive to offer the highest quality care. Providers that are successful in attracting patients will be able to earn revenues that, in the case of NHS Foundation Trusts for example, can be reinvested in other services.
37. Expectations of the patient choice policy at the time of its introduction were that it would assist in driving down waiting times for routine treatments and, more generally, that it would:
 - improve quality and safety in service provision;
 - improve health and wellbeing;
 - improve standards and reduce inequalities in access and outcomes;
 - lead to better informed patients;

¹⁰ In Annex B of this report we discuss the shift from national- to PCT-let contracts in more detail and set out how the contracting process can affect patient choice and competition, including through: (a) the cost of contracting influencing providers' willingness to enter contracts; (b) local variations in service specifications constraining patients' ability to choose between providers; and (c) providing commissioners with greater ability to constrain patient choice and competition as a result of the choice of contract (eg Standard Acute Contract compared with ECN rules).

¹¹ We discuss the reality of how Payment by Results is being implemented for routine elective care by PCTs in paragraphs 95 to 106.

¹² See, for example, section 26 National Health Service Act 2006 which provides that an NHS Trust must exercise its functions effectively, efficiently and economically. Schedule 5 makes provision about the financing of NHS Trusts – para 2(1) of Schedule 5, states that each NHS Trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account. We understand that, in general, the delegated duty of the Chief Executive of an NHS Trust reflects these requirements.

- generate greater confidence in the NHS; and
 - provide better value for money.¹³
38. Given the relatively recent introduction of patient choice and competition in routine elective care, patients and providers are still learning how to make the most of this new environment. Patient awareness of their ability to choose their provider is relatively high at 54%, but there is scope for this to increase.¹⁴ There is evidence that patients are exercising choice. There has been rapid growth in the number of NHS patients being treated at private facilities, and CCP analysis shows that a significant proportion of patients are selecting a provider other than their local NHS provider and that the quality of care offered by a provider is a significant factor in explaining patients' choice. There is also evidence of patients responding to adverse patient safety events when they occur at their local hospital by choosing to be treated elsewhere in the following months.
39. Similarly, there is evidence that providers are still adapting to the operation of patient choice in routine elective care. The King's Fund recently found, in a qualitative study, that the threat of patients choosing a different hospital led some providers to focus more on reputation, and noted that providers spoke about actively seeking to attract patients away from other providers in particular geographical areas and marketing their services to GPs. But, overall, it concluded that direct competition for patients' custom was limited.¹⁵
40. Despite patients and providers still being in the process of adapting to choice and competition in routine elective care, there is already evidence that choice and competition is leading to improvements in patient care. A number of recent studies have found that higher levels of competition in the provision of routine elective care has led to improvements in clinical performance and efficiency. For example, academic researchers have found that higher levels of competition in the provision of routine elective care under the current fixed prices regime has led to improvements in clinical performance.¹⁶ As patients become increasingly aware of their ability to choose and exercise this choice, and providers respond to the incentives that this creates, then the quality and efficiency of routine elective care can be expected to improve further as a result of this policy.¹⁷
41. Notwithstanding this, there is a serious risk that the expected results from the policy of Any Willing Provider, including higher quality services and better value for money, are not going to be realised to their full potential unless practices identified in this report, which excessively constrain patient choice and appear endemic among certain commissioners, are addressed. We discuss these practices in third part of this report (see paragraphs 54 to 137).

¹³ Department of Health, *Framework for Managing Choice, Cooperation and Competition*, 16 May 2008. In extending patient choice of provider in community and mental health services, the Department of Health states that this is "intended to empower patients and carers, improve their outcomes and experience, enable service innovation and free up clinicians to drive change and improve practice" (Department of Health, *Operational guidance for the NHS: Extending patient choice of provider*, July 2011, paragraph 1.3).

¹⁴ Department of Health, *Report on the National Patient Choice Survey, England*, February 2010 available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_116958.

¹⁵ King's Fund, *Patient choice – how patients choose and how providers respond*, June 2010.

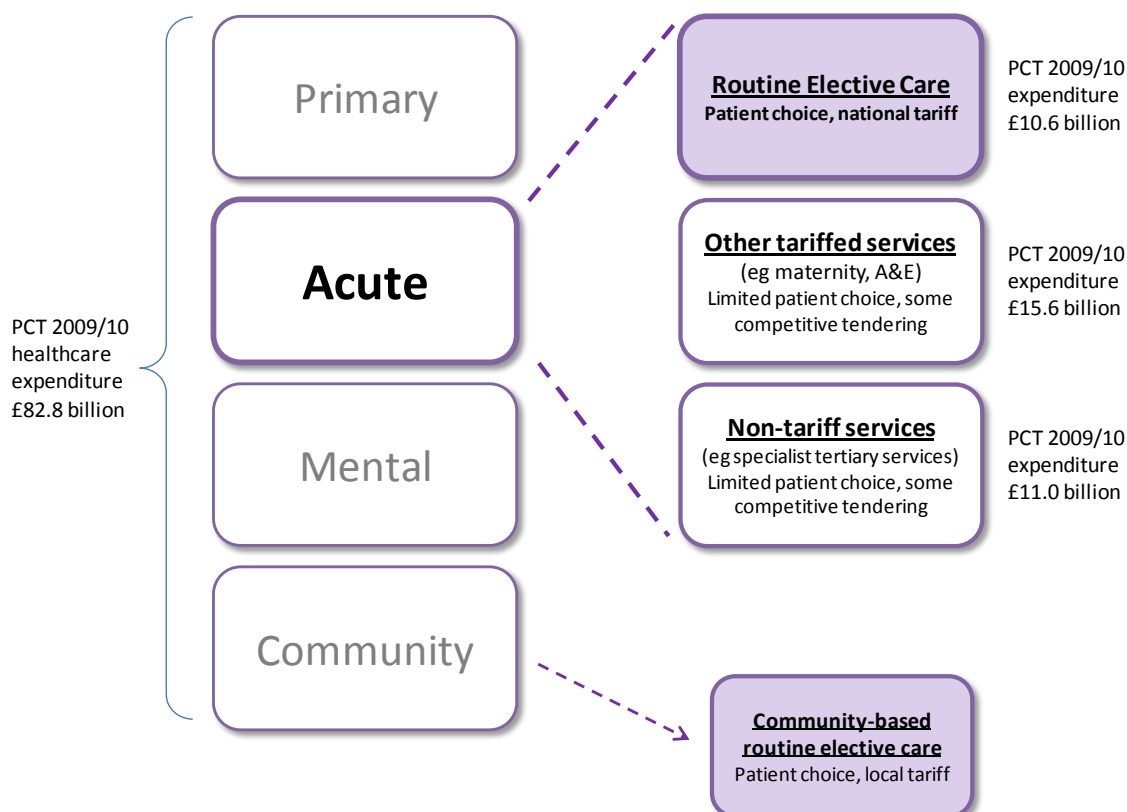
¹⁶ "After the introduction of patient choice over secondary care provider, AMI mortality decreased more quickly for patients living in areas with more competitive spatial hospital markets" in Cooper, Gibbons, Jones and McGuire, 'Does hospital competition save lives? Evidence from the English NHS patient choice reforms', *LSE Health Working Paper No.16/2010*, January 2010 (also in *Economic Journal* forthcoming).

¹⁷ The effects of patient choice and competition in routine elective care is discussed in more detail in Annex A.

THE WIDER POLICY CONTEXT FOR ANY WILLING PROVIDER IN ROUTINE ELECTIVE CARE

42. Any Willing Provider in routine elective care takes place in a wider healthcare policy context. This context is critical to understanding the significance and merits of restrictions on patient choice and competition in routine elective care. In this section we, first, identify how routine elective care – and patient choice and competition in these services – fits into the broader picture of acute and NHS care, and second, discuss the interaction between Any Willing Provider and other policies relevant to routine elective care.
43. Routine elective care can be seen as one part of the suite of acute services purchased by commissioners. These services include:
- (i) *Routine elective care*, which is the subject of this report, and in which the Any Willing Provider model of patient choice and competition operates and where providers are paid according to the national tariff (subject to local adjustments).
 - (ii) *Other tariffed services*, such as maternity services and accident & emergency services, where providers are also paid according to the national tariff (subject to local adjustments) but where there are no rights of patient choice.
 - (iii) *Non-tariff services*, including various specialist services, where there is no tariff and no right of patient choice.

Figure 1: Any Willing Provider services in the NHS



Source: CCP, figures are CCP estimates based on data in Audit Commission, "More for Less 2009/10: Are efficiency and productivity improving in the NHS?", December 2010.

44. In 2009/10, PCTs purchased approximately £10.6 billion of routine elective care services from NHS acute trusts. This compares with £15.6 billion in other tariffed services and £11.0 billion in non-tariff services.¹⁸ Total purchases of routine elective care by commissioners, however, are somewhat greater than the £10.6 billion because a certain amount of routine elective care is provided in the community and by independent sector providers. In total, we estimate that PCTs allocated around 15% (or £12 billion) of their total healthcare expenditure of £82.8 billion in 2009/10 to routine elective care.
45. Another way of measuring the significance of routine elective care is in terms of patient numbers. In 2010/11, there were 5.0 million patient admissions for routine elective care.¹⁹ As a result, it can be seen that the issues discussed in this report affect a substantial proportion of expenditure in the NHS and the lives of many patients. The Government's announcement of the extension of the model of patient choice into community and mental health services in July 2011 reinforces the importance of the lessons arising from this review.²⁰
46. Patient choice and competition has been a central part of the policy framework for routine elective care since 2000. Complementary, supporting policies include the establishment of Foundation Trusts, the national tariff (Payment by Results), the use of independent sector providers, the NHS Choices website, and the Choose and Book appointments system. The introduction of each of these policies has been an important building block for patient choice and competition in routine elective care.
47. The policy framework within which Any Willing Provider operates can also be seen as a set of constraints – or restrictions – on the operation of patient choice and competition in routine elective care. For example, the requirement that providers be CQC registered, decisions on which services should be open to patient choice, and the use of fixed prices all set boundaries within which patient choice and competition can take place. The set of constraints that the policy framework represents is critical to the success of patient choice and competition in routine elective care.
48. While the policy of Any Willing Provider, and its emphasis on patient choice, has been a central part of the policy framework for routine elective care, it is not the only policy aimed at ensuring that patients have access to high quality routine elective care. For example, the target that patients have a waiting time from referral to treatment of no greater than 18 weeks complements the policy of Any Willing Provider by, in effect, setting a minimum standard for waiting times. Patient choice and competition can then act to further reduce waiting times beyond this minimum standard.
49. The requirements of other policies can, however, conflict with patient choice and competition in routine elective care. In the following section, we discuss potential tensions between

¹⁸ Audit Commission, *More for Less 2009/10: Are efficiency and productivity improving in the NHS?*, December 2010.

¹⁹ Department of Health, Provider Based Elective Admission Events statistics available at http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Perfomancedataandstatistics/HospitalActivityStatistics/DH_090403

²⁰ Department of Health, *Operational Guidance to the NHS: Extending Patient Choice of Provider*, July 2011.

patient choice and competition and other requirements and objectives, including budgetary controls on PCTs, service continuity and equitable treatment of patients.²¹

50. When evaluating PCTs' actions which involve restricting patient choice and competition so as to implement or pursue other policy objectives, the CCP (in common with other UK and international authorities charged with evaluating the net welfare effect of economic activity) employs a cost-benefit approach to assess the overall impact of a PCT's actions on patients and taxpayers.
51. That is, where a PCT restricts patient choice and competition, we assess the costs to patients and taxpayers of this restriction and balance these costs against any benefits to patients and taxpayers arising from the restriction. We use this approach in this report to develop our recommendations and guidance as well as more generally in assessing compliance with the Principles and Rules.
52. The table below sets out the provisions of the Principles and Rules most relevant to this review. In particular, the Principles and Rules require that "commissioners should promote patient choice, including – where appropriate – choice of Any Willing Provider", and that "commissioners and providers must not take any actions which restrict choice against patients and taxpayers' interests".

Principle 5: Commissioners and providers should promote patient choice, including – where appropriate – choice of Any Willing Provider ...

Rules	Actions and behaviours
(i) Commissioners must comply with the Secretary of State's Directions regarding patients' right to Free Choice in elective care.	a. Commissioners and providers should respect patients' right to choice as set out in the NHS Constitution.
(ii) Commissioners must have regard to the Secretary of State's guidance on the use of Any Willing Provider for specific services.	b. ... Under Free Choice the opportunity for 'any willing provider' to supply services should not be constrained by the commissioner except where there are serious concerns about aspects of clinical quality or patient safety. Any restriction must be agreed with the SHA. ...
(iii) Where a service is subject to patient choice, commissioners must not unjustifiably refuse to make services available to patients where the provider of the service meets any pre-determined national or local accreditation requirements and where such a refusal would restrict choice or competition against patients' and taxpayers' interests.	... e. Outside of those services where patient choice is required under national guidance and the NHS Constitution, it is for commissioners locally to determine priorities and approaches to expanding choice.
(iv) Commissioners and providers must not take any actions which restrict choice against patients' and taxpayers interests.	

...
Source: Extract from Principles and Rules for Cooperation and Competition. Full version available at www.ccp-panel.org.uk.

²¹ During this review there has been significant public debate about possible tensions between patient choice and competition and delivering integrated services for patients. PCTs did not, however, tell us during this review that restricting patient choice and competition in routine elective care was necessary to deliver integrated services to patients.

53. In assessing restrictions on patient choice and competition, customs, preferences and other influences on individual behaviour, and ultimately organisational behaviour, can also play a role. As with policy-based restrictions, culturally-based restrictions can be positive, negative or neutral in their impact on patients and taxpayers. An example of this type of restriction is the degree of knowledge that patients have about the availability of patient choice and how it can be exercised. Limited knowledge of the availability of choice, if widespread, restricts effectiveness of patient choice and competition in delivering benefits to patients and taxpayers.²²

RESTRICTIONS ON PATIENT CHOICE AND COMPETITION IN ROUTINE ELECTIVE CARE

54. From the submissions made to the CCP during this review, it is clear that a significant number of PCTs are restricting patient choice and competition in routine elective care. In many cases, PCTs acknowledge that they are restricting patient choice, and have told us why they believe this is justified. This section reviews the nature, extent and effect of the restrictions that have been imposed by PCTs.
55. The discussion in this section is in two parts. First, we review restrictions on patients' ability to select their preferred provider of routine elective care (paragraphs 56 to 89), and second, we review restrictions on providers' ability to offer services to patients (paragraphs 90 to 137).

RESTRICTIONS ON PATIENTS' ABILITY TO CHOOSE A PROVIDER

56. PCTs that restrict patients' ability to choose their routine elective care provider most frequently do so through influencing GP referral decisions. Patient choice of provider is also being limited or distorted through the referral processes used in a number of Referral Management Centres. We discuss these two restrictions in the following paragraphs and assess potential benefits to patients and taxpayers that arise from these restrictions.

PCTs influencing or constraining patient choice through GPs

57. Patient choice of provider for routine elective care, in many cases, will occur at a GP surgery with the patient seeking the advice of their GP as to which provider they should use. Patient survey data shows that approximately 49% of patients recall being offered a choice of provider, and of these, around 43% said their GP's advice was the most important source of information on which provider to see. Furthermore, a substantial proportion of patients do not recall being offered a choice of provider (and for many of these patients it is likely that their GP is exercising choice on their behalf).²³

²² Different attitudes to the role of patient choice and competition in the NHS among stakeholders have been displayed during the debate on the Health and Social Care Bill. Inevitably, varying attitudes towards patient choice and competition are reflected in the willingness of individuals, and ultimately organisations, to support the implementation of patient choice and competition (see paragraph 59 for an example of this). These constraints have the potential to ease over time to the extent that: the benefits of patient choice and competition are more widely demonstrated, understood and accepted; individuals become more familiar with how patient choice and competition works and how to make the most of the opportunities that it presents; and with ongoing enforcement of the Principles and Rules and other relevant provisions.

²³ The National Patient Choice Survey reports that 37% of patients who were aware of choice could not recall being offered choice, while 68% of patients who were not aware of choice could not recall being offered choice. Further, around 22-23% of patients reported having no preference regarding the hospital at which they would be treated. (Department of Health, *Report on the National Patient Choice Survey, England*, February 2010).

58. Given this, PCTs can seek to channel the flow of patients to different providers through influencing the advice that GPs give to patients or, more coercively, through putting in place restrictions on GPs' ability to refer patients to particular providers. Our review showed that there are four main mechanisms used by PCTs when seeking to influence GP referral decisions, namely:
- providing information to GPs about providers;
 - making recommendations to GPs about which providers patients should be referred to;
 - placing prohibitions on the referral of patients to certain providers; and
 - putting in place additional approval processes where GPs wish to refer patients to a particular provider.²⁴
59. The provision of information to GPs by PCTs about providers will, in many cases, assist GPs in providing better advice to patients. This is particularly likely to be the case when there is a new provider and GPs have strong existing relationships with incumbent providers. For example, one PCT told us that it has "had some instances when patient choice has been restricted due to the referring GP not offering the full choice of provider for a number of reasons (eg not knowing or feeling confident in some of the providers accredited through the AWP process)". Another PCT told us that "there are still a significant number of GPs who are either 'conscientious objectors' or have concerns in relation to the quality of treatment provided by these [independent sector] providers and the PCT has undertaken significant work to dispel these concerns".
60. PCTs in providing information to GPs, in these instances, are not restricting patient choice or competition, but are facilitating more effective choice through improving the information base available to those making, and advising on, choices.
61. Problems can, however, arise when PCTs provide information that is inaccurate or where, for instance, it is biased towards a particular provider. For example, if there are two new entrants and the PCT only provides information to GPs about one of these providers, then this could distort patient choice compared with a situation in which GPs had information about both of the new entrants.
62. The provision of information by PCTs to GPs about providers can also be accompanied by an implicit or explicit recommendation to GPs about which providers should be favoured by GPs when making referrals or advising patients on their choice of provider. Given their contractual relationship with PCTs, some GPs may feel obliged to follow these recommendations (although this will not always be the case – see paragraph 67), and this can then affect patient choice and competition between providers.
63. Some PCTs have gone beyond trying to influence the advice GPs give to patients and have directly prohibited the referral of patients to certain providers. For example, one provider submitted correspondence concerning patients in two PCTs where their GPs had been

²⁴ Providers also raised concerns about wider measures which had the effect of constraining the operation of patient choice. For example, we were told that the withdrawal of funding support for Choose and Book by some PCTs means some GP surgeries are no longer referring patients electronically, and there are reports of surgeries (and triage centres) being under the impression that choice does not apply for paper referrals.

instructed not to refer patients to that provider. We also saw correspondence concerning another PCT which had prohibited referrals to a particular provider. A further PCT has instituted a system whereby patients wanting to go to certain providers must obtain prior approval from the PCT.²⁵

64. The effect on patients of PCTs influencing referrals in favour of particular providers is that it is likely to result in at least some patients being treated at a provider that does not best reflect the patient's preferences (eg due to quality of service, location or waiting time). In addition, a provider that knows that it is the beneficiary of PCT actions to influence GP referrals will need to try less hard to attract patients, and may therefore offer a lower quality of service than would otherwise be the case.
65. Submissions by PCTs and providers indicate that value for money concerns are the primary reason for PCTs using influence over GPs to restrict patient choice and channel patient flows to particular providers. These value for money considerations arise in at least three different ways:
- first, differences in the tariff charged by acute care providers caused by the market forces factor;²⁶
 - second, lower tariffs negotiated with local community-based providers when routine elective care is shifted from an acute to a community setting; and
 - finally, PCTs being already committed to paying for a certain volume of services from particular providers, such as ISTCs with minimum income guarantees.
66. In relation to the market forces factor, one provider showed us correspondence relating to a patient referral decision where a GP had persuaded a patient not to go to their preferred provider of routine elective care because of the higher cost to the PCT of that provider arising from the market forces factor. We also saw correspondence between an SHA and a provider concerning the higher cost of sending patients to that provider as a result of the market forces factor, and the actions that PCTs in the SHA were, as a result, taking to ensure that patients were treated by other providers. A PCT chief executive told us that "in London where you have providers in close proximity with different uplifts, it is clearly in the PCT's interest to encourage activity to go to those with a lower market forces factors and reinvest the savings in other health improving outcomes".²⁷
67. In relation to the presence of ISTCs with income guarantees, one PCT told us that "as this activity [at the ISTC] has to be purchased by the PCT whether it is used or not, GPs are asked

²⁵ Some insight into the possible extent of these more explicit types of restriction on patient choice is provided by the National Patient Choice Survey in February 2010, which reported that 8% of patients offered choice were unable to go to the hospital they wanted (and 13% of patients not offered choice were unable to go to the hospital they wanted). These figures are not, however, definitive in that they may also be capturing other aspects of the choice issue (eg whether the patient's preferred hospital was available due to the clinical needs of the patient).

²⁶ "The purpose of the Market Forces Factor (MFF) is to estimate the unavoidable cost differences of providing healthcare. Within PbR, the MFF directly funds providers for the relative level of unavoidable costs they face [by applying an index value to the national tariff]. ... In 2011-12 the MFF index has a range from 1.0 to 1.298. The lowest value on the chart of 1.00 is Cornwall Partnership NHS Trust, and the highest value of 1.298 belongs to University College London Hospitals NHS Foundation Trust." (Department of Health, *PbR and the Market Forces Factor (MFF) in 2011-12*, February 2011)

²⁷ Not all PCTs necessarily respond to this incentive, however. For example, a PCT told us that "when going to AWP for services we include a maximum tariff to ensure providing value for money. Whatever pricing agreements are in place, the choice of provider is still left to patients and the PCT does not direct patients to certain providers".

to consider patient suitability for this provider within the wider context of patient choice” although it went on to note that despite this referral volumes to the ISTC remained low. Another PCT told us that “information has been provided to GPs to inform them of how well this [ISTC] contract is being used to support utilisation, but there is no means by which GPs have been forced to refer down a particular route to secondary care providers”.

68. A further PCT told us that it had “undertaken substantial work to ensure that the fixed volume contracts that were negotiated on behalf of local commissioners by the Department of Health are adequately used ... the work we have undertaken with GPs has been to encourage knowledge and awareness of these as choice options for the GPs”. Two more PCTs told us that from the outset of an ISTC contract in their region they had taken “management action to ensure GPs and their patients were aware of the choices and services provided by [the ISTC] to increase the likelihood that patients took up the choice and to minimise the risk that activity did not match the fixed financial commitment”.
69. We are also aware that a number of PCTs have negotiated fixed payment arrangements with acute trusts (see paragraph 101), which raise the same issues as set out above in relation to ISTC contracts with minimum income guarantees.
70. In assessing whether PCTs in responding to the incentives created by tariff differentials are acting consistently with the Principles and Rules, there are potential issues in relation to restrictions on patient choice and competition (Principle 5 – see paragraph 52) as well as in relation to Principle 3. Principle 3 states that payment regimes and financial intervention in the system must be transparent and fair, and that commissioners and SHAs must uphold Payment by Results rules as set out in the Code of Conduct and annual guidance. The Payment by Results Guidance for 2011/12 states that “... patients must be able to choose between providers regardless of price”.²⁸
71. This requirement is clear in relation to restrictions on patient choice that are motivated by price differences arising from the market forces factor. However, the situation is more complex where services have been shifted from an acute to a community setting, and a lower local tariff has been negotiated, and the PCT no longer allows patients to be treated at the local acute provider because of the higher national tariff that would be charged.
72. In these circumstances, there is a question of whether, under the Code of Conduct, the service that has been moved into the community is substantively different from the service that is offered in the acute trust. The Code states that “where the service takes place in the home, or differs from that being offered in hospital, then the activity should be subject to local pricing” (para 10.1.6). However, “where the service to be provided does not take place on trust premises, but is the same as an existing hospital service, and is within the scope of Payment by Results, payment should be at tariff rate” (para 10.1.5).²⁹ If the service that has been shifted from an acute to community setting and meets the Code’s eligibility requirements for

²⁸ Department of Health, *Payment by Results Guidance for 2011/12*, February 2011, paragraph 446 available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124356.

²⁹ The Code of Conduct goes on to say that: “For a service to be the same as a hospital based service it would need to satisfy the relevant HRG and/or OPCS definitions and should not be capable to being delivered through any contractual option to provide GP services including GMS, PMS or APMS.” (para 10.1.6).

a local tariff, then it would appear that commissioners would also be justified in decommissioning this service from the acute provider and thus restricting patient choice to those providers offering the community-based service.

73. Turning to the consistency of these restrictions with the requirement under Principle 5 not to restrict patient choice and competition. As we set out in paragraph 51, the CCP takes a cost-benefit approach. We set out in paragraph 64 the costs to patients of choice and competition being restricted in this way.
74. In terms of any benefits arising from the restrictions puts in place by PCTs, there is a taxpayer benefit from directing patients towards acute providers with lower tariffs³⁰ and from not having to pay providers – due to income guarantees – for activity that is not undertaken. However, in relation to the impact of income guarantees and other fixed payment arrangements, the first best solution to the problem of “paying twice” for activity is not to enter into income or volume guarantees in the first place, rather than trying to distort patient choice to deal with the consequences of the guarantee. (We recognise that in some cases PCTs have inherited contracts with income or volume guarantees. However, in other cases, PCTs are entering into these types contracts with NHS providers – see paragraph 101.)
75. Whether the benefits to the taxpayer of restricting or distorting patient choice and competition outweigh the costs to patient choice and competition need to be assessed on a case-by-case basis. The CCP’s report on the complaint by Circle Health Limited regarding the actions of NHS Wiltshire sets out in further detail how the CCP assesses these issues. In this report we find that the benefits to taxpayers of not having “pay twice” for a service as a result of an ISTC contract in the area did not outweigh the costs to patients of reduced choice and competition in routine elective care.
76. In the light of this guidance and the CCP’s findings in relation to the Circle complaint, we recommend commissioners review their existing practices in relation to any restrictions on patient choice and competition arising from:
- information provided to GPs regarding providers of routine elective care;
 - recommendations to GPs concerning the direction of patients to providers of routine elective care;
 - prohibitions on referrals to any providers of routine elective care;
 - any additional approval processes required before patients can access their preferred provider of routine elective care; and
- take steps to bring themselves into compliance with the Principles and Rules.
77. In addition, to address the information issues set out in paragraph 61, we recommend that the Department of Health requires commissioners to copy to all local providers any information supplied to GPs concerning providers.

³⁰ Where the provider with the higher tariff, which is losing patients, is an acute trust, the extent of the taxpayer benefit depends on its ability to reduce its costs as a consequence of having fewer patients. This, in turn, rests on the relative share of fixed and variable costs at the provider.

78. We further recommend that the Department of Health reviews the way in which the Market Forces Factor is incorporated into the tariff for routine elective care, and assesses whether the incentives that the current arrangements create for PCTs to restrict patient choice and outweighed by other considerations.

Referral management systems

79. Patient referrals for routine elective care can not only be made by GPs, but can also be made through various referral management systems. Different referral management systems include referral management centres, clinical triage and assessment services, peer review and referral audit arrangements, and clinical guidelines on referral thresholds for different treatments. Many PCTs have implemented referral management systems as a means of ensuring that patients receive the appropriate treatment in the appropriate setting, and achieving greater consistency of decision making for secondary care referrals.³¹ These systems also potentially allow PCTs to have greater control over the demand for routine elective care.³²
80. Referral management systems raise many of the same issues in terms of restrictions on patient choice and competition that were discussed in relation to GP referrals in paragraphs 57 to 78. Concerns raised by providers in relation to referral management were that these systems, in addition to being used as a means of reducing unnecessary referrals to secondary care and otherwise improving patient referrals, are also being used to undermine patient choice and channel patients to particular providers.³³
81. These complaints included:
- a telephone assessment service operated on behalf of a PCT by a local NHS Trust, which routinely books patients onto its own lists first;
 - a PCT triage centre using a paper form to fill in patient details and discuss options for treatment, with the local independent sector provider not listed on the form as an option; and
 - a triage centre believing that it did not have to offer choice as it was using paper referrals rather than Choose and Book.
82. Most of the PCTs that made submissions to the CCP regarding their use of triage and referral management schemes set out their commitment to ensuring that patients had the ability to

³¹ See Imison and Naylor, *Referral Management: Lessons for Success*, King's Fund, 2010 for a full discussion of referral management systems. In assessing the effectiveness of referral management schemes, the study finds that although the majority of PCTs had implemented some form of referral management there is limited empirical research on the effectiveness of the interventions in meeting their objectives. The study concluded that although half of the PCTs included in the study believed that their referral management schemes had curtailed demand for secondary care this was not supported by a comparison of referral growth rates between PCTs with and without active referral management schemes. (We are concerned, however, that the empirical approach used in this study may not be sufficiently robust to support this conclusion and consider that further empirical research on the effectiveness of efficient, well designed referral management schemes in reducing the demand for routine elective care is required.)

³² A number of PCTs reported some success in reducing referrals to secondary care and thus saving money. For example, one PCT reported that its Clinical Assessment and Treatment Service and Spinal Assessment and Treatment service had reduced referrals to secondary care by 40% in the last two years by offering alternatives to secondary care. Not all of these arrangements are successful in reducing referrals, however. Another PCT told us that "we contracted for a Tier 2 (community-based) MSK service on the assumption that such a service would have the effect of reducing demand into secondary care. Based on reliable data evidence we have experienced no reduction in secondary care referrals".

³³ Concerns were also raised about aspects of referral management schemes more generally, including the scope of transaction costs, the potential for error and delays, the need for additional patient appointments, and the lack of a personalised service.

choose their provider once a referral decision was made. For example, one PCT told us that “the Clinical Assessment and Treatment Service and Spinal Assessment and Treatment Service is set up as the first part of the MSK care pathway to offer full assessment and conservative treatment options to patients (ie physiotherapy or joint injection). If onward referral to secondary care is required the extended scope practitioner offers a choice of referral routes to the patient”. Another PCT told us that it uses “triage and referral management processes but these then offer full choice after the initial part of patient diagnosis”.

83. In some cases, PCTs noted that the development of local pathways meant that patients could only be offered a choice of those providers offering the appropriate service. For example, a PCT told us that it has “arrangements in place whereby all referrals to hospital ophthalmology services are triaged by qualified optometrists and where these can be managed by local optometrists, patients are offered the choice of these providers rather than acute hospitals”. We consider this to be consistent with the overall aim of using referral management schemes to direct patients to appropriate treatment.
84. Nevertheless, several PCTs told us that they used referral management systems to direct patient referrals to particular providers. One provider submitted correspondence between GPs in a local area in the context of the local Referral Management Service. This letter put forward proposals for the Referral Management Service to:
 - contact patients that had selected one particular provider and discuss diverting them to another provider, including having an explicit discussion with the patient regarding the price differential between the two providers; and
 - automatically referring patients to a particular set of hospitals in preference to others rather than offering patients a choice.
85. The CCP was also provided with the scripts used by referral management centre staff at another location where the instructions to staff are explicit in stating that patients should be directed towards a particular provider.
86. As with distortions to GP referrals, channelling patients to specific providers through referral management systems is likely to impose costs on patients as a result of being treated at a provider that does not best reflect the patient’s preferences (eg due to quality of service, location or waiting time). In addition, a provider that knows that it is the beneficiary of actions to influence referrals towards them will need to try less hard to attract patients, and may therefore offer a lower quality of service than would otherwise be the case.
87. Again, as with GP referrals, PCTs told us that their justification for using referral management systems to restrict or distort patient choice arose from value for money considerations related to tariff differences between service providers and the presence of providers with minimum income guarantees. For example, one PCT told us that one of the benefits of its referral management system is “optimal use of services already paid for” by the PCT. Another PCT told us that the referral management system “has been used to help ensure patients are informed for the ISTC option. Where patients are identified as suitable for treatment at this Centre, the patients are contacted to ensure that they have information (including waiting times and

facilities) supplied about this provider. Between December 2010 and February 2011, 43% of patients approached in this way took up the ISTC option”.

88. As set out in paragraph 75 in relation to GP referrals, whether the benefits to the taxpayer of restricting or distorting patient choice and competition outweigh the costs needs to be assessed on a case-by-case basis. We recommend commissioners review their existing practices in relation to any restrictions on patient choice and competition arising from referral practices at Referral Management Systems within their PCT, and take steps to bring themselves into compliance with the Principles and Rules.
89. In addition, we recommend that the Department of Health requires commissioners to ensure that Referral Management Centres implement the Choose and Book system effectively and share with all local providers the scripts and any other communications use by Referral Management Centre staff when referring patients to a provider for routine elective care.

RESTRICTIONS BY PCTS ON PROVIDERS’ ABILITY TO OFFER ROUTINE ELECTIVE CARE

90. This section examines the nature, extent and effect on patients and taxpayers of restrictions by PCTs on providers’ ability to offer routine elective care to patients. We review three specific mechanisms used by PCTs, namely:
 - first, imposing what are, in effect, caps on the number of patients a provider can treat or will be paid for treating;
 - second, imposing minimum uniform waiting times on providers; and
 - finally, not allowing providers to offer some, or any, routine elective care services.

We review each of these mechanisms in the following paragraphs and then set out our findings and recommendations in relation to these restrictions.

91. The evidence that the CCP has reviewed during this study indicates that PCTs which restrict providers’ ability, or incentive, to offer routine elective care most frequently do so through capping activity at providers. The imposition of minimum uniform waiting times at providers also appears reasonably widespread. According to the evidence we have seen, it is much less common for providers to be prevented from offering routine elective care services.

PCT constraints on routine elective care activity at providers

92. Patient choice in routine elective care, with a system whereby payment follows the patient, is based on the concept that competition between providers for patients will result in higher quality services and greater efficiency. (We discuss this in paragraphs 36 to 40 and Annex A.) Fundamental to this proposition is that providers have both the ability, and the incentive, to attract patients.
93. In practice, however, PCTs constrain the level of routine elective care activity at each individual NHS acute trust. While the precise arrangements vary between PCTs, in general, acute trusts do not have the freedom to attract as many patients as possible, based on offering a higher quality service, and remain confident that they will be paid for treating each of these patients. This, in turn, means that the incentives to improve quality so as to attract additional patients are considerably blunted.

94. This section describes how PCTs manage activity levels at providers, the impact on choice and competition, and whether there are offsetting benefits to patients and taxpayers. We:
- first, outline the mechanisms used by PCTs to constrain routine elective care activity at providers and discuss the effect on patients; and
 - second, discuss the potential benefits to patients and taxpayers of PCT actions to constrain routine elective care activity at providers.

Mechanisms for constraining routine elective care activity at providers and the effect on patients

95. PCT management of routine elective care activity levels at providers through the Activity Planning provisions of the Standard Acute Contract and payment arrangements, including block and capped contracts and implicit threats of non-payment have a significant effect on providers' ability, and incentive, to attract patients. This, in turn, affects patient choice and competition in these services.
96. There are four main mechanisms that PCTs employ to constrain routine elective care activity at providers. These are:
- the Activity Planning provisions of the Standard Acute Contract;
 - block and capped contracts with providers;
 - implicit (or explicit) threats of non-payment for treating patients once a certain volume is exceeded; and
 - locally negotiated variations to the national tariff for routine elective care.
97. The Activity Planning provisions of the Standard Acute Contract require the preparation of an annual forecast of monthly activity levels, including routine elective care, at a provider.³⁴ The Contract also provides for the management of activity levels at the provider so that they are consistent with the Activity Plan forecast. For example, the Contract states that:
- The commissioner and provider shall manage demand in accordance with the Activity Plan (clause 3.1 and 3.2).
 - 'The agreed Activity Plan shall specify a forecast threshold or tolerance for each activity to function as an early warning of where the actual level of demand exceeds the forecast threshold, with the intent that any breach of the forecast threshold will be reviewed by the Parties without delay' (clause 2.4).
 - If the provider breaches a forecast threshold set out in the Activity Plan for any activity, then the provider shall notify the commissioner and the two parties shall agree an Activity Management Plan, which should include proposals to 'remedy the breach' (clause 5.5).
 - The schedule also provides for 'financial adjustment' if there has been a breach of forecast thresholds set out in the Activity Plan and an Activity Management Plan has been implemented and breached (clause 6.1).
98. PCTs vary in their approach to Activity Planning. Some PCTs treat Activity Plans as a limit on the number of patients a provider can treat, while others have a higher tolerance for variation

³⁴ Schedule 3 – Managing Activity and Referrals, Care and Resource Utilisation Techniques and Retention of Payment Scheme (available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124324).

from the Activity Plan. In responding to the concerns about the formulation of Activity Plans, a number of PCTs told us they preferred to use referral thresholds as a means of controlling the number of patients referred to secondary care, but others acknowledged that they were capping activity at individual providers to constrain the overall level of activity.³⁵

99. Another way that some PCTs ensure that actual activity at providers corresponds with the forecast in the Activity Plan is to withhold or challenge payments for the treatment of patients in excess of the number contained within the Activity Plan. For example, a provider submitted a letter from a local PCT stating that “the PCT will not pay for any routine or non-admitted routine activity in excess of the agreed activity profile with each acute provider between December and the end of March [2011]”.
100. A number of providers told us that their experience of treating more patients than allowed for in their Activity Plan resulted in payment being withheld or challenged, and that this then generally resulted in a negotiation in which the final sum paid for these extra patients was, in effect, at a discount to the tariff. Other providers, which had not treated more patients than planned, told us that they were concerned that payment would be withheld or reduced if they did so.³⁶
101. Where activity is unlikely to vary greatly from the level contained in the Activity Plan, PCTs have certainty over their expenditure on routine elective care in the same way as a block contract (where a fixed payment is agreed regardless of activity levels) or a capped contract (where there is an agreed ceiling on payments). A number of PCTs have taken this step and have, in effect, suspended the operation of Payment by Results tariffs for routine elective care and put in place block and capped contracts with acute trusts for routine elective care (and other acute care). As with tightly managed Activity Plans, the acute trusts under these arrangements have little or no incentive to attract additional patients given that they will not be paid for them.
102. Other PCTs, instead of constraining the level of routine elective care activity at providers through Activity Plans or block contracts, are using locally negotiated discounts to the national tariff to lessen the budgetary impact on the PCT – and the incentive for providers – of treating more patients than anticipated in their Activity Plans.
103. We are aware of at least two Trusts where a discount of 50% is applied to the tariff for patient volumes in excess of the Activity Plan. The implementation of this discount is consistent with the Payment by Results Guidance for 2011/12. However, such a discount could have an adverse effect on patient choice and competition where the marginal price for additional patients (at 50% of the national tariff) is less than the marginal cost of treating these patients. In these circumstances, similar to tightly managed Activity Plans and block or capped contracts, the Trusts will have little or no incentive to attract additional patients.

³⁵ The scope for this activity management will extend to former ECN providers as they move on to the Standard Acute Contract with PCTs.

³⁶ The CCP surveyed senior executives from 25 acute trusts, including Foundation Trusts. We asked whether these providers were confident they would be paid for treating more routine elective care patients than the volume contained in their Activity Plan. Only two trusts did not have experience of, concerns about, being paid the full amount for treatment volumes in excess of planned levels

104. In summary, PCTs have – and use – a variety of means of controlling routine elective care activity levels at providers. With the transfer of many independent sector providers from national- to PCT-let contracts (see paragraph 34), the scope for PCTs to use these mechanisms has increased. These mechanisms primarily operate by influencing the incentive that providers have to compete for, and attract, patients to their facilities. The Department of Health states that the objective for Payment by Results is as follows:

“The aim of Payment by Results is to provide a transparent, rules-based system for paying trusts. It will reward efficiency, support patient choice and diversity and encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for case mix. Importantly, this system will ensure a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers.”³⁷

105. The mechanisms used by PCTs to manage levels of routine elective care at acute trusts, in undermining the incentives of providers to attract additional patients for treatment, is in stark contrast to the stated aims of Payment by Results.

106. These mechanisms also, in many cases, appear inconsistent with the Payment by Results Code of Conduct, which states that: “Under Payment by Results, planned activity volumes for elective are important management tools, but will not determine payment. The use of rigid ‘caps and floors’ on activity is inconsistent with the fundamental principle of Payment by Results that payment should be based on the number and complexity of cases treated” (para 8.1.4).

107. The effect on patients of the limited, or absent, incentive providers have to attract additional patients is the loss of incentive for providers to offer higher quality services as a means of attracting patients. That is, the benefits to patients and taxpayers of the system of patient choice and competition are significantly undermined.

108. To assess how widespread these arrangements might be, and thus the extent of their effect on patients, we examined changes in providers’ share of patient volumes for routine elective care across 14 PCTs over the period 2008 to 2010. This showed that the share of routine elective care for the largest provider of routine elective care in nine out of 14 PCTs varied by +/- 2 percentage points. At the same time, routine elective volumes in these PCTs grew by approximately 20 per cent. This stability in the share of routine elective care volumes was also largely reflected for the second and third largest providers of routine elective care in these PCTs. In the remaining 5 PCTs, the largest provider of routine elective care experienced a change in its share of routine elective care volumes of 3-5 percentage points over the two year period. This also appears relatively stable given the large increase in treatment volumes over this period and is consistent with the enforcement of Activity Plans that are based on historical activity or referral patterns.

³⁷ See <http://www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/index.htm>

Benefits to patients and taxpayers of PCT constraints on routine elective care activity at providers

109. PCTs told us that patients and taxpayers benefit from activity management at providers in three ways:
- first, by allowing PCTs to control expenditure on routine elective care;
 - second, through facilitating service continuity and investment in service quality as a result of greater provider stability; and
 - finally, by facilitating the training of clinical staff.

We discuss these two potential benefits to patients and taxpayers in the following paragraphs.

Control of PCT expenditure on routine elective care

110. PCTs told us that patients and taxpayers benefit from the greater control over expenditure on routine elective care that stems from constraints placed on the volume of patients treated at providers (or the amount of money paid to providers for treating these patients). These controls allow PCTs to meet their statutory responsibility to balance their budget each financial year, and avoid the possibility of a loss of expenditure control that ultimately harms patients and taxpayers because of the adjustments that would be required to return the PCT to financial viability.³⁸
111. We agree that patients and taxpayers benefit from PCTs being able to control their expenditure on routine elective care. However, constraining the number of patients that each individual provider can treat is not the only means for PCTs to control expenditure on routine elective care. One PCT told us “the PCT has an obligation to stay within the financial envelope for any service. To ensure we don’t exceed this, we need to understand the maximum number of referrals for a service. But rather than using caps, we manage this through our referral thresholds and ensure that they are appropriate and adhered to by referring clinicians”. We are also aware of a number of other mechanisms used by PCTs for controlling expenditure on routine elective care, including referral management systems (see paragraphs 79 to 89) and uniform minimum waiting times for patients (see paragraphs 123 to 136).
112. In our view, the first-best situation is one in which PCTs were able to control expenditure on routine elective care through setting clinical thresholds for treatment, and using referral management systems to ensure that referrals to secondary care are appropriate and consistent with these thresholds. This then allows the patient to remain free to choose the provider of their routine elective care, and importantly, maintains the incentive for providers to offer the best possible service so as to attract patients.
113. We recognise, however, that not all PCTs will necessarily have developed demand-management programmes to the same degree, and that in certain circumstances additional measures may be required to ensure that expenditure on routine elective care remains within

³⁸ One PCT told us that even at the level of the individual PCT patients would suffer if it did not meet its statutory obligation to breakeven: “Failure to maintain financial balance could have resulted in an external turnaround team being appointed to the PCT to address any financial deficit. It is well reported that such turnaround teams make immediate decisions to solve financial difficulties without involving local clinicians. The impact can therefore be detrimental to patients and jeopardise improvements made to local services by local GPs over previous years”. One PCT told us that “the top priority facing all commissioners at present is cost reduction. The scale required is so great – in the PCTs for which I am responsible its more than 5% per year for the next 5 years – that we will need to take every possible step and be thoroughly pragmatic about what is most effective”.

budget. In these circumstances, the measures that are employed by PCT should, insofar as possible, be neutral between providers.

Continuity of services for patients

114. A number of PCTs told us that tightly managed Activity Planning at providers for routine elective care underwrites provider stability and thus continuity of services for patients. We were told that this went beyond the availability of routine elective care services, and ensured that other services provided by acute trusts are not put at risk.³⁹
115. For a restriction on patient choice in routine elective care to deliver benefits in terms of service continuity, the potential loss of routine elective care volumes by a provider would need to result in a significant risk that other services – with critical access requirements for patients – could no longer be sustained. While this argument is frequently advanced, we did not see persuasive evidence of this relationship, and we would expect commissioners to rely on robust evidence of this relationship before putting in place such a restriction.
116. Moreover, to the extent that other regulatory arrangements are in place to protect essential services in the event of provider failure, restrictions on patient choice and competition as a means of ensuring service continuity are more difficult to justify.

Training of clinical staff

117. We were told that ensuring that providers had a sufficient number of patients is necessary to ensure that providers can train new medical staff given the requirement that medical students establish sufficient levels of experience across a range of areas. This requires providers to employ a number of experienced staff and a sufficient range and volume of procedures and patients so that trainee staff can demonstrate their experience and competence.
118. For a restriction on patient choice and competition to be justifiable in terms of clinical staff training, commissioners need to have adequately explored, and be satisfied that there are no other options available for ensuring the training of clinical staff, including through cooperative arrangements between multiple providers.

Conclusion and recommendations on PCT constraints on routine elective care activity at providers

119. Whether the benefits to patients and taxpayer of restricting routine elective care activity at providers outweighs the costs to patients in terms of a loss of choice and competition needs to be assessed on a case-by-case basis. To the extent that there are benefits, it seems that these are most likely to arise in relation to the control of expenditure by PCTs. However, in any case that might be considered by the CCP, the CCP would also take into account whether the PCT had – in taking action to control expenditure – made sufficient use of mechanisms that would allow the PCT to control expenditure on routine elective care without restricting or distorting patient choice and competition.

³⁹ We were told that ensuring the financial sustainability of providers would benefit patients through ensuring continuity of services to patients as it would support providers to remain in the market, and that by providing Trusts with a critical mass of activity it supports the provision of emergency and complex care, including 24-hour emergency cover, as well as education and training of clinical staff.

120. Given this, we recommend that commissioners review any constraints on routine elective care activity at providers and take steps to bring themselves into compliance with the Principles and Rules.
121. In addition, we recommend that the Department of Health, in the light of our findings regarding payment arrangements takes action to ensure that SHAs and commissioners are implementing Payment by Results in accordance with the Code of Conduct and national guidance, including ensuring that commissioners publish the details of any locally adopted variations to the national tariff.
122. We further recommend that the Department of Health reviews the rationale for the Activity Planning provisions in the Standard Acute Contract, and if these provisions remain necessary assess whether amendments could be made to make these provisions less susceptible to being used to restrict patient choice and competition.

Uniform minimum waiting times for patients

123. Several providers told us of the restriction on their ability to offer routine elective care to patients that arose from the imposition by PCTs of uniform minimum waiting times before providers could treat patients. Uniform minimum waiting times which apply to all providers in an area does not restrict patient choice in the sense that patients can still choose between all of the contracted providers, but it is likely to distort patients' choice of provider compared with unrestricted waiting times. Further, it restricts competition between providers by removing an aspect of differentiation between providers, and thus the incentive for providers with longer waiting lists to increase their efficiency so as to reduce waiting times.
124. At an individual level, making patients wait longer than necessary for treatment is likely to impose greater pain and inconvenience than is necessary on patients.
125. A number of PCTs confirmed their use of minimum uniform waiting times. For example, one PCT stated that "commissioners should be able to stipulate how long patients should wait provided this access time is not greater than the 'Constitutional right' [of 18 weeks]". Another PCT told us that the "minimum waiting time for providers is 15 weeks. This is consistent across all providers. The Department of Health guidance is to treat within a maximum of 18 weeks ... there is no specific guidance on a minimum wait time."
126. Not all PCTs, however, impose uniform minimum waiting times for routine elective care. One PCT told us that it "does not have a policy of minimum waiting times nor would it support waiting times being artificially managed simply to protect any one provider whether it be an IS or NHS provider". Another PCT stated that "we support treatment as soon as a provider can safely deliver".
127. Those PCTs that impose uniform minimum waiting times told us that patients benefited from more equitable treatment, and taxpayers benefited from the reduced expenditure facilitated by increased waiting times.

128. In relation to the equitable treatment of patients, one PCT told us that: “PCTs need to ensure equity of treatment for patients regardless of the provider which they attend for treatment, allowing grossly different waiting times between providers would disadvantage patients who would be unable to attend a certain provider for their treatment due to their complexity or any other clinical issue”. We do not accept, though, that a patient suffers any disadvantage as a result of other patients having conditions that allow them to be treated more quickly. The degree of disadvantage suffered by the patient seems to relate wholly to the speed with which he or she can be treated, and is not related to the treatment times that other patients experience. Making other patients wait longer for their own treatment simply to match the waiting period another patient requires for more complex treatment seems to represent an unfortunate levelling down, or lowest common denominator, approach to patient treatment.
129. In relation to taxpayer benefits, one PCT said that it sought to increase average waiting times from 13 to 16 weeks as a result of the PCT’s worsening financial position. A further PCT told us that “we have asked our local private providers to manage their waiting times for all activity so that their invoice values do not exceed given values” (ie the values contained in the Activity Plan). In our Interim Assessment, however, we questioned the extent to which increasing waiting times for patients would save money for PCTs given that these patients would eventually need to be treated. One PCT in agreeing with this view told us that “limiting activity through controlling waiting time was considered but quickly rejected as a very short term gain with impact of only deferring the ultimate treatment with potential detrimental impact on patients”.
130. However, other PCTs pointed out that the annual requirement to breakeven meant that PCTs would benefit from increasing waiting times, and in effect, deferring expenditure into the following year. An SHA told us that while increasing waiting times would reduce costs over the short-term even though “over the medium term overall costs would balance, PCTs are funded on an annual basis [and] as such, PCTs do not have the flexibility to fund substantial reductions in waiting times in one year and take advantage of reduced demand for treatment in subsequent years”. One PCT executive told us that “PCTs are mainly judged on their annual performance ... This drives a mentality to move irresolvable problems from the year being monitored into future years when there may be other means to resolve the problem. This also encourages PCTs to let waiting lists drift when under financial pressure”.
131. We were also told that increasing waiting times for patients did have the potential to save money overall. “Experience suggests that if patients wait longer then some will remove themselves from the list or will no longer require treatment when it is finally offered. A PCT may therefore save money [overall] by increasing waiting times”.⁴⁰ Nevertheless, where patient treatment is delayed, more complex and expensive care can be required, and so the balance between these two factors is not clear to us.

⁴⁰ We understand that patients will “remove themselves from the waiting list” either by dying or by paying for their own treatment at private sector providers, and that there is a relationship between the self-pay market in private healthcare and the length of waiting lists in the NHS. However, research suggests that the effect of increasing waiting times at all hospitals is unlikely to be significant. A 10% reduction in waiting times is associated with an increase in demand of between 1.35% and 2.35%. Assuming increases and decreases in waiting times have a similar effect, it is likely that an increase in waiting times will have a small impact on overall demand for services.

132. We recognise that patients and taxpayers benefit when PCTs are able to control their expenditure and meet their statutory obligation to balance their budget each year. However, the financial benefit to PCTs of imposing uniform minimum waiting times across providers only arises when waiting times are increased. This is a one-off benefit that cannot be repeated in the following year unless waiting times are increased further. Further, while PCTs may be able to reduce expenditure within a year through increasing waiting times, there is a question as to whether overall NHS expenditure is reduced because providers may be unable to reduce their costs in any meaningful way in response to an increase in waiting times. Where providers are NHS organisations, these costs will be met by taxpayers.
133. In summary, the imposition by PCTs of uniform minimum waiting times on patients for routine elective care represents a significant costs to those patients that are required to wait longer for treatment than would otherwise be the case. It also distorts patient choice of provider, and removes the incentive for providers to treat patients more efficiently so as to reduce waiting times. While there may be some benefit to taxpayers from PCTs managing, and reducing, their expenditure through increasing waiting times, this benefit is a one-off gain to the PCT that cannot be repeated in the following year without increasing waiting times further. At the same time, the increase in waiting times that results from this action continues forwards into future years. Finally, the reduction in PCT expenditure brought about by increasing waiting times is unlikely to be matched by a reduction in provider costs meaning that the overall benefit to taxpayers is likely to be minimal.
134. Given the balance of costs and benefits, and the evidence that many PCTs are able to successfully manage the demand for routine elective care without needing to impose minimum uniform waiting times, the Panel gave very close consideration to recommending a complete prohibition on minimum uniform waiting times. However, a majority of us concluded that PCTs under severe financial pressure – and the number of commissioners in this situation may increase – may in certain cases as a last resort need to use this measure. One member of the Panel (John Wotton), however, considered that convincing evidence had not been provided that PCTs under severe financial pressure would have no means of budgetary control other than the imposition of minimum uniform waiting times and favoured a prohibition of this practice in all circumstances.
135. The majority of the Panel considers the imposition of uniform minimum waiting times as acceptable under the Principles and Rules only when a PCT is under significant financial pressure and all other options have been explored and tested with providers.
136. We recommend that PCTs when imposing waiting time requirements on providers publish on the home page of their website clear information about the minimum waiting time imposed by the PCT on each provider. We further recommend that the Department of Health, and subsequently the National Commissioning Board, publish on their website a list of the minimum waiting times imposed by PCTs on providers in their area.

Restrictions on providers supplying services to patients

137. In the early stages of this review, in the context of the shift from national- to PCT-let contracts, several providers told us that PCTs were refusing to enter into contracts with these providers for routine elective care services. Our understanding is that over the course of this review, these issues have been resolved in nearly all cases. This issue is, however, part of the subject of the complaint by Circle Health Limited regarding Wiltshire PCT (see footnote 1), and the CCP's report on this complaint sets out our approach to this issue. We would refer commissioners and providers seeking guidance in this area to this report.

FINDINGS AND RECOMMENDATIONS

138. In conclusion, the Panel considers that while a number of commissioners appear to be performing well in facilitating patient choice and competition in routine elective care, and successfully balancing the tensions that can emerge between this and other objectives, there is significant variation in practices across PCTs and there are many examples of PCTs excessively constraining patients' ability to choose provider and providers' ability to offer routine elective care services.
139. Given this, the Panel's view is that there is a serious risk that unless practices that appear endemic among certain commissioners are addressed, the expected results from the policy of Any Willing Provider, including higher quality services and better value for money, are not going to be realised to their full potential.
140. This report provides guidance to commissioners on when restrictions on patient choice and competition can be justified because of their benefits to patients and taxpayers, and as a result, are consistent with the Principles and Rules.
141. The practices identified in this report which restrict patient choice and competition are, in many cases, likely to be inconsistent with the Principles and Rules because of limited offsetting benefits to patients and taxpayers. The Panel is not recommending a blanket prohibition on such practices because of the possibility that there may be offsetting benefits of sufficient magnitude in certain circumstances. But, the Panel does expect commissioners to identify in a transparent manner why such restrictions, where adopted, should be allowed and for what period.
142. Commissioners imposing restrictions are exposed to challenge under the Principles and Rules and we encourage commissioners to approach the CCP for informal advice when considering the appropriateness of any restrictions.
143. Having now provided guidance to commissioners, we encourage providers with concerns about restrictions on patient choice and competition to raise their concerns with the relevant commissioner, and in the event of being unable to achieve a satisfactory resolution, to bring their concerns to the CCP.
144. In addition to the guidance in this report, we make the following recommendations to improve the implementation of Any Willing Provider in routine elective care and the operation of patient choice and competition in these services.

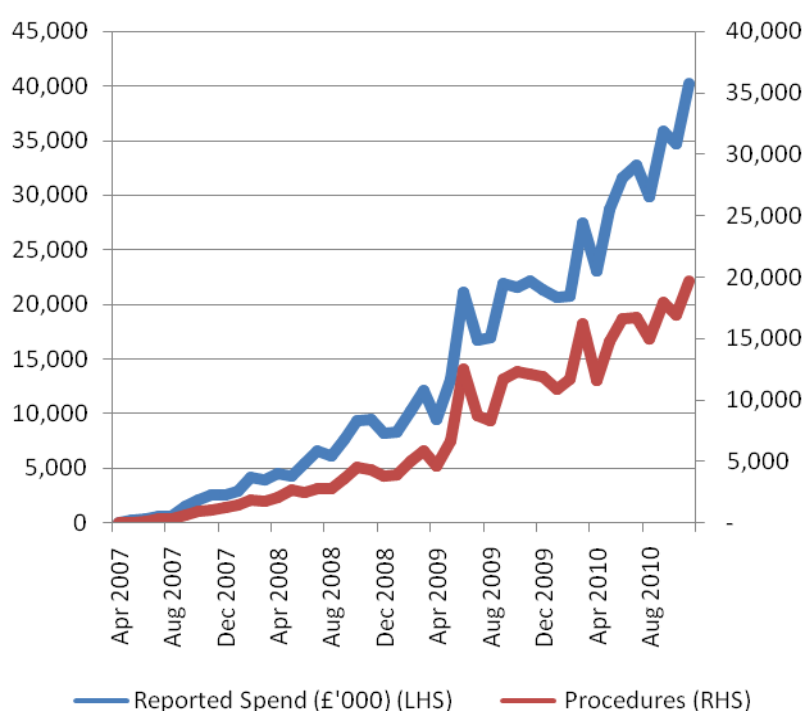
- i. We recommend that commissioners review their existing practices in relation to restrictions on patient choice and competition, and take steps to bring themselves into compliance with the Principles and Rules.
- ii. We recommend that commissioners be required to approve any such restrictions at Board level, and annually publish (eg as part of their annual report or statement of commissioning intentions) details of any restrictions on patient choice they have adopted, the underlying rationale for the restriction, an analysis of its impact and terms of the restriction, including the period for which it will operate.
- iii. We recommend that commissioners also be required to:
 - a. publish the approach they have adopted to Activity Planning with providers in their locality; and
 - b. when imposing waiting time requirements on providers, publish on the home page of their website clear information about the minimum waiting time imposed by the PCT on each provider.
- iv. We recommend that Strategic Health Authorities (SHAs), and in future the National Commissioning Board, implement oversight arrangements to ensure that commissioners are not restricting patient choice and competition in routine elective care against patients' and taxpayers' interests.
- v. We recommend that the Department of Health and subsequently the National Commissioning Board:
 - a. publish on its website a list of the minimum waiting times imposed by PCTs on providers in their area;
 - b. requires commissioners to ensure that Referral Management Centres implement the Choose and Book system effectively and share with all local providers the scripts and any other communications used by Referral Management Centre staff when referring patients to a provider for routine elective care; and
 - c. requires commissioners to copy to all local providers any information they supply to GPs concerning providers.
- vi. We recommend that the Department of Health, in the light of our findings regarding payment arrangements takes action to ensure that SHAs and commissioners are implementing Payment by Results in accordance with the Code of Conduct and national guidance, including ensuring that commissioners publish the details of any locally adopted variations to the national tariff.
- vii. We recommend that the Department of Health, in developing accreditation arrangements for future commissioners, requires that commissioners demonstrate to the National Commissioning Board an understanding of the policies and rules concerning patient choice and competition, and a commitment to complying with their obligations under these policies and rules. Compliance with the policies and rules concerning patient choice and competition should also be made a condition of continued accreditation.

- viii. We recommend that the Department of Health reviews the rationale for the Activity Planning provisions in the Standard Acute Contract, and if these provisions remain necessary assess whether amendments could be made to make these provisions less susceptible to being used to restrict patient choice and competition.
- ix. We recommend that the Department of Health reviews the way in which the Market Forces Factor is incorporated into the tariff for routine elective care, and assesses whether the incentives that the current arrangements create for PCTs to restrict patient choice are outweighed by other considerations.

THE EFFECT OF PATIENT CHOICE AND COMPETITION IN ROUTINE ELECTIVE CARE

1. There is evidence that an increasing number of patients are exercising their right of choice and selecting providers other than their local NHS provider. In particular, there has been ongoing growth in the number of patients choosing to have routine treatment carried out at independent sector providers (see Figure 1). Over the past year, the number of NHS procedures undertaken in independent sector hospitals has grown, on average, by 10% per month, and is now around £40 million per month or nearly £500 million per annum.

Figure 1: NHS patient treatment procedures and expenditure in independent sector hospitals, per month



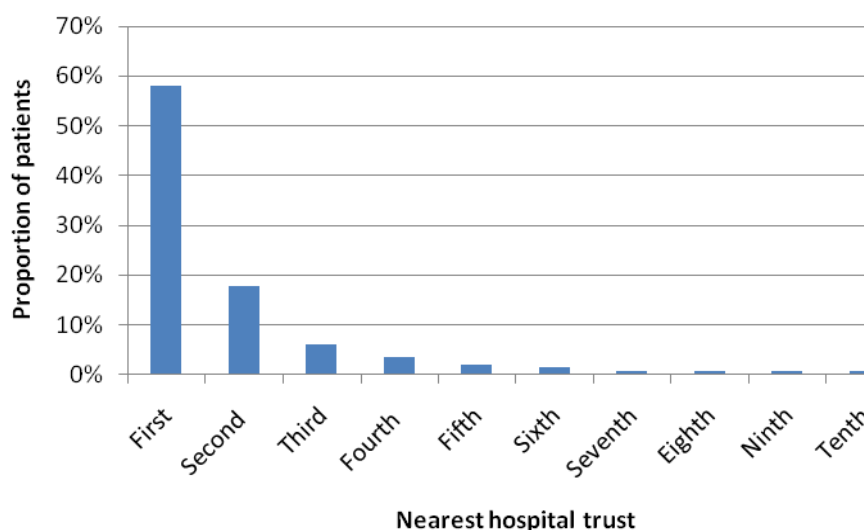
Source: Department of Health

2. In addition, CCP analysis shows that while nearly 60 per cent of NHS patients select the provider closest to their home, the remaining 40 per cent choose to travel further to another provider (see Figure 2).⁴¹ This appears to be indicative of a significant proportion of patients exercising choice and, in many cases, selecting a provider other than their local NHS provider.⁴²

⁴¹ The CCP's analysis is based on 2008/09 Hospital Episode Statistics (HES) data for elective hip replacements. The sample for analysis included 51,505 elective hip replacement patients, 146 NHS and Foundation Trusts, and 216 hospital sites. The HES data was provided by the NHS Information Centre. Copyright © 2011 Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.

⁴² It is worth noting that these figures are not precise estimates of the proportion of patients in our sample actively choosing their provider. This is because, in some cases, patients in a certain area may historically have been treated at, for example, the second closest

Figure 2: Proportion of patients attending their nearest hospital



Source: CCP analysis of HES data for patients undergoing hip operations.

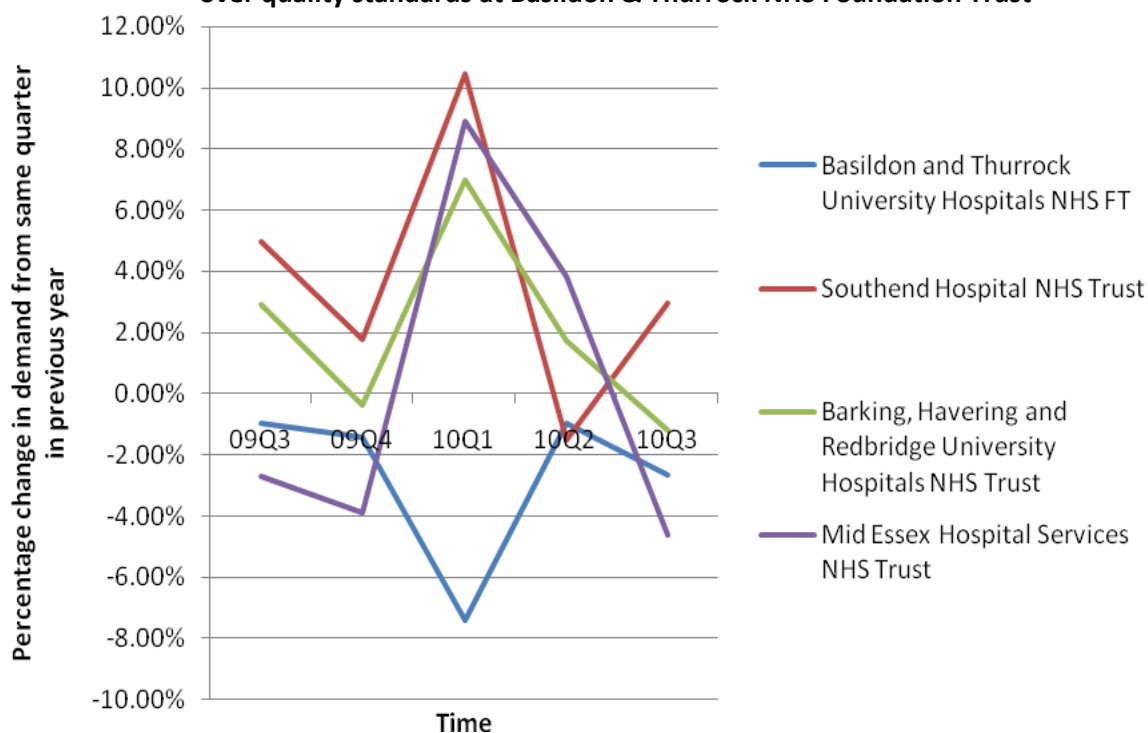
3. NHS Choices, as noted above, provides information on providers to assist patients in selecting a provider for their treatment. The National Patient Choice Survey, commissioned by the Department of Health and published in February 2010, found that the most important source of information for patients in choosing their provider of routine care was their GP (43%). Next were friends and family (29%), a booklet about choice produced by the NHS (6%), the NHS Choices website (4%), staff at a Clinical Assessment or Referral Centre (3%), someone else at a GP surgery (2%), a local patient organisation (1%) and other internet sites (1%).
4. CCP analysis of patients' choice of provider shows that while provider location is important, patients' choice of provider is also influenced by the quality of care offered by providers (as measured by hospital mortality rates, the incidence of infection and CQC quality ratings) and the length of waiting times.⁴³ While these factors might be expected to influence long-term patient referral trends, adverse news about the quality of care at a particular hospital can also have a significant short-term impact on patient referral patterns. For example, in early 2010, shortly after the CQC's findings of 'systematic failings' at Basildon and Thurrock NHS FT was publicly reported,⁴⁴ there was a short, sharp decline in patient referrals for routine elective care.

NHS facility, rather than the closest as measured by a straight line, because of factors such as local travel patterns. Further, some patients may be actively exercising choice, and in doing so, deciding to be treated at their nearest provider.

⁴³ The CCP's analysis uses patient-level data in a classical conditional logit model of demand. The model explores the extent to which patient and GP's choice of hospital is influenced by various factors, including the location, quality and other characteristics of the hospitals they can choose from, and the characteristics of the local area, such as whether it is urban or rural, and the degree of health and income deprivation. The full results of this analysis will be published by the Royal Economic Society in their April 2011 conference papers.

⁴⁴ See, for example, The Times, *Hospital trust's failings may have led to 71 deaths*, 27 November 2009.

Figure 3: Change in patient referrals for routine elective care following adverse publicity over quality standards at Basildon & Thurrock NHS Foundation Trust



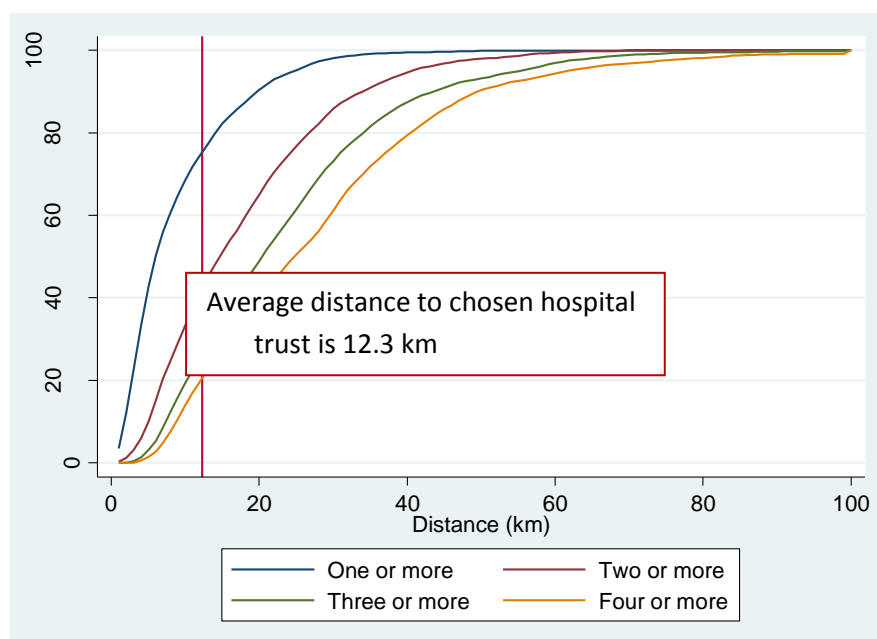
Source: CCP analysis of Dr Foster referral data.

5. Patients' ability to choose between providers is necessarily constrained by the availability of alternative providers in their locality. Inevitably, patients in urban areas are likely to have a greater choice of provider than patients in rural areas. CCP analysis shows that around 40 per cent of patients have access to at least three NHS Trusts within less than 20km, and around 80 per cent of patients have access to at least three NHS Trusts within 40km (see Figure 4). On average, patients travel around 12km to their chosen provider.
6. CCP analysis, as set out in paragraph 4, indicates that the quality of care offered by a provider is a significant factor in explaining patients' choice of provider. Further, analysis of the effects of patient choice on the overall quality of care in the English NHS have generally been favourable. For example, academic researchers at the Centre for Economic Performance at the London School of Economics have found that higher levels of competition in the provision of routine elective care, under the current fixed prices regime, has led to improvements in clinical performance. Specifically, "after the introduction of patient choice over secondary care provider, AMI mortality decreased more quickly for patients living in areas with more competitive spatial hospital markets".⁴⁵ Similar findings have also been reported in other recent studies.⁴⁶

⁴⁵ Cooper, Gibbons, Jones and McGuire, 'Does hospital competition save lives? Evidence from the English NHS patient choice reforms', *LSE Health Working Paper No.16/2010*, January 2010.

⁴⁶ See Gaynor, Propper and Moreno-Serra 'Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service', *NBER Working Paper w16164*, July 2010; Bloom, Propper, Seiler, Van Reenen, 'Management Practices in Hospitals', *LSE Working Paper*, June 2009; Cooper, Gibbons, Jones and McGuire, 'Does hospital competition improve efficiency? An analysis of the recent market-based reforms to the English NHS', *LSE CEP Discussion Paper No.988*, June 2010.

Figure 4: Proportion of patients with choice of at least one, two, three or four hospital trusts



Source: CCP analysis of Hospital Episode Statistics (HES) data.

7. A survey by the King's Fund of qualitative evidence including interviews and questionnaires, found that although just under half of patients they spoke to recalled being offered a choice of provider, choice was important to the majority of patients. An analysis of patients' responses to choices made in hypothetical and real situations showed that patients valued aspects of quality when choosing a hospital. The authors also found that the threat of patients choosing a different hospital led some providers to focus more on reputation. They concluded that there was little evidence of direct competition for patients' custom and, in contrast to the studies reported above, choice has not so far acted as a lever to improve quality, though they did note that some providers spoke about actively seeking to attract patients away from other providers in particular geographical areas and that there was quite a lot of activity around marketing services to GPs.⁴⁷

⁴⁷ King's Fund, *Patient choice – how patients choose and how providers respond*, June 2010.

CONTRACTING WITH PROVIDERS OF ROUTINE ELECTIVE CARE

1. This section reviews how commissioners contract with NHS and independent sector providers of routine elective care, and the impact of these arrangements on patient choice and competition. First, we describe the current contracting arrangements, including the transition from national to PCT-let contracts for independent sector providers, and second, examine the impact of these arrangements on patient choice and competition.

Current contractual arrangements for routine elective care

2. Until recently, PCTs have contracted with NHS providers, including NHS Acute Trusts and Foundation Trusts, for routine elective care while the Department of Health has, in the main, contracted with independent sector providers for these services.
3. PCTs have contracted with NHS providers using the Standard Acute Contract, developed by the Department of Health, which contains a combination of provisions which are either fixed centrally or subject to local negotiation. In contrast, the Department of Health has contracted with independent sector providers using:
 - Independent Sector Treatment Centre (ISTC) contracts, which facilitated investment in new treatment centres, and in many cases included incentives to secure that investment, such as minimum income guarantees; and
 - the ECN and FCN arrangements⁴⁸, which allowed existing facilities, such as those established for private patients, to also be used for the treatment of NHS patients.
4. In January 2010, the Department of Health signalled its intention to bring the nationally contracted ECN arrangements to an end, and for independent sector providers of routine elective care contracted under these arrangements to enter into the Standard Acute Contract with PCTs.⁴⁹ This change represents a step towards placing all providers of routine elective care on a common contractual framework. In addition, it brings together at the PCT level the role of contract counterpart and responsibility for paying for these services. (Under the ECN arrangements and ISTC contracts, the Department for Health is the contract counterpart, but each PCT with patients using contracted facilities pays for these services.)
5. In our Interim Assessment, we concluded that there was a significant risk that new PCT-let contracts would not be in place by 31 March 2011 when ECN arrangements were scheduled to end and, if this eventuated, ECN providers would not be able to offer services to NHS patients from that date leading to a significant loss of choice for patients. As a result, we recommended an extension to ECN arrangements to allow additional time for new contracts to be finalised, and the Government in accepting this recommendation extended ECN arrangements by 3 months until 30 June 2011. Subsequently, the vast majority of new PCT-let contracts were successfully put in place by this new deadline.

⁴⁸ We refer to ECN and FCN collectively as the ECN arrangements.

⁴⁹ Letter to PCTs and SHAs from Department of Health, 15 January 2010.

Impact of contracting arrangements on patient choice and competition

6. During this review, and particularly in the lead up to our Interim Assessment, the CCP received a number of submissions concerning issues arising in the transition from ECN arrangements to PCT-based contracts. Since our Interim Assessment, this transition has, in large part, been successfully implemented. As a result, we do not make any recommendations in this report concerning this change.
7. However, the transition from ECN arrangements to PCT-based contracts has thrown light on how contracting arrangements can impact on patient choice and competition. The following paragraphs seek to draw these points out for the benefit of informing future decision-making.⁵⁰
8. In summary, the way in which commissioners contract with providers of routine elective care can affect patient choice and competition in at least three ways:
 - first, the cost of contracting will influence providers' willingness to enter into contracts to provide these services;
 - second, where local contracting results in variations in service specifications across localities, patients' ability to choose between providers for a particular service can be restricted; and
 - finally, commissioners' ability to restrict patient choice and competition may be influenced by the choice of contract form (eg Standard Acute Contract vs ECN arrangements).

We discuss each of these influences in the following paragraphs.

Cost of contracting

9. The greater the cost of contracting to provide services, the less willing providers will – in general – be to offer these services. The ECN arrangements were a relatively low cost form of contracting for independent sector providers compared with the PCT-let contracts that have now been put in place.
10. Several providers told us of their concerns about the cost of the shift from the national ECN arrangements to PCT-based contracts. Concerns were raised about aspects of both the accreditation and contracting processes⁵¹, including the burden of the accreditation process (given that facilities involved were already being used to treat NHS patients), specification changes during the contracting process, and unrealistic timeframes to put new contracts in place.⁵² The shift to PCT-based contracts also appears to have imposed significant costs on PCTs and SHAs, including the cost of external project and bid management consultants,

⁵⁰ This is not to say that patient choice and competition is the only consideration when deciding on contracting arrangements. Examples of other factors to be taken into account include the flexibility that local contracting provides to respond to local needs, level-playing field concerns for providers, and on the purchasing side, bringing together responsibility for contracting and payment.

⁵¹ In each SHA there has, first, been an accreditation process for providers and their facilities, following by a contract negotiation process with approved providers. In around half of the 10 SHAs, the accreditation process has been conducted at the SHA level, with contracting then undertaken by PCTs. In the other SHAs, accreditation has been undertaken either by individual PCTs or PCT clusters. Following the accreditation process, the contract negotiation process with individual PCTs allows each contracting PCTs to set out its own requirements in terms of reporting arrangements and other aspects of the Standard Acute Contract that are open to local negotiation.

⁵² While one SHA started its accreditation process for ECN/FCN providers approximately 12 months prior to the scheduled end of ECN on 31 March 2011, another SHA did not start its accreditation process until after the CCP was asked to undertake this review.

advertisements, bidder information events, operating web-managed portals for receiving information, and documentation review and evaluation processes (eg in one SHA providers had to submit more than 100 separate documents).

11. In some cases, the concerns raised by providers seem to relate to one-off costs associated with the transition from national contracts to PCT-based contracts, and these costs would most likely not be incurred again in future PCT contracting rounds. In support of this, a number of PCTs told us that the contracts being entered into with independent sector providers are, for the PCTs involved, new contracts. The substantial value of these contracts means that commissioners must use proportionate, appropriate and reasonable due diligence to provide assurance that providers are able to deliver high quality services in a safe and effective manner.
12. Putting to one side any one-off costs arising from this transition, PCT-based contracting involves higher ongoing costs than the national contractual arrangements that it replaces. Providers are shifting from an arrangement where a single national contract is being replaced with multiple contracts with different PCTs. An NHS provider noted that “specialist NHS or Foundation Trusts can often be in a similar situation and although there are host PCT arrangements it is not uncommon for Associate PCTs to have a different set of requirements of providers. An example we currently face is with differing CQUIN requirements and varying ‘Low Priority Procedure’ policies from neighbouring PCTs”.
13. Providers also told us that the Standard Acute Contract is more complex, and thus costly to put in place, compared with the ECN arrangements. An SHA told us that PCTs were also concerned with the costs associated with managing multiple providers, and that transaction costs had the potential to increase as the commissioner base increases and more localised specifications are required.
14. As set out in paragraph 9 of this Annex, the greater the transaction costs associated with contracting, the less willing providers will be to offer services. The shift from ECN arrangements to PCT-based contracts does not appear to have had an immediate effect on the willingness of ECN providers to offer routine elective care to NHS patients.⁵³ As we understand it, each of the 15 ECN providers has sought to enter into contracts with PCTs for the provision of routine elective care. However, it seems likely that the increase in costs for providers as a result of this change will make it more likely that they will in the future withdraw from providing these services either in part or in total, and thus reduce the extent of patient choice and competition in routine elective care.
15. Looking forwards, the replacement of PCTs with GP commissioning consortia means that there will be a substantial task associated with novating existing contracts to new GP commissioning consortia, particularly as each PCT will be replaced by multiple consortia. Unless carefully handled, this has the potential to impose significant further contracting costs on providers of routine elective care, and impact on their willingness to continue providing these services.

⁵³ One provider told us that it estimated the one-off cost to it of shifting from ECN arrangements to PCT-based contracts was around £750,000.

Local contracting and variations in service specifications

16. PCT-based contracting has the potential to restrict patient choice of provider, and competition between providers for patients, where it results in variations between areas in treatment specifications. These variations have the potential to create incentives for PCTs to restrict patient choice to only those providers operating within the PCT area.

Ability to impose restrictions on patient choice and competition

17. The shift from ECN arrangements to PCT-based contracts has increased PCTs' ability to influence, and restrict, patient choice and competition. This is due to PCTs becoming the counterparty to the contract with independent sector providers, and the more ready availability of mechanisms in the Standard Acute Contract, such as Activity Planning (see paragraphs 97 to 100 of the main report), which allow PCTs to restrict patient choice and competition.