Creating a level playing field: a fair environment for patient care
The NHS Confederation brings together the full range of organisations that make up the modern NHS in the UK.

We act as an independent and powerful force in the drive for better health and healthcare. We do this by:

• influencing health policy and the wider public debate
• supporting health leaders with information-sharing, networking and tailor-made services
• promoting excellence in employment to improve the working lives of healthcare staff.

Our work is determined by our members. Our aim is to reflect the different perspectives as well as the common views of the many organisations delivering the new NHS.

Our core membership covers all types of statutory NHS organisation. Our members are the organisations themselves and these organisations are represented by individuals from board level – chief executives, chairs, non-executives and directors. We also have an affiliate membership scheme for commercial and not-for-profit organisations providing frontline services on behalf of the NHS.

For more information on our work, please contact:

NHS Confederation
29 Bressenden Place
London SW1E 5DD

Tel 020 7074 3200  Fax 020 7074 3201
Email enquiries@nhsconfed.org
www.nhsconfed.org
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>2</td>
</tr>
<tr>
<td>Underlying context</td>
<td>3</td>
</tr>
<tr>
<td>Towards a level playing field</td>
<td>4</td>
</tr>
<tr>
<td>Design principles</td>
<td>5</td>
</tr>
<tr>
<td>Conclusions</td>
<td>11</td>
</tr>
</tbody>
</table>
Introduction

During the course of the last nine months, the NHS Confederation and the Independent Healthcare Forum\(^1\) have co-operated to explore how the full range of providers can work together more effectively to deliver high-quality patient care. This report outlines their findings, expressed as some principles which should be considered when developing and sustaining partnerships with independent and voluntary sector providers. It is an accurate representation of the consensus view but, as with all reports involving a number of parties, not every participant agrees with every point.

Our fundamental principle is that there should be a level playing field for all providers of care. Our challenge is to create a framework to address the many practical issues all types of providers involved in this work-stream share. These issues are outlined below.

- The plurality agenda should be used as an opportunity to reshape provision of services more closely around the needs of patients.
- Services are only genuinely contestable if they are open to all providers. In practice, services open to all providers would only work effectively for patients if a number of features are present:
  - strong commissioning, with a local focus
  - a truly mixed economy, including:
    - open and clearly accredited entry mechanisms for new providers
    - a single standard of licensing
    - providers from all sectors within a dynamic market
  - an independent tariff-setting mechanism which balances quality and price pressures
- common regulation, working to better but fewer regulatory standards, underpinned by a meaningful and common dataset which focuses on patient safety and outcomes.
- There is a considerable challenge in managing the transition process as this is where most practical problems currently arise. Issues to resolve include:
  - the need to strengthen commissioning
  - the existence of on-going accounting mechanisms between organisations
  - historic deficits which have been inherited, often from different organisations
  - anomalies within the existing tariff system
  - the need for appropriate payment mechanisms for non-elective care, specialist care and long-term conditions
  - the different and changing regulatory frameworks
  - differences around training, pensions, ‘additionality’\(^2\) and loss of staff.
- There is a need for organisations to understand that they will often have to be involved in multiple, simultaneous relationships with other organisations. These relationships range from competitive ones to full partnerships and need to be governed appropriately. Co-operation between different types of providers is an essential component of making the plurality agenda work for patients. For example, joint ventures across different types of organisations represent opportunities to achieve quick wins for patients.

\(^1\) Followed by the Independent Healthcare Advisory Services
\(^2\) See page 10
Underlying context

Increased independent and voluntary sector involvement in health provision must be considered in the light of a number of underlying issues:

- **The rise of patient choice** – the concept of ‘patient-led’, with its emphasis on public participation and the individualisation of health services using patient choice, is still developing but will have a major impact on the shape for future services.

- **The political environment** – increased diversity of provision, with increased freedoms, is a cornerstone of current health policy and looks set to remain so.

- **Inherent tensions in emerging policies** – the balance of providers introduces flux into the system which must be weighed against the need for continuity of care, particularly for individuals with long-term conditions.

- **The development of a mixed economy** – there are existing lessons to be learnt from many years of collaboration between the NHS and independent and voluntary providers, particularly in the fields of mental health and tertiary care. Alongside this are the lessons from long-term relationships with privately-owned primary care contractor practices such as GP, dental, pharmacy and optometric services, which have been part of the NHS since its inception in 1948.

- **Decentralisation and new local commissioning arrangements** – 85 per cent of NHS spending has now been devolved to PCTs and further devolution of commissioning responsibilities will result from the full introduction of practice-based commissioning by the end of 2006.

- **Public involvement and consultation** – there needs to be greater clarity on how to interpret Section 11 of the Health and Social Care Act 2001 which lays down requirements on NHS organisations to consult the public on the planning of care, and changes how health services are provided.

- **Transparent financial flows and greater financial freedoms** – Payment by Results will be expanded to 90 per cent of acute provision by 2008, and the development of foundation trusts has delivered new freedoms to borrow capital, sell assets and retain surpluses. The Government has given a commitment that all NHS acute and mental healthcare providers will have the opportunity to apply for foundation status by 2008.

- **Increased role of independent sector providers** – programmes such as independent sector treatment centres (ISTCs), commuter walk-in centres and alternative providers of medical services (APMS) have signalled new ways of providing and begun the building of long-term public–private partnerships in some areas.

- **Independent regulation** – the current review of regulators will signpost the future direction both for Monitor and the Healthcare Commission and their respective tariff-setting, quality and corporate governance monitoring roles.
Towards a level playing field

If it is to be sustainable, the expansion of diversity of providers must be underpinned by a series of tenets:

• **A patient-led service** – provision of a high-quality service that treats patients with dignity should be the driving force underpinning all reforms.

• **Stability** – Ministers, the Department of Health and wider regulatory bodies should provide a stable framework and clarity of direction for all organisations involved in healthcare.

• **Co-operation and collaboration** – co-operation across sectors, including through partnership working and more formal arrangements such as joint ventures, should be encouraged to flourish and prosper.

• **Long-term objectives** – apparent short-term gains which risk driving further separation between sectors should be avoided, so that NHS and independent sector confidence is maintained.

It is our belief that challenges in the management of these tenets can begin to be addressed by starting with a set of key principles in the design of services. These are detailed on the following pages.
Creating a level playing field: a fair environment for patient care

Design principles

The following principles form a framework within which a level playing field can be developed.

The provision of new services should be contestable unless there is a good reason
As new services are developed, there should be an assumption of contestability open to all types of providers, including existing NHS organisations, foundation trusts, commercial, not-for-profit and voluntary sector organisations. This should be supported by open and transparent communications at all stages of the process between commissioners and providers at both local and national levels.

The development of a level playing field will require the development of long-term relationships between service providers and commissioners – either practice-based commissioners or the PCT. There may be some exceptional areas, possibly emergency care, for example, which might be designated as 'protected' or unsuitable for competition, but this should only occur where there are good reasons, set against explicit local or national criteria.

Contestability must be tightly managed within the system
While contestability should underpin individual services, the development of pathways of care will ensure that choice, evidence-based high-quality interventions and efficiency are of equal importance for commissioners. There should be a framework, developed with local flexibility, which manages complexity and avoids fragmentation of services within a pathway. Monitoring of the impact of competition on the pathway should be part of the contract monitoring processes. However, it is also important to remember that managing risk is part of managing a range of providers – there must be opportunities to ensure that learning from existing evidence informs changes to care but does not stifle the use of contracts which encourage innovation and the fine-tuning of service delivery over time.

Commissioning must focus on patient outcomes
Strong local commissioning is essential to ensure that patient outcomes are paramount. In practice, this means particular attention needs to be channelled into ensuring:

- transparency in planning, procurement and contracting processes
- commissioning occurs at the appropriate geographical and population levels
- greater flexibility and the scope for innovation is improved by focusing on outcomes
- the administrative burden of the bidding process is streamlined and encourages providers of different sizes
- the skill set of commissioners at all levels within commissioning structures is improved through professional training and recognition
- commissioners are empowered to shape existing service provision so it is appropriate to population needs.

The contracting process must be consistent and transparent, and should encourage innovation
Contracting processes need to be streamlined across regions so that consistency and transparency is improved. In practice, this means:

- balancing quality and price by linking contracting to an independent tariff-setting mechanism
- using standard contracts at a local and regional level which incorporate clear parameters to enable greater responsiveness to respond to local variation
- allowing scope to include capacity for innovation, with an appropriate performance management regime to be used by the commissioner.

It is important we do not confuse greater transparency in the contracting process with inappropriately focused approaches which stifle innovation. Innovation is not encouraged by having competitive tendering by open bids where...
tendering parties give commissioners good ideas for innovative processes and those ideas then migrate to tender documents. This is counter-productive and discourages providers from investing in intellectual resources over price competition. Instead, transparency and competition is best ensured by commissioning by outcomes rather than processes. This approach should sustain long-term relationships.

**Local and national regulatory frameworks need to be consistent across sectors**

Strong local accountability will be necessary as diversity of provision increases. Fewer but better common regulatory standards and a streamlined common dataset should be developed for all providers. There will inevitably be some variation in governance arrangements across sectors, but the standards they assure need to be consistent. Regulation must assure safety and quality standards, improve standards of care, ensure accessibility and responsiveness of care and protect the public purse. Systems will need to be robust and transparent and able to manage the tension between quality and price and not just focus on price alone. Strategic health authorities (SHAs) have a formal role to manage markets, but PCTs' ability to manage the relationships between care providers and assure the location within which care is physically provided is essential to make the system work. Performance management should not be confused with quality regulation. The relative roles of Monitor, PCTs, the Healthcare Commission and any new independent tariff-setter and the Department of Health must be clearly defined. Value-for-money issues should be channelled through the SHAs, supported by the Audit Commission.

There should be:

- greater consistency of regulation to avoid current variations across sectors
- a common system of regulation with benchmarks of performance across sectors but with flexibility to be sensitive to differently sized providers
- clear criteria for unbundling services
- mechanisms that support and maintain universal provision with support from all providers through the NHS values
- a code of practice for advertising and promotion which balances a 'light-touch' approach for most organisations with robust measures to correct misdemeanours,
- a common streamlined dataset
- regulation based on self-declaration, governance and risk-assessment, underpinned by a manageable number of core standards
- removal of the bar to acute and foundation trusts providing community care services, balanced by measures to prevent abuse through vertical integration
- removal of the private patients cap from foundation trusts
- engagement across all providers in the training of clinical and non-clinical staff
- clear definitions of services which will be harder to open up to competition, for example emergency care
- comparable access to finance for investment and freedom to conserve assets
- clarity around levels of market dominance and vertical integration that are acceptable, especially in the context of partnership working and mergers between providers.

Entry and exit mechanisms for providers should be collaborative. There should be open and accredited market entry with a single licensing standard and a wide provider base, supported by the regulatory framework. The framework needs to be able to cope with failure, insolvency and exit, as well as entry, in a fair way. Consultation processes for entry and exit will need to be developed to support strategic commissioning decisions.
New types of co-operation and partnership should be encouraged alongside competition

To date, the policy debate around plurality has largely focused around aspects of competition to the exclusion of discussion about the benefits of co-operation between providers. As new models of provision develop where organisations extend their geographical range and the type of care they provide, co-operation becomes increasingly important to deliver patient care. Co-operation is, therefore, an intrinsic part of delivering competition.

Increased plurality will bring with it complex relationships and issues around probity, both of which must be managed within existing corporate governance systems. One model which may help in developing these systems is the use of joint venture arrangements, where organisations jointly invest and share proportionate risk.

In addition to the design principles outlined in this report which are also pre-requisites for successful partnerships and joint ventures, there needs to be:

- a clearly articulated agreement about the aims and objectives of the venture, as well as shared investment and risk
- clarity around core competencies brought by each organisation to the partnership and planned synergies
- a flexible approach to staffing, enabling free exchange of ideas across organisations, with a clear and manageable approach to the handling of shared assets
- development of a common culture between partner organisations, underpinned by a binding set of values. This brings with it a shared honesty about areas of joint concern.

Payment mechanisms must be structured fairly and be provider-neutral

Payment mechanisms must support diverse providers without unfairly advantaging one group over another. This is one of the rationales for the current tariff system: to provide what should be a straightforward pricing mechanism. The box on page 8 outlines some challenges to this goal and concludes that a payment to compensate providers for unavoidable costs needs to be fairly structured and available to all providers.

In addressing these challenges, two core principles need to be upheld. There must be a balance between pricing and quality. Standard tariffs have a number of benefits:

- reducing the need for price negotiation and its administration
- placing quality of provision rather than cost at the heart of the decision-making process
- fostering productivity by creating a direct relationship between income and outputs
- avoiding ‘loss-leader’ pricing mechanisms.

However, the impact of standard tariffs on the delivery of improved quality is less clear. A balance will need to be struck which rewards the NHS for complex cases, focuses on outputs rather than inputs and is based within an optimum pathway of care. As plans to roll out the tariff across care sectors over the next few years develop, they will also need to reflect the different drivers and timescales at work in elective, emergency, long-term conditions and tertiary and specialist care.
Creating a level playing field: a fair environment for patient care

Tariff unbundling should support patient flows and partnership working but is insufficient on its own and may not offer the kind of comprehensive solution that is expected. For long-term conditions, consideration should be given to using a risk-based capitation payment system rather than one based on individual treatment episodes. This would require the extension of the quality and outcomes framework beyond primary care. The recent *Our health, our care, our say* white paper on social care and NHS services in the community has signalled a readiness to consider the unbundling of tariff to ensure that care packages within pathways can be resourced in a way that encourages the movement of care closer to home. For independent and voluntary sector providers, this supports both joint venture concepts and the involvement of smaller niche providers in the delivery of discrete elements of the pathway in which they have specialist expertise. There is significant potential here in primary care settings.

The Market Forces Factor (MFF) is an index used in resource allocation under tariff to compensate NHS providers for unavoidable variations in costs arising from issues such as the differing costs of staff across regions, regional allowances or weightings, land, buildings and equipment. While there does need to be a proper payment that reflects unavoidable cost differences, this needs to be available to all providers of NHS services. Moreover, as currently structured, MFF takes neither capital nor local deprivation into account. It will also cause problems where there are multi-site providers in different places. In short, MFF distorts organisations’ ability to compete on the same basis.

As we move to greater plurality, an approach needs to be found which avoids these distortions. Fixed tariffs can have a negative effect on the rest of the market because things can sometimes be done cheaper than tariff.

**Why the current tariff system distorts organisations’ ability to compete on the same basis**

Although a tariff-based system is a key enabler of a mixed economy, there are arguments that the way the tariff is currently calculated challenges a level playing field by not comparing like with like.

- Established institutions with outdated physical environments argue that the cost does not reflect their infrastructure-related overheads, whereas those with modern facilities argue that their capital investment costs do not receive adequate compensation.
- Independent sector organisations operating on tariff have been awarded guaranteed volumes as part of initial contracts. However, NHS trusts do not have similar certainties.
- The NHS has a more complex case-mix as ISTCs are able to focus on relatively straightforward cases. The cost of this complex case-mix is argued to be beyond that rewarded by tariffs.
- The independent sector argues that tariffs should also reflect elements that are funded in different ways such as NPfIT, training, NHS Estates, decontamination and pensions, as well as clinical governance and performance management costs.
- VAT is treated differently across sectors, leading to a correspondingly different cost base that is not reflected by the tariff.
- There are some procedures that can be carried out to a considerably higher quality using new techniques, but the accompanying costs are beyond the scope of an average-based tariff.
- Conversely, because tariffs are based on average service costs, they do not enable commissioners to take advantage of economies of scale, discounts for volume or efficiencies that providers can make.
Plurality should not hamper integration of patient pathways
The development of patient pathways across primary, secondary and specialist care will ensure that patient choice can be reflected along with good practice in a single model of care. Patient satisfaction is important and the impact of decisions based on quality will become increasingly evident as consumers become more sophisticated in how they exercise choice. Branded and/or franchised care based on recognised quality marques will compete as boutique providers with more traditional providers within pathways, so enabling patient choices to be available but within a pathway approach. Within this context there is scope for the independent sector, foundation trusts and wider NHS providers to share expertise along patient pathways.

Shared information support will be a critical success factor
The existence of shared information support within partnerships between PCTs and independent sector providers is of great importance, not only for contract monitoring but also for the development of new service models, integrated pathways and workforce and continuity issues. This includes data and common technology standards for that information to flow. This should be incorporated into contract discussions at an early stage and is one of a series of important infrastructure issues that will improve the long-term effectiveness of new partnership arrangements.

Workforce integration is key
The greater depth and breadth in plurality will bring new challenges for management and regulation of the healthcare workforce. As a plurality of providers emerges, it follows there will be an increasingly divergent range of approaches to employment. A balance will need to be struck that avoids setting too many constraints as this will undermine innovation.

As we go through the transition of new providers entering NHS provision, areas relating to additionality and training are particularly pressing (see box on page 10).

In addressing these challenges, two-tier workforce issues must be addressed up front.

• Further work needs to be done to identify solutions which arise from the different advantages that both NHS and independent organisations accrue from current ways of working.

• At present, independent providers need not remunerate staff at the same level as Agenda for Change, nor need they offer NHS pensions except for transferees under TUPE. All elements of the independent sector need to be able to give a clear view so that solutions can be developed which are explicit about the implications for frameworks such as Agenda for Change and pension issues which need to be defined in the context of plurality.

• In addressing challenges around additionality, the system could be strengthened by enabling SHAs to manage workforce risks.

• Further work could be done to identify 'enabling flexibilities' across the employment agenda, to hone the correct balance between local freedom and national consistency. This would enable new models of care across all sectors to adopt new ways to incentivise, train, recruit and retain staff that are appropriate to their needs.

• Training must be available in all environments so that an equivalent approach can be expected from all providers. Skill-mix across providers should be part of selection so that patient choice is enabled by the development of different care models. As the range of providers increases, it is unsustainable to try to keep the vast majority of clinical training provision in one sector.

Shared information support will be a critical success factor
The existence of shared information support within partnerships between PCTs and independent sector providers is of great importance, not only for contract monitoring but also for the development of new service models, integrated pathways and workforce and continuity issues. This includes data and common technology standards for that information to flow. This should be incorporated into contract discussions at an early stage and is one of a series of important infrastructure issues that will improve the long-term effectiveness of new partnership arrangements.

Shared information support will be a critical success factor
The existence of shared information support within partnerships between PCTs and independent sector providers is of great importance, not only for contract monitoring but also for the development of new service models, integrated pathways and workforce and continuity issues. This includes data and common technology standards for that information to flow. This should be incorporated into contract discussions at an early stage and is one of a series of important infrastructure issues that will improve the long-term effectiveness of new partnership arrangements.
## Additionality

The concept of ‘additionality’ was developed to ensure increased capacity delivered by extending the provider-base was not to the detriment of existing NHS service provision through increased staff movement or spiralling pay costs. This is a powerful rationale, and should not be jeopardised without good reason. However, we should also recognise some of the barriers that the policy of additionality creates. These include that it:

- is a barrier to free labour in a system where patients but not staff have choice
- prevents further integration across the sector by maintaining the separation between the independent sector and NHS staff groups
- reduces exposure to a broad case-mix and, therefore, limits the scope for training
- restricts part-time staff who would otherwise choose to split their working patterns between independent and NHS providers
- restricts the ability of joint ventures to work across sectors.

Additionality rules have already been changed for the second wave of ISTCs to allow NHS staff to be employed where there are not staff shortages. This enables increased capacity in provision as a whole and improves integration between the NHS and the independent sector. Further strengthening of the system could be achieved by enabling SHAs to manage workforce risks.

## Training

At present, non-NHS employers benefit from a significant amount of their staff having received NHS training. There is increasing recognition from the independent sector that they should play a role in training, with some independent sector providers already engaging in this. The question now appears to be more about how and where this should be facilitated and how it should be funded rather than whether it should happen.

Welcome attempts have already been made to address this in the context of the second wave of procurement of ISTCs. This brings with it a requirement for providers to work with a broad case-mix of patients to make the range of training available clinically- and cost-effective. The approach being developed here needs to be evaluated, and lessons rolled out to other sectors of care. In practice, it may not be appropriate for this to occur evenly throughout the entire NHS and independent sector, which makes it particularly important that a clear framework with associated costs is developed that enables consistent and fair financial allocations. The current Department of Health Multi-Professional Education and Training (MPET) review needs to take account of the plurality agenda.
Conclusions

There are several key challenges to be met in the development of a level playing field which will enable providers from all sectors to provide high-quality patient care on an equal footing. It is a transitional process which will require constant review to ensure that approaches which are introduced do not themselves introduce perverse incentives or distort priorities. The design principles outlined in this report will help us begin to address these challenges.

In summary, the hallmarks of a successful, plural system working for patients will be:

- strong commissioning, with a local focus
- open and clearly accredited entry mechanisms for new providers
- a single standard of licensing
- providers from all sectors within a dynamic market
- an independent and fair payment mechanism, which balances quality and price pressures
- common regulation, working to better regulatory standards, underpinned by a meaningful and common dataset
- providers and commissioners successfully managing a variety of simultaneous multiple long-term relationships.

For further information on the NHS Confederation’s work in this area, contact graham.kendall@nhsconfed.org or visit www.nhsconfed.org
Need to know how everything in the NHS fits together?

The NHS: a pocket guide 2006-07
New edition, fully updated and now UK-wide

“A timely, authoritative and invaluable resource for those working in and with the NHS”
James Johnson, Chairman of Council, British Medical Association

To order call 0870 444 5841
or visit www.nhsconfed.org/pocketguide

Discounts available for bulk orders

ISBN 1 85947 125 0 • 2006 • 216 pages
Creating a level playing field

Since the formation of the NHS in 1948, care to NHS patients has been delivered through a diverse range of organisations. In recent years policy initiatives have increased the size and scope of new providers, with the formation of the foundation trust movement and programmes to secure acute and diagnostic care from the independent sector. These complement an existing diversity of provision in areas such as mental health, palliative and tertiary care.

Inevitably, the development of new forms of provision in a system as complex as the NHS has led to ambiguities and unintended consequences. This report maps some of the challenges faced by new and existing providers and sets out core principles to create a fair environment (a ‘level playing field’) for all organisations providing care in the new NHS. It follows a series of seminars involving representatives from across all care sectors and from all types of organisations currently providing care to NHS patients. The principles have been designed to ensure that patients’ needs are paramount, as well as ensuring that no one sector is unduly favoured over another.

Creating a level playing field: a fair environment for patient care is intended to contribute to the debate about how the full range of providers can best work together to deliver excellent patient care in the new NHS. It will prove valuable reading for those from both NHS and independent healthcare organisations, as well as policy makers and all those interested in how the UK health system works.

Further copies can be obtained from:
NHS Confederation Distribution
Tel 0870 444 5841 Fax 0870 444 5842
Email publications@nhsconfed.org
www.nhsconfed.org/publications

© NHS Confederation 2006
ISBN 1 85947 130 7

Ref: BOK56901