Cooperation and Competition Panel

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Inside the black box: How competition between hospitals improves quality and integration of services
Cooperation and Competition Panel – Working Papers

To support its work the CCP undertakes a range of in-house research, and from time to time may commission external studies, to improve its understanding of issues relevant to patient choice, cooperation and competition and their role in the NHS.

The CCP Working Paper series has been established to provide a means of publishing this work so that others with an interest in these issues can also benefit from this work.

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Rather, they are intended to serve as a reference for further thinking and to potentially inform discussions between the CCP and others when considering matters arising in our investigations.
CCP working paper 5: Inside the black box: How competition between hospitals improves the quality and integration of services

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INTRODUCTION

1. Recent economic research has shown that fixed-price quality competition in the NHS in England is benefiting patients and taxpayers. This research has focussed primarily on important outcomes of competition, for example the number of lives saved. In this paper we focus on the mechanism of competition (sometimes referred to as the ‘black box’) which has led to these higher quality outcomes.

2. This paper uses information obtained by the Co-operation and Competition Panel (CCP) in its investigations into hospital trust mergers over the period May 2011 to May 2012, to illuminate this ‘black box’. In particular, this paper highlights the types of actions taken by hospital trusts facing competition that are likely to improve the quality of the patient’s treatment as well as the patient’s experience. Competition is one of the levers that can deliver benefits for patients and taxpayers protect and promote the interests of people who use health care services.

3. This paper sets out some background information on the CCP and provides an explanation of how competition is expected to work in the NHS, behaviours one would expect to see if competition were present, and what we observe from information provided to us by NHS Trusts and NHS Foundation Trusts. This paper draws from information provided by the parties and others in the course of our merger inquiries. The strategy and board documents we reviewed covered the period 2007 to 2012. More detail on the information provided to us by hospital trusts is included in the appendices. We have not mentioned hospital trusts by name as information was provided to us in confidence.

4. The paper concludes that in each of the merger cases reviewed by the CCP in the past twelve months, we have found examples of hospital trusts responding to competitive incentives by innovating and investing to improve the quality of their services and the patient experience more generally. They have done this through investment in integration and cooperation with GPs, improved inputs and processes, better patient and GP access to services, market research and communication strategies. This paper therefore sheds some light on the causes of the relationship between competition and better outcomes that has been identified by academic researchers.
BACKGROUND

5. The CCP helps support the delivery to patients and taxpayers of the benefits of choice and competition in the NHS. It makes independent recommendations to the Department of Health and Monitor on mergers, anti-competitive conduct, failures to co-operate and other breaches of the Principles and Rules for Cooperation and Competition (Principles and Rules) involving providers of NHS funded services.¹

6. In the course of our merger reviews we assess whether the merger parties compete with one another, and, if so, whether competitive pressure would remain if the merger were to proceed.² This allows us to reach a view on whether the merger is likely to reduce patient choice and competition and thereby lead to a deterioration in the quality of healthcare services for patients.³ In such a case we go on to assess the benefits to patients and taxpayers of the transaction proceeding and weigh these against the costs to choice and competition identified.

7. In undertaking our assessments we are often presented with evidence that shows a provider under competitive pressure from another trust (or facing a competitive opportunity) responding to that pressure by taking action to improve its service. This evidence is often taken from strategy papers provided by the merger parties, or provided to us by other trusts in the course of our inquiry.

8. This paper reviews this evidence and what it tells us about how providers react when they face competitive pressure. It is not an exhaustive, nor necessarily representative, assessment of how hospital trusts respond to competition, but does illustrate some of the actions that trusts take in response to competitive incentives.

COMPETITION IN THE NATIONAL HEALTH SERVICE

9. Recent reforms to the provision of health services in England have emphasised patient choice and competition as key drivers to improve efficiency and outcomes for patients. A patient’s right to choose is enshrined in the NHS Constitution. Patients’ ability to choose between providers for routine elective treatment is underpinned by a number of systems. 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;

¹ http://www.ccpanel.org.uk/content/Principles_and_Rules_REVISED5.pdf
² Our analysis of the competitive effects of a merger is aligned with that of the Office of Fair Trading and Competition Commission.
³ Decisions to authorise mergers may result in a deterioration in quality of services, see for example the research into the effects of mergers in the NHS: ‘Process and impact of mergers of NHS Trusts’ Fulop et al, BMJ, 2002; and ‘Merger Mania and Hospital Outcomes in the English NHS’ Gaynor, Laudicella, and Propper, 2011. The role of the CCP in relation to mergers is to advise the Secretary of State on whether a loss of choice and competition is likely to lead to a deterioration in the quality of healthcare services. The CCP does not provide advice on whether other risks of the merger will lead to deterioration in the quality of healthcare services (for example, loss of management focus). This advice is currently provided by SHAs.
• *Payment by Results*, which remunerates providers for routine elective care according to patient treatment volumes through a framework of fixed tariffs covering a range of procedures; and

• *NHS Choices*, which provides performance information on each provider to assist patients in selecting their preferred provider.

10. GPs act as gatekeepers who assess the needs of patients and make referrals to secondary care for those patients who cannot be treated by primary care clinicians. The system allows all patients to choose the provider of their first outpatient appointment. Patients choose between NHS trusts (including NHS Foundation Trusts) as well as nationally-contracted independent sector providers of routine elective care.

11. According to the NHS Operating Framework, hospital trusts are expected to plan and deliver an operating surplus. NHS Foundation Trusts can keep and reinvest their surplus revenue. All NHS Trusts and NHS Foundation Trusts are expected to at least earn enough revenue to meet their costs. Revenue is earned from their commissioner either by attracting patient referrals and the associated national tariff payment, or by winning contracts to provide services that are not covered by national tariffs.

12. Hospital trusts therefore have an incentive to compete with other providers of NHS funded hospital services to attract patient referrals and win contracts. They can respond to competitive incentives by attempting to counteract an action by another provider, or by pre-emptively taking action themselves.

13. Those hospital trusts that provide poor services and lose patients or do not win contracts risk becoming financially unviable. While no hospital trust has been allowed to fail, poor financial performance has consequences and may ultimately mean that a hospital trust is acquired by a more successful provider or downgraded to become an outpatient hospital.

14. Given that *Payment by Results* prices for elective care are fixed, hospital trusts must differentiate themselves on the basis of quality. In this environment, hospital trusts could be expected to ‘become more responsive to patients’ needs, stimulating innovation, improvements in the quality of care and increases in productivity’. They could also be expected to undertake market research to gain a better understanding of their customer, what their competitors may be doing, as well as to communicate proactively improvements in their services.

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4 The Health and Social Care Act 2003 introduces a failure regime for NHS foundation trusts based on ‘de-authorisation’. To date the Department of Health and Monitor have employed a variety of strategies in relation to failing hospitals (eg turnaround teams, financial support, acquisition by foundation trusts, acquisition by NHS trust, and franchise to non-NHS provider amongst others). The regime provides for intervention before service failure. In other industries intervention typically occurs when an organisation files for bankruptcy, or goes into administration. In the NHS the Department of Health or Monitor are able to intervene earlier in the process before the financial failure leads the trust to breach CQC standards.

5 Department of Health, Liberating the NHS: Regulating Healthcare, July 2010, paragraph 6.1
RECENT ECONOMIC RESEARCH

15. Recent economic research has shown that fixed-price quality competition in the NHS in England is improving outcomes for patients and taxpayers. There is evidence that patients are responding to choice and competition. Patient awareness of their ability to choose their provider is relatively high at 54%, and there is scope for this to increase.⁶ 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 provider of NHS hospital services and that the quality of care offered by a provider is a significant factor in explaining patients’ choice.⁷ There is also evidence of patients responding to adverse patient safety events when these occur at their local hospital by choosing to be treated elsewhere in the following months.

16. Recent economic research has also shown that choice and fixed-price quality competition is benefiting patients and taxpayers.⁸ A number of recent studies have found that higher levels of competition in the provision of routine elective care have 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 have led to improvements in clinical performance.

17. The analytical approaches used in this research are widely accepted by economists as good practice. However, some commentators have said that the research does not prove that competition has led to these improvements, just that increased competition is associated with better quality outcomes for patients. This paper sheds some light on the causes of this relationship by setting out some of the ways in which hospital trusts have responded to competitive incentives by innovating and investing to improve the quality and integration of their services. It may therefore increase the confidence that can be placed in the results obtained by empirical research.

⁷ Beckert, W., Christensen, M. and Collyer K. “Choice of NHS-funded hospital services in England” The Economic Journal, 122 (May), 400–417
WHAT DO WE OBSERVE?

18. Between May 2011 and May 2012, the CCP reviewed 8 acute trust mergers. In each case, we concluded that both of the merging providers competed with at least one rival, and usually more than one, to attract referrals.

19. The competitive responses that we observed were directed towards ‘customers’ (as many of the NHS Trusts and NHS Foundation Trusts refer to them) – that is users of the service, and referrers into the service, not just the funders of the service (see Box 1 for some examples of this).9 We observe hospital trusts competing to be the provider of choice for each of the following groups:

- patients,
- GPs,
- consultants, and
- commissioners.

Box 1: Who is the customer?

One hospital trust [3×] explained that in the context of the provision of healthcare services, it is important that the concept of the customer is not limited to simply the funders of the particular service but includes all those individuals and organisations involved in the decision making process. These include: patients and their families and carers; GPs; commissioning consortia; PCTs; specialist commissioners; and district general hospitals.

Similarly another hospital trust [3×] explained that it ‘sells’ services to several types of customers:

- Patients and the general public who choose their healthcare provider;
- GPs who refer patients to the trust and may influence patient choice, and who also receive imaging and pathology services from the trust; and
- GP Practice based commissioners and PCT commissioners.

Competing to be the provider chosen by the patient

20. Hospital trusts10 have an incentive to invest in aspects of the service that are important to patients. This is because it is the patient who receives the healthcare services provided by the hospital and it is therefore the patient who has the biggest incentive to select a hospital that provides the best

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9 The different identities of the ‘customer’ create a principal-agent distinction since the patient (the principal) is often represented by an agent (their GP or their consultant) who advises or makes a choice on their behalf. This means there is scope for the incentives of the agent to differ from those of the patient. This can have an impact on the providers’ incentives to invest in different aspects of their service.

10 In this paper references to hospital trusts should be understood to refer to NHS Foundation Trusts and/or NHS Trusts.
service for them. The more information available to the patient (including advice from their GP), the greater the ability of the patient to make an informed decision that reflects their own personal balance of priorities (for example, convenience of accessing the hospital, survival rates, infection rates, facilities, quality of nursing).

21. The evidence reviewed suggests that providers understand that the outcomes and the reputation of the trust are communicated to patients by word of mouth (based on the experiences of patients, GPs, and staff), by the local and national media, by national regulators (CQC, Monitor), and by websites (NHS Choices, Dr. Foster, Patient Opinion). Hospital trusts that want to attract more referrals will therefore have an incentive to innovate and invest in the aspects of the hospital’s performance that matter to the patient.

**Competing to be the provider chosen by the GP**

22. Hospital trusts have an incentive to invest in aspects of the service that are important to GPs. This is because the role of the GP is often pivotal for those patients who are referred to hospital (rather than arriving in accident and emergency). The GP is the gatekeeper to hospital services. The GP assesses the patient and decides whether referral to hospital is necessary. If the GP decides that a referral to hospital is necessary then the GP will refer the patient to the hospital that the patient chooses.

23. Our research has shown that a GP’s previous referral decisions are important in predicting which hospital a patient will be treated at.\(^{11}\) This is consistent with research from the Kings Fund that finds that while most patients who choose their provider rely on the experiences they and their family and friends have had at the hospital, approximately 36 per cent of patients used advice from their GP to choose a hospital.\(^{12}\) Moreover despite having a right to choose their hospital, approximately 50 per cent of patients do not recall being offered a choice by their GP.\(^{13}\) This suggests that in many cases the GP chooses a provider for the patient without giving the patient the opportunity to choose.

24. GPs therefore have a key role in influencing the hospital where patients choose to receive treatment. Hospital trusts that want to attract more referrals will therefore have an incentive to innovate and invest in the aspects of the hospital’s performance that matter to the GP.

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\(^{11}\) Beckert, W., Christensen, M. And Collyer, K (2011), 'Choice of NHS-funded hospital services in England', Economic Journal, 122 (May) pp400-417

\(^{12}\) Dixon et al. Patient choice: how patients choose and how providers respond. London: The King’s Fund, 2010

\(^{13}\) Dixon et al also found that GPs often think that they know which patients want to choose a hospital and which ones do not. However, the research showed that these assumptions were often incorrect. The research also showed that patients in patients living outside urban centres were more likely to be offered a choice.
Competing to be the provider chosen by the referring consultant

25. Hospital trusts have an incentive to invest in aspects of the service that are important to consultants at other hospitals. If a patient needs a referral for further specialist care after being seen at a hospital (a tertiary referral) then the decision as to which hospital to refer them to is made by their consultant. Within a teaching hospital this may simply be an internal referral to a different consultant within the same hospital. However, patients in district general hospitals who require more specialist treatment will need to be referred to a different hospital. While the referring consultant can discuss their choice of provider with the patient, the patient does not have a right to choose a provider.

26. The referring consultant therefore has a key role in deciding which hospital trust provides more specialist treatment where it is required. Hospital trusts that want to attract more referrals will therefore have an incentive to innovate and invest in the aspects of the hospital’s performance that matter to the referring consultant.

Competing to be the provider chosen by the commissioner

27. Hospital trusts have an incentive to invest in aspects of the service that are important to commissioners. This is because commissioners pay for the services that hospitals provide to patients using taxpayer funds. Where patients and their clinicians are able to choose which hospital treats the patient, the commissioner is prevented from incentivising that decision by the existence of a mandatory fixed tariff for each procedure. However, in some services, for example accident and emergency, patients do not generally choose between hospitals due to the urgency of the treatment. In these services the commissioner chooses (or designates) a provider on behalf of the patient and gives a contract to its chosen hospital trust to provide the service.

28. The commissioner therefore has a key role in deciding which hospital trust provides services such as, for example, accident and emergency. Hospital trusts that want to retain their accident and emergency department will therefore have an incentive to innovate and invest in the aspects of the hospital’s performance that matter to the commissioner.

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14. Teaching hospitals provide both routine and more specialist services. Their specialist services receive referrals from consultants in non-specialist hospitals which are referred to as tertiary referrals because they are made by a secondary care provider (as opposed to secondary referrals that are made by a primary healthcare provider, e.g. a GP).

15. However, note that there are some instances in which these tariffs are not followed by local commissioners at present (see for example the CCP report into the Operation of ‘any willing provider’ for the provision of routine elective care under ‘free choice’ [http://www.ccp.Panel.org.uk/cases/Operation_of_any_willing_provider_for_the_provision_of_routine_elective_care_under_free_choice.html]). This can distort competition by reducing the incentive of providers to invest in improving services in order to attract referrals and can thereby adversely affect patients and taxpayers.

16. In other cases commissioners might select a small number of providers to provide high fixed cost and low volume services. Patients and referring clinicians are then able to choose between these providers but the commissioner has a key role in designating (on behalf of the patient) the set of providers from which they can choose. For example commissioners have recently designated a small number of providers of paediatric heart surgery.
EVIDENCE OF COMPETITIVE INTERACTIONS IN THE NHS

29. In the section that follows we set out the types of responses to competitive pressure that we have observed from the 8 hospital trust merger cases the CCP has reviewed over the past twelve months. Some of these responses were at the planning stage whilst others had already occurred. We have excluded aspirations to improve outcomes that did not explain how they would be achieved. We also draw out how each of these responses reflects the incentives that the providers face.

30. We have observed that the main response to competitive pressure has been investment to deliver quality improvements and to communicate this to the customer groups identified above. Investment has fallen into four broad categories and has generally been funded by the provider through a reinvestment of their existing income streams rather than additional support payments from the taxpayer. Investment has been in:

- improving integration and cooperation (for example, better/faster discharge summaries);
- improving an input or process (for example, staff, facilities, infection control processes);
- improving access to services (for example, outpatient clinics); and
- market research and communication.

INVESTMENT IN IMPROVING INTEGRATION AND COOPERATION

31. In this section we summarise the types of investments that trusts have made in improving integration or cooperation in response to perceived competitive pressure. The trusts generally expected that the improvement would impact upon the quality of the service that they provided and so, if communicated, would attract additional referrals that would improve the financial performance of the trust. Actions included the following (more detailed case studies are at Attachment A):

- A proactive GP engagement strategy that includes a specialist primary care facilitator, practice visits, educational sessions to increase trust visibility, regular newsletters, information on ‘who’s who’ in the trust circulated to GPs, or networking events.
- Introducing process improvements such as better discharge summaries, improved x-ray waiting times or electronic x-ray results.
- Locating staff such as phlebotomists in GP practices to reduce waiting times.
- Aligning services to practices, for example allocating named midwives to each GP practice.
- Cooperating to move services into community settings.
- Increased engagement and cooperation in designing integrated care pathways.

17 Under a command and control model hospitals will from time to time be granted central funding to renew their estate and equipment. Within a competitive model the same is true, however a provider may have the additional ability to invest earlier, or to invest a greater sum if it is able to reduce its costs and build up a surplus with which to supplement its investments. This additional investment therefore does not come from the taxpayer but from productivity gains. The investment made by a competitive provider can therefore be over and above that which would otherwise be made.
32. The strategy papers we reviewed expressly acknowledged the competition that the trust was facing, the opportunities that it presented, and consequences should they not respond. An example is in Box 2.

**Box 2: Example: integrating care**

One hospital trust (>) identified that it faced a threat of competitors taking some of what it considered to be its “core service” contracts. To mitigate this risk it planned to use market intelligence to understand better the nature of this threat and to concentrate on providing a high quality service. For example it noted that a neighbouring rival hospital trust was integrating community services into its hospital based services. The hospital trust’s competitive response was to invest in creating an integrated care plan and to work with local GP commissioners to design integrated service pathways. The hospital trust identified that building upon its strong relationship with local GPs was an opportunity for it. It explained that these GPs considered that clinical quality at the hospital trust was high, however it identified there was some dissatisfaction with its weak administrative support processes. It therefore considered that it needed to improve its IT system, its patient administration (discharge summaries) and its communications.

**INVESTMENT IN IMPROVING AN INPUT OR PROCESS**

33. In this section we summarise the types of investments that hospital trusts have made in improving either an input or a process within the service in response to perceived competitive pressure. The hospital trusts generally expected that the improvement in the input or the process would impact upon the quality of the service that they provided and so, if communicated, would attract additional referrals that would improve the financial performance of the hospital trust. Actions included the following (more detailed case studies are at Attachment B):

- reduce waiting times;
- modernise the estate or new infrastructure or equipment;
- increase capacity utilisation rates;
- improve infection control processes to attract referrals;
- increase staff numbers, for example, more midwives, to support increased quality care; and
- improve achievement against indicators that measure quality of performance, such as infection control, mortality, in-patient satisfaction survey targets), and communicate the success.

34. We have also seen examples of cases in which hospital trusts have sought to highlight to commissioners the weaknesses in the quality of service provision at other hospital trusts, in the hope of encouraging commissioners to consolidate activity in these services by switching activity to their hospital.
35. Whilst it is the case that many of these investments could have been made without competition, the documents reviewed suggest that the additional pressure of competition appears to have improved the business case to support the investment to improve the quality of care that is provided. An example is in Box 3.

**Box 3: Investment in capacity**

One trust [△] identified that there was a risk that insufficient support capacity for clinical developments could lead to a weakness in clinical service delivery and that in that scenario it considered that activity and hence income might be lost. It had therefore developed a mitigation strategy that included increasing investment in its support capacity, for example, capital investment to upgrade the estate and its utility infrastructure, investing more in imaging technology, and expanding its critical care facilities.

The trust noted that having the latest and best treatments gave it a competitive advantage. It therefore intended to recruit research orientated medical staff and make capital investments in equipment in order to take advantage of clinical technical advances. It considered that by investing capital in upgrading its hospital and in new clinical equipment it could expand its market share.

**INVESTMENT IN IMPROVED ACCESS TO SERVICES**

36. In this section we summarise the types of investments that hospital trusts have made in improving access to services in response to perceived competitive pressure. The hospital trusts expected that improving access and increasing the convenience of their service would attract additional referrals to their services. Actions included the following (more detailed case studies are at Attachment C):

- Increasing the number and frequency of community clinics, outpatient clinics and satellite service provision to provide services in better locations for patients.
- Maintaining outpatient departments at community and smaller hospitals in order that the first outpatient appointment (that often leads to an elective hospital admission) is in a convenient location.
- Increasing opening hours for services.
- Giving GPs access to diagnostics and electronic communication of results.
- Introducing shuttle buses between sites.
- Introducing directly bookable services for GPs.

37. In these examples the existence of competitive pressure appears to have strengthened the business case for maintaining (or opening new) local services (see Box 4). Conversely without competition the
financial incentive of providers is to reduce costs, for example this might involve closing smaller hospitals, community hospitals, and outpatient clinics and consolidating services at a single site. Mergers that reduce competition may therefore increase the risk that high quality local services will be closed.

**Box 4: Example: Preserving and enhancing local services**

One hospital trust [\>] noted that given the large number of local hospitals in its region, choice was becoming increasingly important. It decided that it needed to measure its patients’ perception of its performance on key choice factors, raise its performance and communicate these improvements through marketing. It found that location remained the most important choice factor nationally and said that this would have implications for the mix of services that it provided at its smaller second hospital site.

An independent sector provider of NHS services [\>] told us it had recently invested in building and opening a new outpatient clinic 10 miles away from its hospital site to improve accessibility for patients in that area. Its rationale for this additional investment was that it would increase the number of referrals that it received from the area.

Another hospital trust [\>] noted that in parts of its catchment area, its referrals were already ‘secure’ (by which it meant patients were not at risk of switching to a rival hospital trust) and so it considered that providing additional local clinics in these locations would not be worthwhile. In contrast a different trust [\>] said that in order to mitigate the threat of another trust providing outpatient services from [\>] community hospital the trust had bid for and won the contract to provide services from the hospital. The trust noted that this had allowed it to offer its services to the patients located in [\>] and [\>] who may previously have chosen [\>] hospital which is part of a rival trust.

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18 We note that access may necessarily be reduced if commissioners decide to consolidate services in order to increase patient safety; however this is distinct from providers deciding to reduce access in order to reduce their costs.
INVESTMENT IN MARKET RESEARCH AND COMMUNICATIONS

38. The above paragraphs have focussed on the action hospital trusts have taken to improve different aspects of quality. In addition to this, we have also seen significant work by hospital trusts both to identify which aspects of their services customers care about most or would like to see improved, and then to communicate their strength or performance improvement in these areas. In this section we summarise the types of investments that hospital trusts have made in market research and communication in response to perceived competitive pressure. The hospital trusts expected that these investments would help them to attract additional referrals to their services or win additional contracts from commissioners. Actions included the following (more detailed case studies are at Attachment D):

- Conducting customer surveys and market research.
- Developing a clear communication plan to highlight the quality of services provided, for example to highlight successful initiatives to deliver more integrated care through the use of multi-disciplinary teams to highlight good results against key performance indicators.

39. Many of the documents that we reviewed show a hospital trust identifying an opportunity to compete to expand its volume at the expense of a rival with a lower quality service. The opportunity to win additional volume was based on the higher quality service the hospital trust provided, however the hospital trust also recognised the need to communicate the quality of the service in order to win the additional volume. Box 6 provides an example of where a hospital trust credited its strategy of communicating its high quality outcomes with an increase in patient income.¹⁹

¹⁹ It should be noted that communication of improvements to patients, GPs and others relies on the improvement having been achieved. Communication that is misleading would be a breach of the Principle and Rules, amongst other things.
CONCLUSIONS

40. Recent economic research has shown that fixed-price quality competition in the NHS in England is improving outcomes for patients and taxpayers. This paper illustrates how these improvements are likely to have been achieved by undertaking a qualitative assessment of the competitive strategies that hospitals employ when responding to the incentives that the system has created for them. These strategies may not always be successful, and the type of strategy may vary across providers. However in all the merger cases reviewed by the CCP in the past twelve months, we have seen examples of hospital trusts responding to incentives by innovating and investing in strategies that they expect to improve the quality and integration of their services.

41. This competition for referrals and commissioner contracts has focussed on the customers for those services – essentially on improving the quality of services for patients, GPs, consultants and commissioners. Hospital trusts have responded to customer and market surveys by investing in better integration of services, processes and infrastructure, customer access and communication. They have responded to both the threat of a competitor, actual loss of market share and to opportunities presented by the perceived weaknesses in a competitor’s service offering.

42. Whilst we have not directly measured the impact of these changes, we are encouraged that hospital trusts have actively responded to competitive pressure by focusing on what matters to patients, commissioners and referring clinicians. In the documentation provided to us, hospital trusts have recognised that they need to innovate and improve to attract income, and that such improvements must be sustained over time.
**INVESTMENT IN INTEGRATION AND COOPERATION**

1. This attachment provides examples of cases where we found that a hospital trust responded to a risk that the ‘customer’ would select a rival provider instead of it, by an investment in improving some aspect of their process for interacting with other providers.

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<th>Opportunity/threat</th>
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| To compete for GP referrals.                                                       | Developed a GP engagement strategy to ensure that the hospital trust retained the loyalty of those GPs that refer to it and to engage with GPs in its wider catchment area where it had identified growth opportunities. The strategy included:  
  ● undertaking a programme of visits to GP practices;  
  ● ensuring that clinical links such as educational sessions are established to enhance the hospital trust’s visibility; and  
  ● identifying any clinical services where market share is at risk which requires immediate action.  
  Outcomes from implementing the strategy included:  
  ● improved quality of its discharge summaries (which improve the integration of primary and secondary care);  
  ● improved waiting times for X-ray reports since the hospital trust responded to complaints by introducing electronic pathology links that allow GPs to review results within 24 hours; and  
  ● the offer of free phlebotomists in large GP practices to reduce waiting times. |
| Responding to a range of competitors, especially teaching hospitals, other providers that have no CQC concerns and NHS Foundation Trusts. Recognised that some rivals are stronger competitors on particular specialities in terms of their reputation with local clinicians, patients and commissioners. | Hospital trust reported that it had transformed GP perceptions of it by engaging with GPs and significantly improving clinical quality. Actions included:  
  ● appointing a primary care facilitator whose role includes building contacts with local GPs and informing them about the hospital trust’s services and performance;  
  ● bimonthly electronic newsletter (providing information on referral protocols and service developments) to GPs in catchment area;  
  ● creation of pathology pigeon holes in which letters and information for each GP practice are attached to the results of pathology samples;  
  ● the creation of a database of GP practices in the hospital trust’s key referral areas; |
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<td>Increase revenue through attracting more expectant mothers to choose its service and increase deliveries in its hospitals at the expense of other neighbouring hospitals (both within its own PCT and in neighbouring areas).</td>
<td>As a first step the hospital trust gathered information on the needs and preferences of people in these areas through discussions with GPs and patients. Following discussions, the hospital trust decided that aligning its midwives to specific GP practices would improve the service and meet the demands that it had identified. It hoped to strengthen and increase its market share from each GP practice as a result of this strategy.</td>
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<td>Competitors taking some of what the hospital trust considered to be its “core service” contracts.</td>
<td>To mitigate this risk the hospital trust planned to use market intelligence to understand better the nature of the threat and to concentrate on providing a high quality service. For example it noted that a neighbouring hospital trust was integrating community services into its hospital based services. The hospital trust’s response was to create an integrated care plan and to work with local GP commissioners to design integrated service pathways. The hospital trust identified an opportunity to build upon its strong relationship with local GPs. It explained that these GPs were clear that clinical quality at the hospital trust was high. However it identified there was some dissatisfaction with its weak administrative support processes. Its response was to improve its IT system, its patient administration and its communications.</td>
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<td>National Tariffs and NHS Foundation Trust status provided an incentive to deliver cost effective services and create surplus to reinvest in the latest developments in patient care. Wanted to increase revenue.</td>
<td>The hospital trust identified that it needed to maintain its reputation and its low costs and improve its services. It also identified that improving access by delivering care in the community and reducing waiting times would enhance its reputation with GPs and patients. It also sought to mitigate the risk of losing activity by ensuring it had a healthy relationship with commissioners, and engaged with them in all aspects of pathway redesign with primary care.</td>
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| Increasingly competitive market and needed to increase referrals. Trust estimated it was losing around £4-5million a year in revenue as a result of referrals that had been switched away from it and were now being sent to tertiary centres outside the area. | The trust planned to focus on win back lost referrals and develop new referral bases through the following actions.  
- Being more responsive to the requirements of referrers and commissioners, improving access times and patient transfers.  
- Providing timely and accurate information for those referring patients as well as the relevant GPs. This would include not only details on specific patients but also more general information about the services on offer in the trust.  
- Forming strategic alliances, establishing joint consultant appointments and outpatient clinics in other trusts, developing shared care protocols and implementing joint on-call rota networks. |
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| • Providing reassurance that secondary care services in other trusts are not under threat and seeking to enhance their secondary referral base with resources and services that the Trust had to offer.  
• Undertaking market research studies to investigate actual and perceived barriers to referrals to the trust.  
• Focusing on understanding the needs of patients and GPs, improving communications and relationships. | The hospital trust focused on (a) improving its relationship with nearby GP practices with low referral rates to the Hospital, (b) appealing to disaffected GPs in the catchment area of rival hospitals that were distracted by mergers; (c) areas at the periphery of its catchment area where it considered there was scope to expand its market share on a specific service line (e.g., maternity).  
The hospital trust analysed data on the referral patterns of GPs in neighbouring areas as well as those in their catchment area that had less than 80 per cent referral rates. It set out a plan to explore the reasons these GPs had for referring or not referring to the trust. It noted that the key factors that influenced a GP referral were:  
• waiting times,  
• the distance to the hospital,  
• the GP’s “old boy network”,  
• cultural factors, and  
• patient choices.  
The hospital trust noted that its short waiting times, discharge summary documents and advice lines might be useful benefits to patients and GPs. |

Source: Table compiled from information in documents collected by the Cooperation and Competition Panel.
INVESTMENT IN IMPROVING AN INPUT OR PROCESS

2. This attachment provides examples where the providers’ response to perceived competitive pressure was to invest in improving either an input or a process within the service. The hospital trust expected that the improvement in the input or the process would impact upon the quality of the service that they provided and so, if communicated, would attract additional referrals that improve the financial performance of the hospital trust.

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<td>Competitors with overlapping catchment areas that created both opportunities and threats to hospital trust’s existing market shares. Noted that much of the decision making process rests with the GP and described concerns that the quality of competitors’ services may be perceived to be better than its own because of a more modern estate at other hospital trusts and historic perceptions of service quality at the trust.</td>
<td>The trust identified that customers in periphery areas have low attachment to particular services and can chose to use a different service easily based on perception, reputation and customer care factors. The hospital trust concluded that it must: • show product differentiation to competitors in terms of outcomes and quality; and • ensure that its key audience is aware of these factors. It noted that it had not been strong enough to do this in the past but reported that its current services had demonstrably improved in key quality measures (infection control, mortality, inpatient satisfaction survey) and the hospital trust was now in a position to communicate its high quality product to GPs, patients, and the public. It set itself a number of targets to measure its success, including: • increasing its market share in its two local PCTs by 1.5 per cent over the next year; • improving the recommendation rate that it receives on NHS choices; • increasing the hospital trust’s income by £0.5 million; • increasing its market share in peripheral areas from 2 per cent to 3 per cent; and • increasing the proportion of staff that recommend the hospital trust as a place to be treated.</td>
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<td>Erosion of GP referrals had occurred in the past which the trust attributed to its historical under-performance. Impact of uncertainty created by competition amounting to nearly 40 per cent of the hospital trust’s forecast surplus and approximately 3 per cent of its elective income.</td>
<td>The hospital trust concluded that it could gain £3 million from “competition” if it was successful in regaining GP referrals by: • achieving the 18 week waiting time target; and. • improving CQC ratings and waiting times The hospital trust explained that since the erosion of referrals had occurred the trust had</td>
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### Opportunity/threat

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<td>Increased competitive activity by other NHS hospitals or the private sector for elective services threatened to reduce the contribution to overheads and indirect costs by £4 million.</td>
<td>improved its performance and was close to being compliant with the 18 week waiting time target while it expected that its CQC rating was to be improved on previous years. 20</td>
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| To attract additional patients and income to the hospital trust as well as take referrals from local rival providers that had either experienced difficulties with their services, or were at capacity. | The hospital trust responded by:  
- planning to invest £3.5 million in using an existing building to create a new elective orthopaedic centre which it expected would improve the efficiency, quality and image of its services (the business plan anticipates a contribution to overheads of 20 percent) rather than rationalising the estate by selling the building; and  
- using outpatient clinics as an effective way to attract referrals and research into demographic trends that pointed towards growing demand. |
| The hospital trust calculated the profit it would earn by increasing market share by 1 per cent of a specialist service that was commissioned by a regional specialist commissioning group.  
The hospital trust provided 41 per cent of scoliosis treatments with another 10 per cent of procedures provided by rivals who do less than 12 procedures per year. | The hospital trust described its intention to highlight to commissioners that the rival services did not have sufficient levels of activity and that this created a clinical governance issue. It wanted to use its higher quality service as leverage to win this additional 10% of activity from commissioners. |
| Patient choice – the hospital trust identified the importance of infection rates to patients when exercising choice. | The hospital trust was investing to continue its success in reducing hospital acquired infections through:  
- an infection control team with a lead nurse and full time administrative support;  
- one ICN (infection control nurse) linked to each division within the hospital trust, and  
- the infection control team being involved in all building plans and refurbishments that take place at the hospital trust.  
The hospital trust attributes its major decrease in C-Dif and MRSA to a combination of strategies, including changing to a chlorine based cleaning product (except in the neo-natal unit), changing the antibiotics recommended for patients over 65; a policy requiring that... |

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20 Example illustrates that the number of GP referrals that the trust attracted changed in response to the quality of the service, and that the underperformance of the service damaged the financial position of the trust and led to the trust improving its service offering. Notably the improvement in the quality of service was enjoyed by all of the trust’s patients and referring GPs, not only the ones that switched provider when quality decreased. This could explain why research has shown that choice has not increased health inequalities in the way that was expected by those who mistakenly claim that choice inevitably leads to worse care in more deprived areas. This inverse care proposition is based on the funding formula rather than patients’ ability to choose between taxpayer funded healthcare providers (Richard Cookson and Mauro Laudicella. Effects of health reform on health care inequalities. 2011. Final report to the NIHR SDO Programme and the DH Health Reform Evaluation Programme. Also Richard Cookson, Mauro Laudicella, Paulo Li Donni. Does hospital competition harm equity? Evidence from the English National Health Service. CHE Research Paper 66, York: University of York, 2011 available at www.york.ac.uk/che/publications/in-house)
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<td>any use of IV cannulae be a prescribed event that is audited weekly on all wards; increased training of staff; the introduction of needle free bungs; MRSA screening; weekly hand hygiene audits; and a permanent deep clean team that rotates through the wards.</td>
<td>The hospital trust noted that research shows that easy convenient access to services is a key factor in the choice of service provider. The hospital trust invested in improving patient access to services as an important differentiating feature, for example.   * Diagnostic services were opened on Saturdays.  * Extended working day offered on imaging, MRI, CT, and ultrasound at its main site.  * Plans to further extend opening hours for outpatient clinics and diagnostics in order to make services more easily available for patients with daytime commitments.  * Plans to launch three sessions per day (instead of the more standard two sessions per day) in order to reduce waiting times.</td>
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<td>The hospital trust noted that research shows that easy convenient access to services is a key factor in the choice of service provider.</td>
<td>Increase income through patients choosing the hospital trust. It considered that progress on reducing waiting times would enhance the trust’s income. It also considered that hospital acquired infections represented a threat to the perception of the trust’s services and therefore constituted a threat to the trust’s income. The hospital trust had responded by:  * Implementing a detailed infection control plan and planned investment in developing new approaches to infection reduction, including enhanced screening services and better antibiotic management.  * noting that if it’s comparatively low waiting times were successfully communicated to patients this could lead to growth in elected activity of 1.5 per cent while working towards the introduction of a no wait service in which the only delay for patients would be through their own personal choice.</td>
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<td>The hospital trust noted that research shows that easy convenient access to services is a key factor in the choice of service provider.</td>
<td>Increase the profitability of its maternity department. The hospital trust decided to reinvest its surplus in recruiting additional midwives to improve its maternity services.</td>
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<td>The hospital trust noted that research shows that easy convenient access to services is a key factor in the choice of service provider.</td>
<td>Risk that insufficient support capacity for clinical developments could lead to weaknesses in clinical service delivery with the impact of reducing the hospital trust’s activity and income. The hospital trust developed a mitigation strategy that included:  * increasing capital investment to upgrade the estate and its utility infrastructure;  * investing more in imaging technology; and  * expanding its critical care facilities.</td>
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<td>The hospital trust noted that research shows that easy convenient access to services is a key factor in the choice of service provider.</td>
<td>Expand market share. The hospital trust noted that having the latest and best treatments gave it a competitive advantage. It therefore intended to:  * recruit research orientated medical staff; and  * make capital investments in equipment to gain access to clinical technical advances.</td>
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<td>The hospital trust noted that research shows that easy convenient access to services is a key factor in the choice of service provider.</td>
<td>Expand market share in the provision of a service that was worth £8.2 million. The hospital trust currently conducts 60 per cent of that activity. The hospital trust decided to invest a further £550,000 in capital expenditure to further develop its specialist ward and increase its chances of winning additional activity.</td>
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| To protect its existing regional referral base and develop new referral sources. Hospital trust sought to expand its catchment area from 1.6 million to 2.6 million, and to increase revenue from £35 million to £97 million. | Developed a marketing plan for its specialist cardiac service and innovated its service offering.  
- Reviewed the quality of the service and its responsiveness and communications with decision makers (patients, GPs and consultant cardiologists in district general hospitals).  
- It mapped its relationships with district general hospitals in the region to identify how comprehensive its existing relationships were, and identified two target customers (both district general hospitals) with whom it hoped to build a relationship  
- It looked at the revenue loss from losing one of its key customers (£3m) and the revenue gain from winning a different one (£9m).  
- The hospital trust identified the different key requirements of its customers (referring consultants, referring GPs, patients, and commissioners), for example it noted that referring consultants at district general hospitals will look at the standards of its competitors, the availability of ‘in-reach’ sessions, and the offer of ‘out-reach’ clinics. Similarly GPs want rapid access and will also compare the standard of service to those of competitors.  
- The hospital trust also targeted GPs in areas linked to competitors in order to circumvent the role of the district general hospital consultants in those areas (to obtain direct referrals from GPs in the area rather than referrals through the consultants in the local hospital). |
| Increase referrals. | The hospital trust sought to attract referrals from consultants in district general hospitals disseminating new technological products to the district general hospitals that refer specialist cases to the trust. For example it identified angiograms and angioplasty within cardiac services as an example in which the technology was introduced first at the specialist centre before being disseminated to other non-specialist providers. |
| Regain lost referrals. | Hospital trust noted that it had lost referrals from a district general hospital some years ago and had recently regained them by establishing:  
- a streamlined process,  
- one-stop clinics, and  
- fast track referrals.  
The hospital trust identified that the referrals from another district general hospital could be lost to a rival if it deferred the investment required to maintain the quality of its service. For example it noted that a 25 year old ultrasound machine needed to be replaced to... |
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<td>opportunity to change referral patterns. Patterns reflected the historic development of services, historic alliances and personal relationships.</td>
<td>The hospital trust sought to take advantage of opportunities to change referral patterns, for example as individuals retire, new guidance is issued on minimum numbers of procedures per annum, if dissatisfaction emerges with the level of service provided, through patient choice, if difficulties arise in recruitment; and, through technological change or medical advance.</td>
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| Increase its profitability by growing its well known and specialist services       | The hospital trust planned to increase its market share in its existing catchment area; and extend the catchment area to include nearby areas with high population growth rates by:  
  - continuing to invest in its services (it has self-financed two major capital investments in specialist centre in order to significantly improve the quality of the facilities); and  
  - improving the quality of its services by improving back up facilities (for example introduction of level 2 and 3 critical care services, and an expansion in its existing capacity to provide bone marrow transplants. |

Source: Table compiled from information in documents collected by the Cooperation and Competition Panel.
### INVESTMENT IN ACCESS

3. This attachment provides examples of investments that improved patients’ ability to access services in their local area in response to perceived competitive opportunities or pressure. The hospital trusts expected that this would attract additional referrals to their services and so the existence of competition is likely to strengthen the business case for maintaining (or opening new) local services.

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<td>Increase the share of births that took place at its Hospital.</td>
<td>Calculated the proportion of patients at each GP practice in its area that choose to give birth at its hospital and the proportion that instead gave birth at a series of other local hospitals. After analysing the information the hospital trust considered how it could target and address the issues underlying those results. It concluded that it needed to examine the overall quality of care and the reputation of the unit amongst GPs, patients and their families and friends. For example it also decided to consider the business case for improving access by running more antenatal clinics in the community.</td>
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<td>Relationship with patients.</td>
<td>Hospital trust set itself the strategic objective of providing clinics and diagnostic services at times and location that reflect patient preferences. It did so by increasing the hours of its outpatient department at one of its community hospitals in order to deliver higher levels of asset utilisation and productivity whilst at the same time improving the experience for its patients.</td>
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<td>Relationship with GPs to increase referrals.</td>
<td>Hospital trust increased its diagnostic capacity to enable it to provide direct access to diagnostics for GPs. For example it noted that it had made significant investments and improvements in its imaging service with extended working days being introduced as well as new equipment (multi-slice CT scanner and state of the art MRI scanner). To help the hospital trust deliver a service that GPs could have confidence in and secure referrals it conducted a usage survey that highlighted which areas the trust needed to improve. The areas were:</td>
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21 Patients do not currently have the right to choose their provider of maternity services under the NHS constitution. However in practice the majority of patients are given this choice by their GP (subject to provider being able to provide the clinically appropriate treatment for their pregnancy that meets NHS standards and costs). In any case choosing to give birth in a midwife-led unit, or at home is subject to the proviso that if complications occur then treatment will be necessarily be provided in the clinically appropriate setting (eg a consultant led obstetric unit).
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<tr>
<td>a. Clinical services. The action plan here was to reduce length of stay rates and improve discharge procedures</td>
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<td>b. Communication to GPs. The action plan here was to establish a primary care liaison service which would monitor referral patterns from GPs and assess the impact of competitor activities on the hospital trust’s existing market as well as building better relationships with GPs. The hospital trust noted that its reputation amongst GPs for the quality of its discharge summaries had improved from being the worst in the area two years ago to being the best in the area in more recent surveys.</td>
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<td>c. Transport and access. The action plan on this issue was to introduce a new one stop hysteroscopy clinic, a shuttle bus between sites, and a transport booking service to coordinate journeys and improve patient flow</td>
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<td>d. The community hospital site. The action plan involved moving some services into these facilities in order to grow community and acute services within the hospital</td>
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<td>e. Appointments process. The action plan here was to implement directly bookable services and to open appointment lines from 8 until 5.30 Monday to Friday.</td>
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To increase referrals from the periphery of its catchment area.  
The hospital trust identified that the provision of radiotherapy, outreach oncology services and linking into the local multidisciplinary teams is the key to securing referrals. To secure and consolidate the trust’s position regionally, it also wanted to take a leading role in developing and implementing satellite radiotherapy units throughout the region.

To increase referrals.  
Research by the hospital trust indicated that patients would travel further to be treated by the secondary care consultant that saw them in their community clinic. The hospital trust considered that it in light of this, it could use community based facilities to significantly impact its referrals and ultimately its market share of inpatient treatment. The hospital trust therefore put together a plan to expand the location and frequency of its outpatient clinics in community hospitals, day centres, and GP practices across its catchment area to increase referrals and ultimately its market share.

To increase referrals  
Provider invested in building and opening a new outpatient clinic 10 miles away from its urban-based hospital site in order to improve accessibility for patients in that area.

To increase referrals  
Hospital trust sought to improve patient access by introducing new outpatient clinics at the local community hospital. This had the result of increasing the number of referrals,
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<td>Mitigate the threat of another hospital trust providing outpatient services at a community hospital and thereby attracting inpatient referrals away from the trust.</td>
<td>The hospital trust bid for and won the contract to provide outpatient services from the hospital. This enabled the hospital trust to offer its services to patients in specific areas who may have chosen another nearby rival hospital for inpatient treatment. Similarly the hospital trust said that it is considering whether to start providing outpatient services in a nearby health centre in order to attract patients requiring inpatient treatment away from a rival hospital trust. The hospital trust said that it will look to promote its services in key marginal locations and it will look to develop outpatient services in strategically identified areas in the county to attract the local population to the trust for inpatient treatment.</td>
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Source: Table compiled from information in documents collected by the Cooperation and Competition Panel.
INVESTMENT IN MARKET RESEARCH AND COMMUNICATIONS

4. We have seen significant work by hospital trusts both to identify which aspects of their services customers care about most or would like to see improved, and then to communicate their strength or performance improvement in these areas. The following are some examples of the types of investments that hospital trusts have made in market research and communication in response to perceived competitive pressure. Please note that other examples of work in this area are included in the other attachments.

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<td>GP referrals. GPs were key ‘brokers’ for the hospital trust’s business, therefore the trust needed to ensure that they were aware of and updated on the trust’s skills, so that they could recommend the trust to patients.</td>
<td>To build relationships with GPs, hospital trust had a strategic plan that included: plans to review the hospital trust’s contact with GPs; developing a who’s who in the consultant team with pictures and biographies; developing an e-newsletter for GPs; and collating information for a programme of networking events for GPs. Also planned to build new relationships with commissioners to foster and maintain commissioner satisfaction with service provision.</td>
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<td>Loss of virtual monopoly through patient choice</td>
<td>To be a provider of choice the hospital trust suggested it would need to: improve waiting times; focus on the whole patient experience; develop customer care within the organisation; market the quality of its services; support services becoming more efficient by improving financial information on which areas are cost effective and which are not; continually review its infrastructure; and promote ongoing discussions with GPs about how they want to see services develop. The hospital trust conducted research that assessed the level of competitive pressure on each of its services. Having identified those services under most pressure it considered how it could compete effectively. It suggested that it needed to begin by understanding the true costs of the services that it provides since this would allow it to drive down overheads and reduce its costs.</td>
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The hospital trust analysed its referral data and classified its catchment area into three zones according to whether it received: (a) all referrals (except specialist services); (b) the majority of referrals; or (c) only a small number of referrals. The hospital trust decided to consult its clinical staff to determine what actions it needed to take to attract all the referrals in zone (b). For example the hospital trust was developing plans to create an outpatient department at a community hospital in order to attract referrals from that area. The hospital trust considered it would be difficult to influence referrals in zone (c), however it resolved to investigate what was important to these patients when they make their choice of healthcare provider.

The hospital trust identified its low market share in two of the larger volume cancers (which were often treated by local district general hospitals), and desire to change referral patterns

Hospital trust wanted to differentiate its service for two of the largest volume cancers, and attract patients away from the local district hospital, on the basis of:

- its higher quality service (evidenced through its multidisciplinary approach),
- better outcomes,
- access to trials,
- comprehensive service, and
- advanced and immediate reconstruction by plastic surgeons.

An opportunity to increase thyroid cancer referrals from local district general hospitals

The hospital trust identified that in its area three local district general hospitals were conducting between 4 and 14 thyroid cancer cases per year. The trust noted that such small volumes were neither efficient nor good for patients. The trust therefore identified an opportunity to increase the referrals it received by communicating its own key selling points. For example:

- its surgeons do a lot of cases,
- it has short waiting times for clinics,
- it employs sub-specialists in pathology, and
- it has a one stop clinic with cytopathology that can provide immediate test results for

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22 The trust notes that its multidisciplinary teams can be differentiated from those at district general hospitals on the basis that all members of the team are specialists including the pathologists, radiologists, nurses, therapists and surgeons in a specific area of cancer and see a lot of cases.

23 The trust notes that each of its surgeons treats a greater number of cancer patients than are seen in a district hospital. It says that their skills are therefore developed and maintained as they see a wider range of conditions and cancer of different types and complexity. Similarly the pathology and radiology departments are large enough to allow individual scientists to specialise in specific areas of disease and/or tumour sites. This increases the accuracy of diagnosis and ensures timely treatment.

24 The trust notes that patients increasingly search for and choose centres where non-licensed drugs or treatment are offered.

25 Many hospitals do not offer reconstruction by a plastic surgeon either immediately or post-operatively (only 10 per cent of patients in the UK receive this treatment). Instead the primary surgeon does whatever reconstruction is done immediately. The trust notes that specialist reconstruction leads to better outcomes, better patient satisfaction, and less chance of infection.
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| Commissioners stopped purchasing inpatient paediatric elective orthopaedic services from the hospital trust and began purchasing them instead from a nearby rival. Following this loss of volume the trust was unable to remove all the costs associated with providing the service (eg overhead costs.) | Hospital trust responded by seeking to increase patient volumes in its other services to use the spare capacity available after the loss of the paediatric service. Strategies to increase volumes included  
- ensuring they had a customer-focused approach with regard to the quality of care and treatment and the customer service they provide to patients.  
- raising the hospital trust’s profile, by bringing the established world class expertise of the trust to the attention of patients, commissioners, referring clinicians and potential service users.  
The strategy proved successful and within two years the hospital trust had identified year-on-year growth in patient income of 10 percent |

Source: Table compiled from information in documents collected by the Cooperation and Competition Panel.