

Re-think or re-brand?

Government NHS policy after the “pause”

The government's response to the Future Forum has been hailed by some as a substantial and positive change. But our analysis of the detailed proposals suggests that, despite some concessions and u-turns on specific issues, the changes are as much a re-brand of the original policy as a re-think of it, whereas other proposals actually threaten to make the amended Bill even worse than the current draft.

Concessions

In some areas, the Future Forum report has acknowledged our criticisms and the government has now conceded, despite having rejected many of the same proposals when made by unions or tabled by the Opposition in Committee. These are among the key concessions:

Monitor

- Monitor's primary duty will change from promoting competition and its competition powers are to be restricted.
- Monitor's power to force NHS hospitals to hand over facilities such as operating theatres and diagnostic scanners to private rivals will be removed from the Bill.
- The Command Paper states that the system of “designation” for essential services – where Monitor would determine which services would be protected and which would be allowed to fail – will be abandoned and a new “failure regime” will be created.

Clinical commissioning

- The new clinical commissioning groups will be responsible for the whole local population. They will be statutory bodies with names that make it clear they are NHS organisations.
- The boards of the groups will have to publish minutes and details of all contracts as well as meet in public.
- Multi-disciplinary commissioning will be introduced.

Providers

- Any Qualified Provider will be limited to tariff only services and phased in over a longer period.
- NHS and private income will have to be separately accounted for by Foundation Trusts.
- The 2014 deadline for FT authorisation has been relaxed and FT governance made more transparent.
- The government will consider a training levy on private providers who use NHS-trained staff.

Other issues

- NHS bodies will have new duties to promote integration.
- The Board and consortia will have a duty to “promote” the NHS Constitution, which goes beyond the current requirement to “have regard” to it. Entitlements within the Constitution will be given a stronger legal basis.

- The existing duty on the Secretary of State will be restored and only Parliament can impose new charges for NHS treatment.
- It will be illegal to set targets for more private provision.
- NICE has retained some powers through the "back door" as patients will have the right to insist on NICE-approved treatments.

Problems

For all that any concessions are welcome, there are still serious problems, including:

- Significant caveats apply to the practical impact of many of these concessions.
- Many of the damaging original proposals have either been left as they are entirely or will in practice remain much the same, often being achieved by different means.
- Some new proposals have been made that may actually make the Bill even worse than it was to begin with.

Some of the more notable problems include the following areas.

Privatisation

- The government will "carry out further work on the feasibility" of the Right to Challenge. This proposal will open up a new route to the privatisation and in so doing extend the application of EU competition law.
- Similarly, the Command Paper backs the Future Forum's proposals for more "social enterprise" and extension of the "Right to Provide" which again will open up another avenue of privatisation that had seemed abandoned before the FF reported. The government may intend to pursue these new "Rights" using the enabling powers in the Bill rather than give Parliament any say. Again, this raises questions around competition law.
- The strong language on a "level playing field" is meant to reassure but could just be cover for a corporate subsidy given the original proposals for differential tariffs and a 14% bonus for private providers. Though the government has ruled out private providers being paid extra simply for being privately owned, they are still considering factors such as payment of corporation tax, which amounts to the same thing. Even if tariffs end up taking account of other higher NHS costs and therefore favour NHS providers overall, it is

unacceptable for tax to be included in the equation at all, as it will result in a higher price for private providers than would otherwise have been set.

- Similarly, the provision making it illegal to set targets for increased private sector provision has been spun as a safeguard against privatisation. But it would also appear to prevent a future government returning to the policy of the NHS as a preferred provider without new primary legislation. This proposal, though it may superficially appear reassuring, may actually be designed as a trap.

Competition & Monitor

- Monitor will still be tasked with enforcement of EU competition law and the Competition and Co-operation Panel will be given a new statutory role, effectively taking over as the competition regulator now that Monitor's duties have changed.
- Though the CCP is preferable to Monitor as originally envisaged, it is still highly problematic and if it remains appointed by the Secretary of State could easily be turned in to the kind of competition enforcer that ministers originally intended to create.
- Though there is a new rhetorical emphasis on integration there is no detail on whether there will be specific powers to promote it, nor is it as clear that collaboration will be promoted in the same way.
- Any Qualified Provider will still be implemented, starting as early as next April. It was always likely to start on tariff services anyway, and Monitor may extend tariffs as it develops pricing methodology so this change may not be as significant as suggested.
- Furthermore, the announcement that community services will be the first in line is extremely alarming as it is already evident that the Care Quality Commission is unable to effectively regulate providers. Companies such as Southern Cross and Castlebeck already have CQC licenses to operate and are thus "qualified providers" and already operate in many areas that would overlap with NHS community services.
- The "choice mandate" will give considerable power to the Secretary of State to push competition through a variety of policy levers once the political situation has calmed and media scrutiny has moved on. Given that we know Andrew Lansley's intentions, and it is unlikely that any successor will be fundamentally more sympathetic to the NHS, the power of direction given to central government in this area is alarming.

- Overall, the impression given is that “choice” is a re-branded version of the “competition” originally intended. The Future Forum report on competition makes clear that it is still considered to a central part of the overall proposals, just implemented in a different way.
- This will include, for example, even tougher duties to be imposed on commissioners to promote patient choice, the detail of which may lie with the Secretary of the State or Commissioning Board rather than on the face of the Bill.
- Duties to promote the NHS Constitution and on health equality do not appear to apply to Monitor or the CCP, only to the Commissioning Board and commissioning groups (which the government still refers to as “consortia”). Monitor will only need to “have regard” to the Constitution, which is its existing duty. There is no mention of other commissioners such as local authorities or Public Health England.

Universal provision

- Though ministers said that they have accepted the restoration of the original duty on the Secretary of State, they have only specifically committed to restore subsection (1) of the original Section 1 – the promotion of a comprehensive service – rather than subsection (2), the duty to provide or secure the provision of services. This will only be a duty on the Secretary of State in so far as it is exercised through the new arms length bodies.
- Furthermore, this may have limited impact in practice. If the clinical commissioning groups can still determine what services and treatments are provided in their area, there is still likely to be a postcode lottery.

Providers

- NHS Trusts will still have to become Foundation Trusts eventually and all the same problems will then apply.
- The Private Patient Income cap will still be lifted.
- Though the government response indicates that designation will be replaced, the existing proposals will remain in the Bill for the time being while the government considers a replacement.
- The recommitment motion makes clear that the application of insolvency law to FTs will also remain. Much of the failure regime appears to be retained, and the government’s statements on the matter have been vague. There is still the prospect of hospitals being allowed to go bust if they cannot compete in the market.

Commissioning

- Commissioning management can still be sub-contracted (i.e. privatised) just not statutory responsibility for the ultimate end results. The government’s reassurance on this is spin – the work of commissioning can still be done by UnitedHealth or KPMG, so long as the board signs off any formal decisions. This is more of a clarification of the status quo than a change to it.
- It is still unclear what actual processes for monitoring and addressing commissioner conflicts of interest will be put in place – the only confirmed details are that the National Commissioning Board must authorise them and that a lay representative will be responsible at local level. This falls far short of a register of interests or any other comprehensive statutory system.
- There is no proposal at all to address conflicts of interest among other commissioners such as members of the Commissioning Board and its committees. This is particularly concerning as the government is reportedly planning to appoint private sector representatives to all levels of the NCB.
- The new clinical commissioning groups may still represent part of a local authority area, which means that there is a danger of GPs representing the more affluent end of a borough, for example, effectively selecting the “better” patients by drawing the boundaries.

Democracy & participation

- The Health and Wellbeing Boards do not seem to have any automatic staff (let alone trade union) representation and will normally only have a minority of elected councillors, with backbenchers and opposition groups excluded entirely.
- The Boards will also be given a duty to involve “users and the public” but not staff.
- There has been no confirmation that the government will implement the Future Forum proposal that trade unions would be directly represented on the HealthWatch Citizens’ Panel, which was the only union representation suggested by the FF. In general there is not much detail on how this would work, and the Panel is framed as a way of promoting competition when the emphasis should be on citizens as opposed to consumers.

Cherry picking

- Plans to prevent “cherry picking” focus on the selection of individual patients by secondary providers. This is only one side of the problem, however. Firstly, the same issue might apply in primary care, and we are still waiting for details on how the government intends to extend patient choice in to the primary sector.
- More significantly, there is the problem that low-risk high-volume secondary care by definition can only take on the “easier” patients but many NHS hospitals will use that to cross-subsidise low-volume high-risk care. There may also be clinical reasons that single providers need to perform both. But many private providers will only specialise in the former and can therefore divert patients and income simply by competing within the market. The initial government response only suggested that guidance will be developed on “bundling” services while the Command Paper adds that more work will be done on the whole issue by the Royal Colleges.

Other issues

- One of the more important FF proposals was to develop a “social value” framework for procurement – but the government’s response appears to have replaced this with “best value”. If the purchaser-provider split is to be retained, a social value approach that included assessment of ethical criteria and considered factors such as the impact of job security and decent pay on the health of employees would be preferable to a traditional approach. But this proposal seems to have been quietly dropped by the government, which did not even acknowledge it in its formal response.
- Choice and personal budgets, along with other proposals in the Bill, would provide a starting point for an insurance system and there will be some suspicion that this is the ultimate end point of the current direction of travel.
- Generally, the changes create an enormous amount of top-down power, which with Andrew Lansley as Secretary of State can only be regarded as alarming. They are also a far cry from the stated intention of the Bill to devolve power and remove political interference.

Confusion

Some of the changes in the Bill appear to have been very poorly thought-through and, though they may not be ideologically motivated, are unworkable, inconsistent or damaging to good management of

the NHS. Other attempts to meet criticism have simply created inconsistencies rather than a better system overall.

Commissioning

- The requirement for at least two lay representatives and one hospital consultant and one nurse on every commissioning group board excludes Allied Health Professionals and other disciplines. Doctors and nurses represent only around half of the total clinical workforce in the NHS but will be the entirety of the mandatory decision makers on commissioning. This approach was rejected as tokenistic by the Future Forum but the government has over-ruled them for what many will suspect are political reasons rather than any serious considerations of policy. This not a serious attempt to create a structure for multi-disciplinary commissioning.
- Furthermore, the doctor and nurse cannot do any work for any provider commissioned by that consortium. This will be completely impractical or costly in many areas (perhaps requiring long distance travel and expensive recruitment and remuneration) and means that the value they can add to the work of the commissioning group is questionable.
- It is also inconsistent as the same requirement does not seem to apply to GPs or members of the National Commissioning Board or its committees, who may remain as commissioners even if they are connected to providers. This makes it appear that those with connections to NHS providers are treated more harshly than those with financial interests in private companies, a bizarre situation.
- There is similar confusion on the proposals for membership of the National Commissioning Board, which the government has said will now include a medical director and a chief nursing officer but without mention of other specialist expertise. The Royal Colleges will be involved but it is unclear what other professional bodies will be. There is a danger that Allied Health Professionals and other clinical disciplines are excluded from governance at national as well as local level.
- If GP practices can opt out of involvement in consortia (even if not membership) this could leave active participation in commissioning and key decisions to an unrepresentative minority of GPs, who may be ideologically motivated or have financial interests or connections to providers. There is a danger that this worsens rather than solves the problem.

- Similarly, removing any deadline for the clinical commissioning groups to take over, which was meant to reassure critics and address problems with the Bill, could instead just leave us with a patchwork of unequal systems and arrangements across the country. This would make the postcode lottery even worse and lead to more bureaucracy, costs and chaos during an extended period of change.
- If consortia must follow local authority boundaries this seems to suggest that a new wave of re-organisation will be required in areas where that is not the case already. In practice, they may be granted exemptions – but that will render the proposals for co-terminosity completely meaningless. The future is uncertain for many of these organisations and their patients.
- Clinical senates appear to be a new tier of management separate to the multi-disciplinary commissioning process. They will sit alongside networks in the National Commissioning Board. How this structure will work in practice is still unclear and there is again the danger that the attempt to correct flaws in the original plan just adds another layer of bureaucracy in to it.
- But the Command Paper’s wording is confusing on the issue, referring to emergency and urgent care being commissioned geographically and a duty to commission services for unregistered patients, but not making clear what happens with those who are registered with a practice that sits in one clinical commissioning group but live in the geographical area that is the responsibility of another. The provision that a majority of a group’s registered patients must live within its boundaries suggests it will still commission on practice lists and it is not clear how this requirement can be absolutely guaranteed alongside a completely open choice of GP.
- The details of new education and training proposals are due to be worked on over summer – meaning that Parliament is being asked to legislate now without knowing the ultimate shape of what it is voting for in the meantime.
- The Future Forum recommended that the new provisions on transparency should apply to private providers as well as NHS Foundation Trusts but it is unclear whether anything on those lines will happen. The Command Paper says that it would be “difficult” to do so and the government will look for “alternative ways” to promote transparency.

Questions unanswered

- The new form and function of Monitor are still unclear. The government has not set out a full wording for its new duties, and the Future Forum report itself appears to contain two different proposals for this. In practice, potentially contradictory duties may simply let it perform its role as seen fit by its senior staff – so it may carry on as before. It is not clear how it will carry out its roles such as licensing if not on the basis of competition.
- It has not been made completely clear how commissioning will work when choice of GP is introduced – has the government completely relented on its plans to create a market in “health tourism” by allowing commissioning to be on the basis of practice membership rather than geographical population? That seems to be the implication of making the clinical commissioning groups responsible for their whole populations. This still means that those who can afford to move home may be the only people who can still play the market in this way.
- Nor is there any recognition that the “commercial confidentiality” exemption makes the Freedom of Information Act extremely hard to apply in practice where there are contractual relationships with commercial providers.
- It is not clear how the new reconfiguration process will work, for example how it will interact with designation or its replacement process, what it applies to (e.g. provider or commissioner initiated reconfigurations, or economic restructures) and how the ultimate recourse to the Secretary of State can work alongside removing any ministerial operational responsibility.

Conclusion

It is clear that, despite some sops to critics, the bulk of the damaging proposals made in the government's initial Bill could still be implemented through the revised legislation.

Some of the most specific elements have been abandoned after they were highlighted, but this is not a step forward if they are simply replaced by vaguer provisions that can be implemented after the Bill is passed and without sufficient scrutiny.

In other areas, the details provided have been so scant that serious analysis is not even possible, and will be extremely difficult to undertake within the timetable now proposed for the recommitted Bill.

Worst of all, there are some proposals that may achieve what few had thought possible – making the Bill even worse than it was. Some of these are simply

the result of a botched policy process, attempting to graft on elements of a different system of clinical commissioning to the original concept, while others appear to be PR stunts, tactical moves or fixes for political reasons without regard for the practical impact on the NHS.

Perhaps most concerning, however, is the suspicion that the package as a whole is not a change of direction but simply an attempt to achieve the government's original plans by different means.

Despite some welcome u-turns, much of the government's intent can still be realised through the Bill. The government's response to the Future Forum has been a clever attempt to re-brand its original proposals. But it is no substitute for a genuine re-think.