AUGUST 2011

Securing continued access to NHS services:

Technical annex

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To be read alongside

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- Briefing notes on Government amendments to the Health and Social Care Bill: Report stage (Commons)

A: Introduction

1. The Government is committed to ensuring the NHS remains free to patients, when they need it, wherever people live and irrespective of who provides their services. This commitment is reflected in Clause 1 of the Health and Social Care Bill, which confirms that the Secretary of State would continue to have an overarching duty to promote a comprehensive health service throughout England. The Secretary of State would discharge this duty through an improved system of commissioning NHS services – that is clinically-led, at a local level, overseen and supported by the NHS Commissioning Board – and would retain power to intervene, where necessary, to ensure that the Board performs its functions well.

2. GP-led, clinical commissioning groups would lead in securing access to NHS services that meet the needs of their population, promoting continuous improvement in quality of care and value for taxpayers' money. This would be achieved by commissioning services from a range of providers and encouraging the development of innovative types of provision.

3. Patients would have greater control over their care and should be able to choose their preferred provider wherever possible. Providers and clinical staff would need to tailor their services to meet patients' preferences, driving improvements in both quality and productivity. Where providers are successful, they would have greater potential to innovate and invest in improving services. But, in the unlikely event that a provider gets into difficulty, the system must protect patients and, where necessary, enable the regulators – Monitor and the Care Quality Commission (CQC) – to intervene early to address safety, quality and performance issues; with the Secretary of State remaining ultimately accountable.

B: Securing continued access to services

4. The Health and Social Care Bill sets out a framework for securing continued access to NHS services, building upon the existing system, which was established by the previous Government under the Health Act 2009.

5. If a provider of NHS services gets into financial and/or clinical difficulties, there must be effective safeguards to protect patients' and taxpayers' interests by securing continued access to essential services that patients depend upon for their care and delivering value for money. The existing legislation offers this protection where services are provided by NHS trusts and foundation trusts – so we will retain the basic framework and improve upon it. However, we believe the system should offer equivalent protection for all essential NHS services, regardless of the type of provider, and that is why our proposals extend that protection for services delivered by other providers.

6. The Government's proposals would improve the current framework and ensure that:
    - patients' interests would be protected – they must be able to get the services they need and those services must continue to be high quality – meeting the essential safety and quality registration requirements monitored by the CQC and relevant clinical guidelines and quality standards issued by NICE;
    - the process for securing access to essential NHS services would be clinically-led, through clinical commissioning groups, at a local level, and overseen by the NHS Commissioning Board;
    - commissioning processes would remain subject to statutory requirements for ensuring appropriate consultation and local involvement; retaining local authority scrutiny over all service provision;
    - Monitor, in its role as sector regulator, would be able to support commissioners by regulating proactively to prevent providers taking

actions that could significantly undermine their continued ability to deliver essential NHS services. Monitor would also be able to intervene, where necessary, to support individual providers to address problems, where possible.

- where services become unsustainable in their current form, proposed solutions would be driven by the clinical case for change; agreed by clinical commissioning groups and developed through consultation with the broader clinical community, the local health and wellbeing boards, Local HealthWatch and the public; and
- taxpayers' interests would also be protected, by securing solutions that make best use of available NHS resources and avoiding rewards for failure or "bail outs" for poor quality or inefficient providers.

C: Why do we need to develop the current framework?

7. The current legal framework already makes provision for supporting the continuity of essential NHS services, for instance by enabling Monitor to appoint someone to take control of the affairs of an NHS foundation trust if it is, or is likely to become, unable to pay its bills. However, the current arrangements:
    - **are not comprehensive.** The current framework covers only foundation trusts and NHS trusts. Where other types of organisations are providing NHS-funded services, we need equivalent arrangements to protect patients and taxpayers in the event of a provider becoming unsustainable.
    - **have not prevented poorer quality and inefficient service provision for NHS patients.** Poorer clinical quality is commonly associated with poor financial management – as illustrated by the strong correlation between organisations with financial deficits and relatively poorer performance on key indicators (eg. healthcare acquired infections and access to A&E). Moreover, the current legal framework would allow politicians and commissioners to protect providers regardless of their efficiency or quality. Financial subsidies have propped up unsustainable and inefficient services, taking money away from successful providers to bail out poor management inappropriately and creating perverse incentives. The Government intends to put this right by strengthening incentives for improvement so that patients receive the highest quality healthcare from the best providers available.

8. The Government wants to develop and improve on the current arrangements, to ensure a fair, transparent and comprehensive framework to support the continuity of services that:
    - protects access to essential services for patients whilst enabling commissioners to replace services with higher quality or better value options, where this is in the interests of patients and taxpayers;

- is led by local clinical commissioners and supported by Monitor, with proactive intervention in response to providers in difficulty, with the aim of supporting recovery and preventing providers becoming unsustainable, wherever possible;
- ensures that there is appropriate consultation with the local community;
- is driven by the clinical case for change, based on the evidence of best practice in improving outcomes for patients. If the status quo is unsustainable, local clinical commissioning groups would have to endorse the proposed solutions, and relevant Clinical Senates and clinical advisors would also be consulted; and
- is underpinned by incentives for providers to respond more quickly to patients' demands, make efficiency savings and manage risk effectively, in order to avoid becoming unsustainable.

9. Together this will mean that poor quality services are improved, innovation will occur to improve patient experience, and in some cases, providers will decide with commissioners that they are not best placed to deliver specific services.

10. The recent listening exercise on the Government's plans for NHS modernisation emphasised the importance that people place on how continuity of NHS services is secured. There is widespread support for a transparent and fair framework, including from the Health Select Committee and others. However, the Government recognised that there were concerns around the detail of its original proposals to secure continued access to NHS services. In particular:
    - the practicalities of 'designating' in advance essential services that would be protected in the unlikely event that a provider became unsustainable;
    - balancing the need for independent decisions with democratic accountability; and
    - bringing foundation trusts (FTs) into the scope of company insolvency procedures.

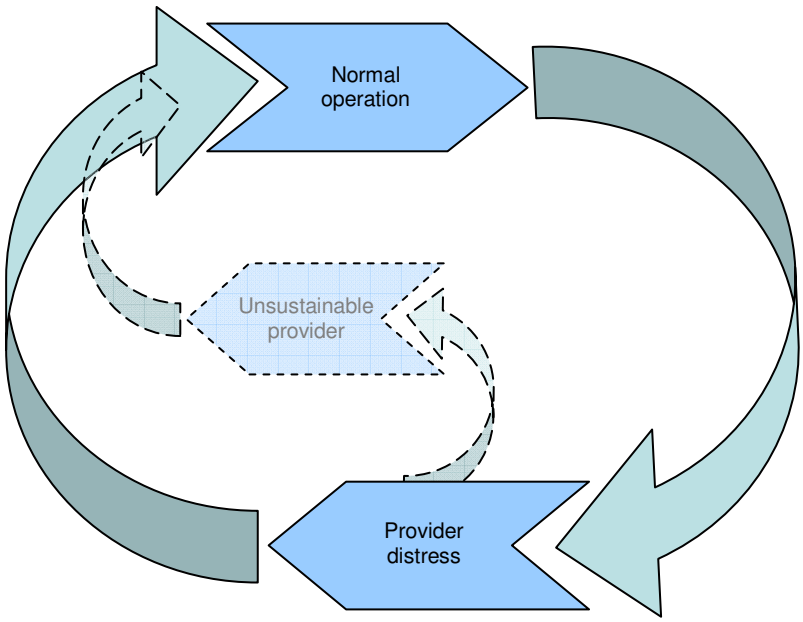
11. The Government therefore proposes to amend its original proposals, whilst retaining the principles that underlay them. Under its revised proposals:
    - **Monitor would intervene proactively where providers were at risk of or facing serious difficulties,** with the aim of supporting recovery and preventing providers becoming unsustainable, where possible.
    - **The unsustainable provider regime for foundation trusts (FTs), established under the Health Act 2009, would be maintained but significantly improved.** In the light of the listening exercise, the Government has concluded that this regime continues to be more appropriate for FTs, rather than an insolvency-based approach previously proposed, but the regime would be improved to make it more independent and transparent to reduce unnecessary costs and delays. NHS trusts would continue to be governed by the existing Health Act 2009 without any amendments.
    - **This would be complemented by a separate regime for non-statutory providers (such as companies)** that delivered essential NHS services which became unsustainable and would provide equivalent safeguards for patients and taxpayers.
    - **Local health and wellbeing boards, Local HealthWatch and the wider local community would be consulted** on proposals to secure continued access to essential NHS services.
    - **FT providers would not "revert" to being under the direct control of Ministers.** A foundation trust would retain its foundation trust status and the public and staff, as members and governors, retain their roles and have every opportunity to support the recovery of the FT and avoid it becoming unsustainable. This would give Ministers less room to make decisions that may differ from taxpayers' interests. However, in order to maintain democratic accountability local authorities would, as under the current regime, retain scrutiny of all service changes. In addition, the Secretary of State would retain a veto over proposals for securing access to essential NHS services in the event that a provider became unsustainable. Such a

veto would be subject to certain criteria and would be expected to only be used in exceptional circumstances.

D: How the framework would operate

12. The operation of the improved framework can be illustrated as a cycle. In normal operation, a provider would be efficient and deliver high quality care. However, some providers may experience clinical and/or financial difficulties and it may be necessary for Monitor to intervene. This may be for only a short period of time, with the vast majority of these providers successfully turning around their operations and returning to normal operation. However, a small number of providers may not be able to complete this turnaround and could become unsustainable. At this point, there would need to be special arrangements to secure continued access to essential NHS services and where appropriate, help providers return to normal operation.

Figure 1: The cycle to secure continued access to NHS services[1]



13. In order to provide clarity in the regulatory framework and improve overall efficiency, we would expect Monitor to establish transparent and objective tests to

[1] A provider could return to normal operation at any stage: following a period of "distress" or after becoming unsustainable.

determine when intervention is necessary and what level of support a provider would require (e.g. a "distress" test and an "unsustainability" test). This would provide certainty to patients and providers on when Monitor could intervene to ensure that high quality care is maintained; whilst also ensuring that regulation remains proportionate.

Normal operation

14. To obtain a licence to supply NHS services, providers would require CQC registration, where they provide regulated activities, and it is anticipated that Monitor would also require providers to meet financial stability checks. (There would be a joined-up registration/ licensing process across Monitor and the CQC). Therefore, under normal operation, any licensed provider should be financially sound and able to deliver high-quality services.

15. Local clinical commissioners would have a clear role and statutory duties to secure access to NHS services to meet the healthcare needs of their populations. They would achieve this by commissioning services from a range of providers and encouraging the development of innovative types of provision.

16. However, in certain circumstances additional safeguards may be needed to prevent a provider ceasing to provide an essential service or disposing of important assets used to deliver essential services. Monitor would therefore have power to support commissioners in securing access to such services by imposing requirements on providers, through licence conditions, to ensure they protected the resources needed for the continued provision of essential NHS services (eg free cash flow). In line with *Better Regulation* principles, however, Monitor would regulate providers in proportion to risk, with more stringent conditions only coming into effect if it was considered that a provider was at risk.

17. Additional support to secure continued access to services could come through the ability for commissioners and providers (or if they cannot reach agreement,

providers alone), to apply to Monitor for a modification to the price determined in accordance with the national tariff. Monitor could approve and/or set the level of the modification under certain circumstances (using the methodology agreed between Monitor and the NHS Commissioning Board), if the provider could not, at the tariff price, cover its costs with an efficient service. This would help ensure continuity of services where there were unavoidable additional costs of delivering a particular service. This modification would not constitute a "bail out"; rather it would reflect strong economic arguments to modify the price where commissioners' requirements were otherwise uneconomic to provide. For example, when a provider delivering an essential service is located in a sparsely populated area, it could cost more because the volume of patients is insufficient to deliver the service within the tariff price.

Intervention to support improvement and recovery

18. Monitor would be responsible for carrying out an ongoing assessment of risk. It would identify and support providers who might become unsustainable. Where appropriate, Monitor would step up its oversight of and support for a provider, but the provider would continue to be responsible for managing its own affairs and for delivering the services it was contracted to supply. Monitor would have discretion to limit its intervention, in the event that it was confident that the provider was capable of reaching a turnaround solution. This is consistent with the principles of *Better Regulation*, the approach Monitor takes today, and the approach in other sectors.

19. However, where Monitor was concerned that there were significant difficulties that could risk ongoing service provision, they would have power to require the provider to appoint a turnaround team to help the provider's management meet their licence conditions.

20. Monitor would also have powers to trigger a planning process where the commissioner and provider would work together to develop plans, based on the

best information available, to secure continued access to services, in the event that the provider became unsustainable. The Government expects that commissioners would engage with the clinical senates, relevant clinical advisors, health and wellbeing boards and reflect their views in the plans. In addition, commissioners would be expected to maintain appropriate impact assessments (which would be published), which would inform this process. As part of the impact assessment, commissioners would be required to consider where the withdrawal of services would result in damage to health or increase health inequalities, having regard to the current and future needs faced by their local population, and equality of access to services.

21. In acting to support providers in "distress", Monitor would engage and work with the relevant commissioners, the CQC and the providers themselves. This is consistent with the current arrangements for NHS foundation trusts and reflects the new duties that Monitor and the CQC would have to co-operate with and supply information to one another.

22. The Secretary of State would retain power to provide financial assistance to FTs in "distress", including power to provide loans or injections of Public Dividend Capital.

Unsustainable providers

23. As a last resort, in the unlikely event where previous interventions had been unsuccessful and a provider became unsustainable in its current form, Monitor would trigger the "unsustainable provider" regime and appoint a suitably qualified person ("continuity administrator") to take control of the provider's affairs.

24. Once the regime had been triggered, the lead commissioner (nominated by the NHS Commissioning Board, or the NHS Commissioning Board itself) with input from the continuity administrator and Monitor would determine which services were essential, informed by any planning undertaken during the "distress" stage.

Commissioners would work with the continuity administrator and agree[2] proposals to secure continued access to these essential services, before the continuity administrator consulted widely on them.

25. Different legal frameworks would apply for foundation trusts and non-statutory (independent and third sector) providers but with equivalent safeguards:

Unsustainable providers: foundation trusts

26. The unsustainable provider regime for FTs would be based on the existing regime established under the Health Act 2009[3]. However, the Government would make a number of improvements, bringing it closer to the regime that applies to the independent sector. The regime would be more independent and transparent reducing unnecessary costs and delays with additional safeguards for patients and taxpayers.

27. As per the existing legislation, Monitor would appoint a Trust Special Administrator (TSA) to take control of the FT's affairs and help secure continued access to services. The TSA would prepare a report to Monitor, recommending how to secure continued access to essential services identified by the commissioner. The commissioner would be required to agree the report, before the TSA consulted Health and Wellbeing Boards, the public and other interested parties on the proposals. The TSA would agree any changes to these plans with commissioners in response to issues raised during the consultation and then submit a final version of the report to Monitor.

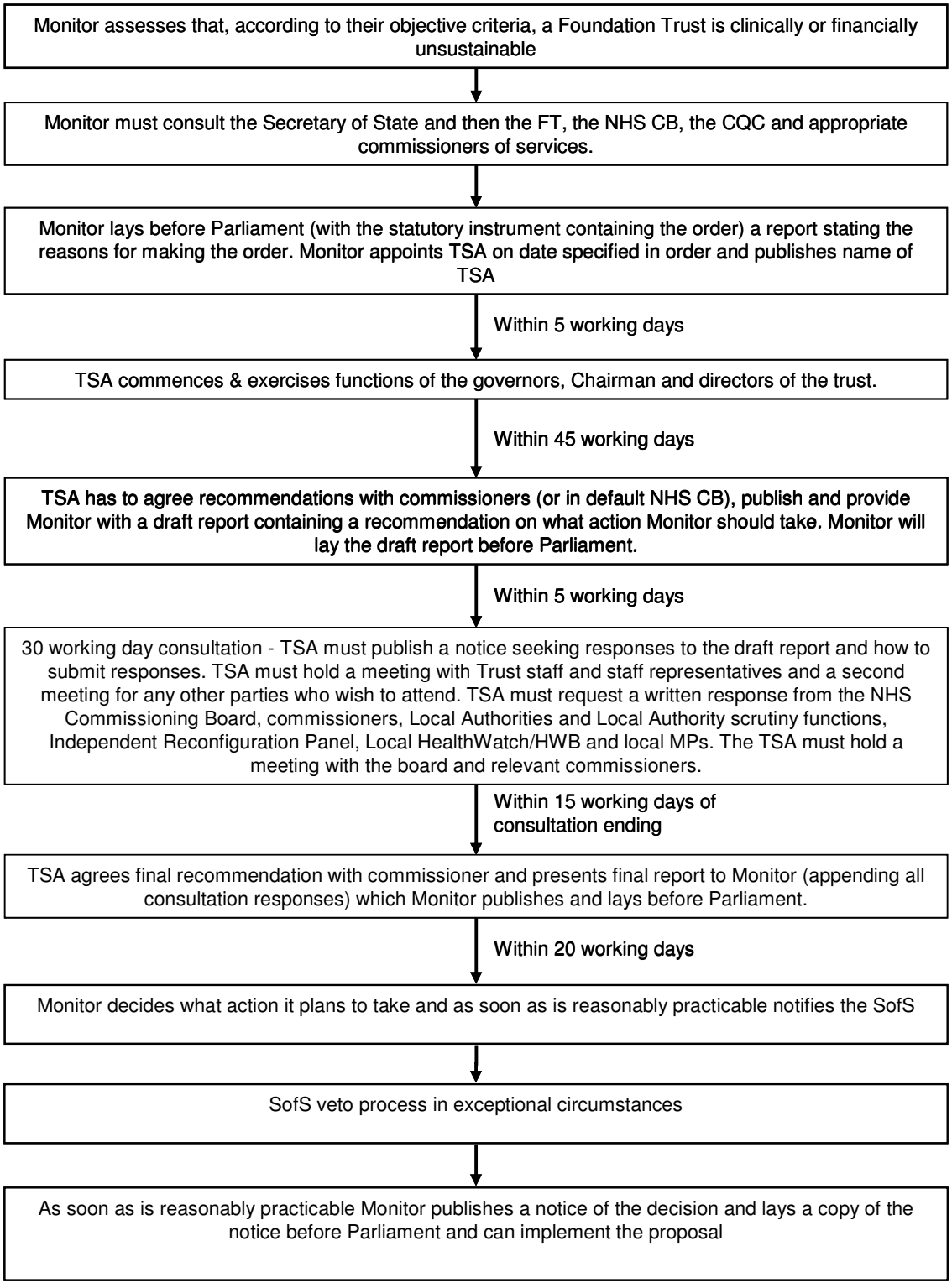
28. Before Monitor decided what action to take in relation to the services, it would need to be assured of the clinical case for any change. Monitor would secure that

[2] If commissioners could not reach agreement, the NHS Commissioning Board would facilitate agreement and make a final decision if necessary.
[3] At least until 2016, some NHS Trusts would not have been able to achieve Foundation Trust status. These Trusts would continue to be governed by the existing Health Act 2009 without any amendments.

the CQC had made an assessment of the provider's current service provision, to highlight any concerns over quality and patient safety, and would expect the TSA to:

- secure endorsements from local clinical commissioning groups (or the NHS Commissioning Board, if appropriate) and where possible, secure endorsements from relevant Clinical Senates and/or clinical advisors on the clinical case underpinning the recommended solution; and
- consult the Independent Reconfiguration Panel on any proposals for service change.

Figure 2: The Foundation Trust unsustainable provider regime



Key: FT – Foundation Trust TSA – Trust Special Administrator HWB – Health and Wellbeing Board NHS CB – NHS Commissioning Board CQC – Care Quality Commission

29. Once Monitor was satisfied that the report met the terms of the TSA's appointment, Monitor would be required to submit the final report and proposals to the Secretary of State, who would be able to intervene, only where he could demonstrate, either:
    - failure by the TSA, or Monitor to follow due process; or
    - failure by the NHS Commissioning Board, and/or the relevant clinical commissioning groups to secure continued access to services, or secure services of sufficient safety and quality or provide good value for money.

30. In addition, this power of veto would only be used in cases that have been locally disputed. It is expected that such a veto would only be used in exceptional circumstances.

31. If the Secretary of State vetoed Monitor's proposals, the Secretary of State would, as under current legislation, be required to provide a written statement to Parliament explaining the rationale for doing so. By intervening, the Secretary of State would ask Monitor and the commissioners to reconsider. It would then be for the TSA to agree revised recommendations with the commissioners, having regard to the reasons for the Secretary of State's veto; and submit their revised proposals to Monitor. Monitor would need to be satisfied that the revised recommendations met the terms of the TSA's appointment. If satisfied, it would be required to notify the revised recommendations to the Secretary of State.

32. The Secretary of State's power of veto would be the last stage in a "triple lock", ensuring that patients' interests were protected and represented in discussions and decisions about service changes. The other aspects of this would be the key role for local authorities and local HealthWatch in the process and commissioner and Monitor agreement to the proposals. Monitor would have access to advice from the CQC and any responses to the consultation proposals provided by the Independent Reconfiguration Panel, which would help ensure that its decisions took proper account of patients' interests.

33. Overall, these arrangements draw heavily on, but significantly improve, current arrangements. In particular, they provide additional safeguards for patients and taxpayers by creating:
    - objective, transparent requirements, based on a systematic assessment of the impact on patients (including where ceasing to provide the service would result in material harm to patients or increase health inequalities), to be met if an unsustainable FT is going to continue providing services;
    - requirements for widespread local consultation, including through health and wellbeing boards;
    - strong clinical input into the development of proposals for continued access to services, both through clinical commissioning groups and the involvement of clinical senates and clinical advisors;
    - continued democratic accountability, both at local level, through local authority scrutiny of the proposals and through the Secretary of State, who would remain ultimately accountable for promoting a comprehensive health service and for ensuring that Monitor and the NHS Commissioning Board performed their functions adequately; and
    - a strong focus on quality of care and patient safety, through Monitor's ongoing engagement with the CQC and the requirement that the CQC provides an assessment of the provider's current service provision, which would be reflected in the development of the proposals to secure continued access to services.

34. In addition, the position of creditors will be improved compared to the Government's previous proposals. Creditors would be entitled to be repaid in full either by the unsustainable FT (or its successor). However, it would be possible for the FT (or its successor) to negotiate with the creditor (or through the Foundation Trust Financing Facility), to restructure any repayments to more viable terms.

Unsustainable providers: non-statutory providers

35. A further substantial improvement to the framework would be the introduction of a regime - complementary to the FT unsustainable provider regime - for non-statutory (independent and third sector) providers. If an independent or third sector provider, that supplies essential NHS services becomes unsustainable, patients' interests would be protected through a health special administration procedure. This would be based on existing corporate insolvency law, with the details set out in secondary legislation, on which there would be extensive consultation.

A standing fund

36. In order to ensure sufficient funding was available to secure continuity of essential services if a provider becomes unsustainable, Monitor would have the power to create a standing fund, which could cover:
    - the direct costs of the continuity administrator (eg professional fees);
    - the costs associated with rescuing essential services i.e. the difference between operating costs and the costs that a provider was able to recover through the national tariff or other reimbursement systems; and
    - costs associated with restructuring to secure continued access to essential services.

37. If Monitor deemed this appropriate, it would be able to set the fund up as a "risk-pool", funded through compulsory levies on providers and commissioners. This insurance-type mechanism – where the size of the levy could reflect a provider's risk of becoming unsustainable - would create an incentive for providers to become more sustainable and thus reduce their levy.

Return to normal operation

38. It is possible that a number of solutions would be identified by the continuity administrator to ensure the continuity of essential services that were clinically and financially sustainable. These could include any or a combination of:

- **Supporting the provider's recovery**. In this case, the provider's services, which are considered to be essential, would be delivered by the previously unsustainable provider. On an ongoing basis, notwithstanding the need to address any inefficiencies, the commissioner may face a higher cost associated with service provision reflected in the higher tariff approved by Monitor. This would not constitute a "bail out", but the unavoidable costs of delivering the commissioners' service requirements, which would otherwise be uneconomic to provide.
- **Restructuring services**. Services could be delivered in different ways that provided higher quality care for patients, met their needs and wishes better and/or represented better value for money. For example, a service delivered previously by a hospital might be provided in the community or in people's own homes.
- **Transfer of services**. Services and the assets needed to deliver them could be transferred to another provider.

39. Monitor would agree the best route to implement the agreed solution, subject to the Secretary of State's right of veto. This could be through the continuity administrator or through an alternative management team. For a provider to pass back into normal operation it would have to demonstrate that it was and would continue to meet the requirements of its licence going forward.

E: Conclusion

40. Securing continued access to NHS services is vitally important to individuals and communities. The Government's framework is designed to ensure a proactive response to support providers with the aim of preventing them becoming unsustainable, where possible. There would be a range of safeguards to secure continued access to care, including in the event of a service being transferred to a different provider. This approach would not force patients to use, or taxpayers to subsidise, poor quality, inefficient services or providers. Rather, it would protect patients' and taxpayers' interests by securing continued access to NHS services and maintaining or improving quality of care where the status quo is no longer sustainable.