Unite evidence to the Health and Social Care Bill Committee – Health and Social Care (Re-committed) Bill: Government Amendments

This evidence is submitted by Unite the Union - the country's largest trade union. The union's members work in a range of industries including manufacturing, financial services, print, media, construction and not-for-profit sectors, local government, education and health services.

Unite represents approximately 100,000 health sector workers. This includes seven professional associations – the Community Practitioners and Health Visitors' Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicists Association (HPA), College of Health Care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA) – and members in occupations such as allied health professions, healthcare science, applied psychology, counselling and psychotherapy, dental professions, audiology, optometry, building trades, estates, craft and maintenance, administration, ICT, support services and ambulance services.

Executive Summary

- Unite remains strongly opposed to the Health and Social care bill. It will be a disaster for the NHS, public purse and service users.

- The amendments do little to allay Unite members concerns about the privatisation and fragmentation of the UK's most treasured public service, the NHS.

- Many government amendments are limited, tokenistic, unclear or fall far short of the changes necessary to make this Bill acceptable. Others are far from the concessions or beneficial steps that the spin has suggested and may make the Bill worse rather than better.

- Several of the Future Forum's recommendations and changes identified in the government's response are not reflected in actual amendments. Some issues will be revisited after the unnecessarily rushed Committee Stage, others will be pursued outside the Bill itself, limiting Parliamentary scrutiny entirely, while still others remain entirely unclear.

- It is clear that this process was about changing the politics rather than the policy.

Unite Case in detail:

1 <u>Introduction</u>

1.1 Despite the spin, Unite believes that the government's response to the Future Forum has failed to make substantial and positive changes to the Health and Social Care Bill. Unite 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. Some proposals actually threaten to make the amended Bill worse than the current draft.

1.2 Unite therefore remains strongly opposed to the Health and Social Care Bill. As proposed the amendments fail to tackle substantial concerns raised by Unite and a huge array of other organisations and experts about the original bill.

1.3 In the sections below Unite highlights the areas where the amended bill makes acceptable **concessions**, continues to have serious **problems** and areas that create substantial **confusion** and remain unclear.

2 Concessions

2.1 Unite welcomes the limited concessions that have resulted from the Future Forum report. It should be noted that many of these same changes had previously been rejected out of hand when made by unions or tabled by the Opposition in Committee. The key concessions are grouped under subheadings below:

2.2 Monitor

2.2.1 Monitor's primary duty will change from “promoting competition” and it will be given a duty on integration.

2.2.2 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.

2.2.3 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.

2.2.4 Monitor will have some powers to prevent the “cherry-picking” of individual patients and restrict price competition.

2.3 Clinical commissioning

2.3.1 The new clinical commissioning groups will be given responsibility for unregistered patients in the Bill itself rather than by regulations. They will also commission emergency care on a whole population basis.

2.3.2 They will be statutory bodies with names that make it clear they are NHS organisations.

2.3.3 The boards of the groups will have to meet in public and there will be regulations to govern transparency, which will apparently require them to publish their minutes and details of all contracts.

2.3.4 Multi-disciplinary commissioning will be introduced.

2.4 Providers

2.4.1 Any Qualified Provider will be limited to tariff only services and phased in over a longer period.

2.4.2 NHS and private income will have to be separately accounted for by Foundation Trusts (FT).

2.4.3 The 2014 deadline for FT authorisation has been relaxed and FT governance made more transparent.

2.4.4 The government will consider a training levy on private providers who use NHS-trained staff.

2.5 Other issues

2.5.1 NHS bodies will have new duties to promote integration.

2.5.2 The Board and consortia will have a duty to "promote" the NHS Constitution rather than just “have regard to” it.

2.5.3 The duty on the Secretary of State will be strengthened and only Parliament can impose new charges for NHS treatment.

2.5.4 Some of NICE’s powers have effectively been retained via a funding direction and patients will have the right to insist on NICE-approved treatments.

3 Problems

3.1 Unite believes that there are still serious problems with the Bill. These can be summarised as follows:

- Some of the positive recommendations of the Future Forum have not been clearly adopted by the government.
- Significant caveats apply to the practical impact of many of the concessions that have been made, while others will be extremely complex and difficult to implement.
- Many of the apparent concessions in the Command Paper have not translated into actual amendments to the Bill.
- 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.

The more notable problems have been grouped under the following areas.

3.2 Privatisation

3.2.1 The government will "carry out further work on the feasibility" of the Right to Challenge. This proposal will open up a new route to privatisation and in so doing extend the application of EU competition law.

3.2.2 Similarly, the Command Paper backs the Future Forum's proposals for more "social enterprise" and extension of the "Right to Provide" which will open up another avenue of privatisation that had seemed to have stalled before the FF reported. Again, this threatens to extend the reach of competition law.

3.2.3 The government seem to intend to pursue these policies without tabling amendments to the Bill, avoiding Parliamentary scrutiny.

3.2.4 The strong language on a "level playing field" is meant to reassure but could just be a 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 private providers being attributed with higher values than they would otherwise have been set. Some of the amendments may actually make this problem even worse than it was originally.

3.2.5 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, is actually a trap.

3.3 Competition & Monitor

3.3.1 Monitor will still be tasked with enforcement of EU competition law and the Competition and Co-operation Panel (CCP) will be given a new role, effectively taking over as the competition regulator now that Monitor's duties have changed.

3.3.2 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 into the kind of competition enforcer that ministers originally intended to create. The amendments do not make clear how this will be implemented so it will not be scrutinised in the Bill Committee, even though a statutory underpinning was promised.

3.3.3 Though there is a new rhetorical emphasis on integration, the duty in the amendments is limited compared to those on competition and so are the powers to enforce it. There is not such an emphasis on collaboration.

3.3.4 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 is tasked by the amendments to the Bill to extend tariffs as it develops pricing methodology, so this change may not be as significant as suggested. The changes are more about expanding tariffs than restricting competition.

3.3.5 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 not resourced sufficiently 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.

3.3.6 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.

3.3.7 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 immediate successor will be fundamentally more sympathetic to the NHS, the power given to central government in this area is alarming.

3.3.8 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.

3.3.9 This will include even tougher duties to be imposed on commissioners to promote patient choice through amendments to the Bill but presumably also by other central policy directions that do not need Parliamentary approval.

3.4 Universal provision

3.4.1 Even though ministers said that they have accepted the restoration of the original duty on the Secretary of State, the wording of subsection (2) is different. It refers only to the Secretary of State's duty to act so as to secure the provision of services through the exercise of his functions.

3.4.2 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.

3.4.3 This appears to be the case because the changes to the "Section 3" duty on the Secretary of State to provide the specifically listed services. This is particularly worrying for those services that Section 3 allowed the Secretary of State to provide only in so far as he considers "appropriate" for them to be provided as part of the NHS. This applies, for example, to services such as health visiting. The legal duty to determine the extent to which it is appropriate to provide such services as part of the NHS will now lie with the local commissioning consortia.

3.5 Providers

3.5.1 NHS Trusts will still have to become Foundation Trusts eventually and all the same problems will then apply.

3.5.2 The Private Patient Income cap will still be lifted and no further safeguards have been put in place to prevent this impacting on NHS services. This will lead to a two tier system in the NHS, where those with the ability to pay will be able to take advantage of accelerated or more comprehensive services. This Clause has not even been recommitted so cannot be re-examined.

3.5.3 Though the Command Paper states that the system of "designation" will be replaced, the existing proposals will remain in the Bill for the time being while the government considers a replacement.

3.5.4 The application of insolvency law to Foundation Trusts also remains in the Bill for the time being and it is unclear whether it will be replaced. The failure regime is being reviewed. Press reports suggest that a more flexible system will be put in place but there has been little in the way of officially confirmed detail. There is still the prospect of hospitals being allowed to go bust if they cannot compete in the market.

3.6 Commissioning

3.6.1 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 a clarification of the status quo rather than a change to it.

3.6.2 It is still unclear what actual processes for monitoring and addressing commissioner conflicts of interest will be put in place and most of the detail will be provided through regulations. Parliament is being asked to vote on these provisions without any detail of the system it will put in place. The only confirmed details are that the Commissioning Board must authorise consortia, though only on the basis of meeting the regulations, that the constitution must be published, meetings must be held in public. The government says that they will provide for the

appointment of two lay representatives, for the publication of minutes and "details of contracts". This just highlights how weak the controls were in the first place and falls far short of a register of interests or any other comprehensive statutory system.

3.6.3 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 given reports that the government is planning to appoint private sector representatives to the Board.

3.6.4 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.

3.6.5 It has also raised concerns that some of them are so small that they might not be financially efficient due to their small scale and would be vulnerable to failure in case of any financial difficulties. For example, several pathfinder consortia reportedly cover populations of only just over 20,000. This is particularly concerning given the lack of detail on a failure regime for the consortia, not least as compared to providers.

3.6.6 There is concern that the CCBs will only have responsibility for meeting the emergency needs of their local geographical population, for those not on their lists, which will create in a divide to access health services, particularly by those from more marginalised communities.

3.6.7 There are also no safeguards put in place that will ensure that fragmented services – whether along lines of clinical pathways or from within disciplines - are kept together.

3.7 Democracy & participation

3.7.1 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.

3.7.2 The Boards will also be given a duty to involve the public but not staff.

3.7.3 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 Future Forum.

3.7.4 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.

3.8 Cherry picking

3.8.1 Plans to prevent “cherry picking” focus primarily on the selection of individual patients by secondary providers. This, however, is only one side of the problem. 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.

3.8.2 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.

3.8.3 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, though there is little detail on this.

3.8.4 The amendments seem to imply that Monitor will need to create a highly complicated system of tariffs covering the range of different types of providers and treatments, balancing this against the need for greater administrative simplicity. It is hard to see how this can be achieved without either allowing some price competition or cherry-picking on the one hand, or creating a nightmarishly complicated pricing system on the other. This might even end up preventing commissioners and NHS providers negotiating lower prices even where this is in the public interest, which sometimes occurs within the NHS now, because such an arrangement would be anti-competitive.

3.9 Other issues

3.9.1 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" and even that is not given any greater definition in the amendments. 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. This proposal seems to have been quietly dropped by the government, which did not even acknowledge it in its formal response.

3.9.2 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.

3.9.3 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.

3.9.4 Ironically, given the government's rhetoric about bureaucracy, the overall effect of the amended Bill will be a huge expansion in the number of health bodies.

4 Confusion

4.1 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 or complexities rather than a better system overall.

4.2 There are also many questions that remain unanswered and specific policy proposals that are still being worked out even as the government is rushing the Bill through Parliament.

4.3 Commissioning

4.3.1 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 is not a serious structure for multi-disciplinary commissioning, but, as it is not dealt with through amendments, it cannot be properly scrutinised by Parliament.

4.3.2 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. The detailed wording of the government's briefing notes also seems to weaken the description of the "hospital doctor" to the point that it might actually be met by a GP anyway.

4.3.3 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.

4.3.4 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.

4.3.5 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.

4.3.6 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.

4.3.7 If consortia must not cross 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.

4.3.8 Similarly, the provision that emergency care and treatment of unregistered patients will be commissioned on a “whole population” basis, whereas all non-emergency services for registered patients will be on the basis of practice lists, seems to work against a “Population Health” approach and may be a recipe for more bureaucracy.

4.3.9 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.

4.4 Questions unanswered

4.4.1 The Command Paper said that a duty would be placed on the Secretary of State for workforce training and education but the briefing notes denied that any amendments in this area were promised.

4.4.2 More widely, the general details of new education and training proposals are due to be worked on over summer and proposals on a provider training levy need to be developed – meaning that Parliament is being asked to legislate now without knowing the ultimate shape of what it is voting for in the meantime.

4.4.3 It has not been made completely clear how commissioning will work when choice of GP is introduced, especially given that the government say that a majority of a group's registered patients must live within its boundaries. Proposals on how choice of GP will work in practice are subject to a separate consultation process.

4.4.4 Similarly, other processes of consultation and policy making on areas ranging from public health to information strategy mean that Parliament must pass the recommitted Bill without the wider picture, even though there is considerable overlap between the policy areas that are being developed separately and those dealt with in the Bill.

4.4.5 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.

4.4.6 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.

4.4.7 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 supposedly removing any ministerial operational responsibility.

4.4.8 There will be no Impact Assessment for the Bill as amended until the recommitted Bill has completed all of its Commons stages.

5 Conclusions

5.1 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.

5.2 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.

5.3 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.

5.4 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.

5.5 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.

5.6 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.

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12/07/2011