Continuity of services and designating commissioner requested services

Key Points

- This guidance represents an important step towards putting a failure regime into place that identifies and protects 'essential' patient services and injects more transparency into a system of funding transfers between NHS organisations to support failure that has until now been very opaque.

- The process for designating services set out in this guidance is, however, potentially very time consuming if the process is followed in full. It implies considerable data analysis, substantial engagement with local clinicians, patient groups and other stakeholders, and additional research if inequalities dimensions are to be fully understood.

- We are concerned that clinical commissioners may not have the capacity to do this in the short term and that it may also be challenging for commissioning support units.

- It might be helpful if some of the other objectives implied by the policy were made more explicit or explored further. Is it to expose more providers to genuine risk of failure and therefore exit (i.e. those not designated as essential), thereby stimulating improvement? Is a secondary objective of the policy to stimulate the market in local health economies?

- Or is the process better understood as an opportunity for commissioners to complete a thorough review of the quality and configuration of every service provided in a local area? Making these underlying objectives more explicit (or at least clarifying whether or not they are relevant) would go a long way to building public legitimacy for both the process of implementing an effective failure regime and the role of Monitor as a sector regulator more generally.

Consultation response

Date 8 November 2012

We are pleased to be able to respond to Monitor's consultation on service continuity and designation of protected services. The Nuffield Trust is an authoritative and independent source of evidence-based health service research and policy analysis. Our aims include promoting informed debate on health care policy in the UK. Below, we offer some brief overall comments and answers to some of the specific questions posed by the consultation document.

Overall comments

This guidance represents an important step towards putting a failure regime into place that identifies and protects 'essential' patient services and injects more transparency into a system of funding transfers between NHS organisations to support failure that has until now been very opaque .

The process for designating services set out in this guidance is, however, potentially very time consuming for commissioners, if the process is followed in full. It implies considerable data analysis, substantial engagement with local clinicians, patient groups and other stakeholders, and additional research if inequalities dimensions are to be fully understood. We are concerned that clinical commissioners may not have the capacity to do this in the short term and that it may also be challenging for commissioning support units.

It is essential that Monitor is able to clarify the status of this guidance. The Act stipulates that commissioners 'should have due regard' for such guidance. What does this mean? Do commissioners have to follow the process in full or only in part, or can they develop their own process? Could Monitor engage with relevant stakeholders (such as the NHS Confederation, NAPC, NHS Alliance and others) to establish which parts of the process are feasible and which elements are desirable, but not practically possible?

If commissioners, providers and local stakeholders are to be meaningfully engaged in this process, it might be helpful if some of the other objectives implied by the policy were made more explicit or explored further.

What is the underlying objective for those services deemed non-essential? Is it to expose more providers to genuine risk of failure and therefore exit (i.e. those not designated as essential), thereby stimulating improvement? If unprotected services are allowed to fail and exit, many patients will feel inconvenienced by having to travel further. How will commissioners set thresholds for establishing what degree of patient inconvenience is or isn't acceptable? How will they communicate this to local patient groups?

Is a secondary objective of the policy to stimulate the market in local health economies? It is clear from the guidance that the process of designation implies an extensive analysis of the market for all services in a given area. Is it, as the document suggests, designed to stimulate commissioners to encourage new entrants, e.g. p29: "commissioners have an opportunity to encourage entry into the market"?

Or is the process better understood as an opportunity for commissioners to complete a thorough review of the quality and configuration of every service provided in a local area? Instead of this being an exercise solely aimed at identifying services to protect in the event of failure, could it, or should it be, reframed as an opportunity to improve the

range and quality of services more generally (which is indeed hinted at in various points of the document, for example in relation to understanding the link between volume and quality)?

Making these underlying objectives more explicit (or at least clarifying whether or not they are relevant) would go a long way to building public legitimacy for both the process of implementing an effective failure regime and the role of Monitor as a sector regulator more generally. Without this, there is a risk that Monitor's role could be perceived as distracting managerial and clinical effort from the more pressing concerns of guaranteeing both the quality of, and access to, NHS services in a time of financial austerity.

Question 1: *Do you feel that the 25-30% market share threshold (over which particular care must be taken in the exploration of alternative provision) is appropriate? If not, what threshold do you feel would be appropriate?*
It is difficult to answer this question without a clear explanation of how the '25-30%' threshold itself has been arrived at. Is this a rule of thumb used by other regulators? If not, where has it come from? Furthermore, as the guidance itself points out, there is more than one method of calculating market share, so additional explanation might be needed here, especially if it is being left to commissioners to conduct these calculations themselves. Will Monitor have the capacity to lend expertise to commissioners to do these calculations?

Question 2: *Given the details outlined in the guidance and framework, how long do you estimate the Commissioner Requested Services (CRS) designation process will take? Do you think the timeframes will be different if a provider approaches a commissioner to initiate the process?*
The guidance describes a four-stage process, which is clearly explained and logically laid out:
1. Information gathering
2. Assessing whether suitable alternative providers exist
3. Assessing whether there are any health inequality impacts
4. Assessing whether there are any impacts on interdependent services

This process potentially represents a considerable workload, and Monitor may wish to provide some more detail before it is possible to estimate how long it will take.

The guidance makes clear that initially all mandatory services provided by foundation trusts will automatically fall into the CRS category. It is stated that within a defined period of time (yet to be finalised), services should be designated as CRS on the basis of a systematic and evidence-based approach. Within each commissioning area, there are potentially multiple services that could be assessed (the case studies include pathology, paediatrics, urgent care, rheumatology and mental health services). The guidance states (p6) that commissioners should first 'consider the high volume, high interdependency services' as well as those where there are fewest alternative providers. Given the potential workload that this process represents for commissioners and others, Monitor may need to consider offering more guidance on how commissioners might prioritise this initial work.

It will also be important for commissioners and Monitor to understand how providers and stakeholders view CRS status in practice. Given the public unease at the possibility

of services being closed down as a result of reconfiguration for quality and/or financial pressures, it is possible that local people will want to cast the CRS net as wide as possible, to ensure that services continue, and possibly as a means to lock out competitive pressure. This could have the effect of freezing efforts to reconfigure local services. On the other hand, some providers will be ambivalent about CRS status: it brings with it costs (in the form of contributions to the risk pool), much closer scrutiny from Monitor, and the accompanying restrictions on disposing of assets may inhibit service innovation.

Given the likely competing stances of local stakeholders, what should be the role of health and wellbeing boards and other representative bodies in deciding the appropriate scope of designation?

Where commissioners are asked to assess the strength of potential alternative provision, the guidance asks them to establish whether alternative providers would be able to absorb the extra capacity from a failed service. It should be pointed out that this is not a neutral question, in a financially challenged system; is it not in the financial interests of rival providers to say yes? How should commissioners establish the robustness of any plans to deploy extra staff and capacity? Commissioners themselves might also have their own conflicts of interest, where their GP members have, or plan to set up, alternative forms of provision.

The guidance also encourages commissioners to think about whether new entrants could be encouraged to absorb the work of a potentially failed service. It will be important to be realistic about how quickly any new entrants could be established, particularly given that the rules/guidance about setting up a 'fair playing field' for alternative provision are yet to be drawn up.

The Health and Social Care Act defines protected services not only as those where no viable alternative exists, but also where the withdrawal of a service would also worsen health inequalities. As the guidance makes clear, this is an important but complex dimension. A potential increase in travel times that would be feasible for patients in general might present much greater challenges to those on low incomes, or living in areas where public transport is inaccessible, or for patients disadvantaged in other ways. The guidance suggests that data about those currently using services are assessed according to income groups, socio-economic status, ethnicity and 'other relevant protected characteristics'. We would question how available some of these data are, particularly in relation to income and ethnicity (especially for community or primary care services where ethnicity may not systematically be collected). There is also a dearth of information about disability or whether patients and services users are also carers themselves, which might have a big impact on their ability to travel to alternative providers. The case studies give examples of services in 'deprived areas', but what weight should be given to disadvantaged patients living in more affluent areas?

We would urge a much more thorough explanation of this topic, as it will also be essential for commissioners to be able to present transparent data to their local stakeholders (including local government and patient groups) about why some users of some services may merit more protection than others (particularly where the majority of services users are themselves elderly and may also feel under-represented).

The guidance acknowledges that commissioners might need 'more research' (p34) on the inequalities dimension. It is likely that the designation process as a whole will represent a considerable analytical challenge, which might in some cases be assigned to commissioning support units (which may service multiple CCGs). Will Monitor and/or commissioners be able to assure the quality of the analysis and any related consultation done by CSUs? Will it fall to CSUs to work together with Monitor to establish some common or minimum standards of analysis?

The guidance rightly points out the importance of assessing the interconnectedness and interdependence of services: it is likely that the NHS Commissioning Board's local area teams and local clinical senates and networks will have an important role, which it may be useful for Monitor to clarify. Services do not exist in isolation, and there may be cases for designating pathways or networks in some cases, especially if services have been commissioned via some integrated care approach.

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