Executive summary

This response details the British Medical Association’s (BMA) position on the specific areas for reform contained in this consultation, building on the views set out in our response to the White Paper ‘Equity and excellence: Liberating the NHS’. We hope all these suggestions will be considered and used to develop the proposals in a way that ensures the maximum benefit for patients and the NHS.

The BMA does not support the direction taken in the NHS in England in recent years, which is continued by many of the proposals set out in the White Paper and this consultation. We remain opposed to the commercialisation and active promotion of a market approach in the NHS, and to the threats to national terms and conditions of service for doctors. We wish to see an NHS that is a public service working cooperatively for patients.

The BMA believes the abolition of the cap on the amount of income foundation trusts can earn from other sources has the potential to act as an incentive for foundation trusts to undertake more non-NHS activity at the expense of NHS provision. If unfettered, this could lead to a two-tier health service, as foundation trusts invest more resources in non-NHS facilities.

Statutory controls on borrowing should be retained, to ensure that financial risk can be properly managed. At a time of huge change and economic pressure across the whole NHS, when trusts are being pushed to rapidly achieve foundation trust status, it does not seem sensible to move to a more autonomous system of financial regulation.

Mergers, de-mergers and acquisitions should only occur where it is clinically appropriate and safe to do so; evidence-based and clinically-led in partnership with patients; when it improves the quality of patient care and where new services will genuinely offer a more cost-effective alternative than existing arrangements.

The quality of patient care should not be adversely affected by potential changes to foundation trust governance arrangements. Recent difficulties at foundation trusts have arisen where Boards have become too focused on certain areas of business, to the detriment of other important areas such as clinical care.

The BMA questions the proposal to create a staff-only membership model for some providers from the start of their existence as foundation trusts. This would appear to be driven by a political desire to expand the social enterprise sector. We do not believe this is what NHS staff wish to happen or that it would benefit patients if forced upon staff.

We are concerned that intensifying the pressure on NHS trusts to achieve foundation trust status within the next three years will drive them to place the achievement of this target above all others, including safe patient care.

Only those trusts that achieve 100 per cent compliance with the New Deal should be granted foundation trust status. It must be a prerequisite for achieving foundation trust status that trusts are in full compliance with and properly implementing European Working Time Directive Regulations.

The BMA is concerned that the joint licensing role of the Care Quality Commission and Monitor will lead to unnecessary bureaucracy and cost.

The BMA does not support Monitor’s role as promoter of competition in healthcare and believes its focus should be on ensuring quality. Competition between providers should only be enforced where it can be demonstrated that there will be proven benefits for NHS patients and that they have been consulted.
We would urge Monitor to exercise caution over the use of powers to prevent anti-competitive behaviour. Before making decisions about anti-competitive behaviour, Monitor should seek the views of patients and clinicians, to find out which services are valued and which others are desired within a community, rather than force competition when it is inappropriate.

The BMA opposes the introduction of competition simply to create a market. Where it can be shown that introducing competition would be beneficial to patient care, it will be essential that there are equitable and transparent funding and contractual arrangements for all providers of NHS services. Monitor should ensure that private providers have no unfair advantage over NHS providers in respect of their funding or other recompense.
Liberating the NHS: Regulating healthcare providers
BMA Response

1 Introduction

1.1 The BMA is an independent trade union and voluntary professional association, which represents doctors and medical students from all branches of medicine all over the UK. We have a membership of over 140,000 worldwide. We promote the medical and allied sciences, seek to maintain the honour and interests of the medical profession and promote the achievement of high quality healthcare.

1.2 It is important to highlight that, with devolution, healthcare policy has become increasingly divergent across the four nations of the UK, and the BMA’s response to the policies and priorities set by each administration will vary according to the particular national context. The NHS in England has already moved further towards competition and marketisation in health than the devolved nations, and is now significantly different to the service in the rest of the UK. This response has been written to reflect the position of the BMA solely in the terms of the implementation of proposals in the English NHS, and should not be seen as representing the BMA’s views more generally on the way forward for the NHS across the UK.

2. Direction of travel in the NHS in England

2.1 Doctors are passionate supporters of the NHS and recognise the importance of playing a key role in shaping the future of the system. The BMA acknowledges that any health system needs to evolve, underpinned by full consultation with the medical profession, patients and the public and with a rational and agreed plan that has clinical leadership in partnership with patients at its core.1

2.2 However, the BMA is critical of the direction of travel seen in the NHS in England in recent years, which is continued by many of the proposals set out in the White Paper and associated consultations. This response should be viewed in the context of our continuing opposition to the commercialisation and active promotion of a market approach in the NHS and to the threats to national terms and conditions of service and education and training for doctors contained in the White Paper. We wish to see the NHS restored as a public service working cooperatively for patients. We are committed to an NHS that:

1. Provides high quality, comprehensive healthcare for all, free at the point of use.
2. Is publicly funded through central taxes, publicly provided and publicly accountable.
3. Significantly reduces commercial involvement.
4. Uses public money for quality healthcare, not profits for shareholders.
5. Cares for patients through cooperation, not competition.
6. Is led by medical professionals working in partnership with patients and the public.
7. Seeks value for money but puts the care of patients before financial targets.
8. Is fully committed to training future generations of medical professionals.2

3. Freeing providers

- Do you agree that the Government should remove the cap on private income of foundation trusts? If not, why; and on what practical basis should such control operate?

3.1 The BMA believes the abolition of the cap on the amount of income foundation trusts can earn from other sources has the potential to act as an incentive for foundation trusts to undertake more non-NHS activity at the expense of NHS provision. If unfettered, this could lead to a two-tier health service, as foundation trusts invest more resources in non-NHS facilities.

---

3.2 The BMA would be concerned if increased resources were invested in developing services
to realise private charges at the expense or to the detriment of NHS care delivered by
foundation trusts or other NHS institutions. These concerns are allied to the BMA’s ongoing
unease that the NHS is experiencing a range of reforms that act to promote
commercialisation within the health sector and encourage the pursuit of surplus and/or profit
within the context of delivering NHS services or associated care. It is our view that, given
foundation trusts’ existing freedoms, their focused business model and their growing
influence in the NHS, making such a sweeping change would accelerate the pace of change
and give rise to greater private provision within the NHS.

3.3 It is essential that foundation trusts maintain their primary purpose of providing NHS
services and are able to demonstrate that their private income is beneficial to patients and
the local NHS economy.

- Should statutory controls on borrowing by foundation trusts be retained or removed in the
  future?

3.4 The BMA believes statutory controls on borrowing should be retained, to ensure that
financial risk can be properly managed. At a time of huge change and economic pressure
across the whole NHS, when trusts are being pushed to rapidly achieve foundation trust
status, it does not seem sensible to move to a more autonomous system of financial
regulation. The new system of economic regulation may well provide incentives for financial
discipline, but Monitor should nevertheless retain control over borrowing limits.

- Do you agree that foundation trusts should be able to change their constitution without the
  consent of Monitor?

3.5 The BMA does not agree that foundation trusts should be able to change their
constitution without the consent of Monitor. To ensure that proposed constitutional changes
were appropriate, foundation trusts should have to obtain regulatory approval from Monitor
and in the process explain why the changes were required and how the needs of patients
and the local health economy would be better served under an altered constitution. If
Monitor was to reject a proposal for change then an explanation would be required and the
foundation trust should have the right to appeal. All constitutional changes should be in the
public domain to ensure transparency.

- What changes should be made to legislation to make it easier for foundation trusts to merge
  with or acquire another foundation trust or NHS trust? Should they also be able to de-
  merge?

3.6 We would stress that mergers, de-mergers and acquisitions should only occur where it is
clinically appropriate and safe to do so; evidence-based and clinically-led in partnership with
patients; when it improves the quality of patient care and where new services will genuinely
offer a more cost-effective alternative than existing arrangements\(^3\). Such large scale change
to the delivery of services must be sustainable and should not be made solely to address
political or financial priorities\(^4\). Patient services must be improved, consolidated or extended
as a consequence of the change. Foundation trusts must be able to demonstrate the benefits
and risks and any potential impact of changes to patients, NHS commissioners and other
healthcare professionals.

3.7 Any relaxation of the legislation to make it easier for foundation trusts to merge, acquire
or de-merge should be accompanied by appropriate regulation and merger controls used by
the Competition Commission and/or Office of Fair Trading.

\(^3\) Hospital reconfiguration: Good practice guide. BMA, 2007. Available at
http://www.bma.org.uk/healthcare_policy/nhs_system_reform/Hospitalreconfiguration040507.jsp

\(^4\) GP – Providing healthcare closer to home. BMA, 2007. Available at
http://www.bma.org.uk/healthcare_policy/community_care/Providinghealthcareclosertohome.jsp
• What if any changes should be made to the NHS Act 2006 in relation to foundation trust governance?

3.8 The quality of patient care should not be adversely affected by potential changes to foundation trust governance arrangements. Recent difficulties at foundation trusts have arisen where Boards became too focused on achieving centrally imposed targets and the financial dimensions of management, to the detriment of other important areas such as delivering good clinical care. Maintaining high-quality patient care must be at the heart of all foundation trust decisions and activities.

3.9 The BMA would agree that flexibility to adapt governance should only be available for some foundation trusts, and even then only with the consent of their governors. Trusts that recently achieved foundation trust status and foundation trusts that have had difficulty with patient care or financial management should be required to operate successfully, with proven governance arrangements in place, before being allowed the opportunity to change their governance model. This should help to ensure that the quality of patient care is not compromised by poor governance and inexperience. There should be a clear and transparent measure of management standards which ensures that the standard of patient care is properly monitored before trusts may earn the flexibility to alter governance arrangements. New governance arrangements must be similarly monitored and assessed.

3.10 The BMA questions the proposal to create a staff-only membership model for some providers from the start of their existence as foundation trusts. This would appear to be driven by a political desire to achieve the White Paper’s aim of creating ‘the largest and most vibrant social enterprise sector in the world’, rather than by a desire to improve patient care or staff influence. We do not believe this is what NHS staff wish to happen, or that it would benefit patients if forced upon staff.

• Is there a continuing role for regulation to determine the form of the taxpayer’s investment in foundation trusts and to protect this investment? If so, who should perform this role in future?

3.11 We believe there is a role for regulation to determine the form of the taxpayer’s investment in foundation trusts. Monitor should be empowered to determine the form of taxpayers’ investment and take action to protect this investment. Monitor should refer cases to the Competition Commission as appropriate.

• Do you have any additional comments or proposals in relation to increasing foundation trust freedoms?

3.12 The BMA is concerned by the Government’s determination for all NHS Trusts to become foundation trusts, given the notably poor outcomes that have been seen in a small number of cases. We are concerned that intensifying the pressure on NHS Trusts to achieve foundation trust status within the next three years will drive them to place the achievement of this target above all others, including safe patient care. At a time of huge change and financial pressure across the whole NHS, it may be that cutting staff and reducing overheads are judged as the best way to achieve foundation trust status, putting patient safety and care at risk. The BMA would like NHS hospitals to be part of a collaborative, publicly owned, system of the provision of care for clinical need, rather than being run as businesses. In addition, we do not believe poorly performing hospitals will improve their standards by moving to a more autonomous system of financial regulation.

3.13 It is imperative that only those trusts that achieve 100 per cent compliance with the New Deal be granted foundation trust status. Furthermore, we believe it must be a prerequisite for achieving foundation trust status that trusts are in full compliance with and

---

properly implementing European Working Time Directive Regulations’. We are extremely concerned that the emphasis on gaining foundation trust status in a short space of time will mean these standards are not met.

4. Licensing

- Should there be exemptions to the requirement for providers of NHS services to be subject to the new licensing regime operated by Monitor, as economic regulator? If so, what circumstances or criteria would justify such exemptions?

4.1 The BMA would welcome confirmation that GP practices not offering provider services to patients will not be subject to the licensing regime operated by Monitor. With this exception we cannot see any circumstance where there would need to be exemptions to the requirement for other providers of NHS services to be subject to the licensing regime.

- Do you agree with the proposals set out in this document for Monitor’s licensing role?

4.2 The BMA is concerned that the joint licensing role of the Care Quality Commission and Monitor will lead to unnecessary bureaucracy and cost. We would like to see further information on how the joint licensing regime would work, how bureaucracy and cost would be reduced and consideration of alternatives to this proposal.

- Under what circumstances should providers have the right to appeal against proposed licence modifications?

4.3 The BMA believes that providers should have the right to appeal against proposed licence modifications in most if not all cases subject to a ‘prima facie’ case/leave to appeal. We agree that groups of providers should have the right to appeal to the Competition Commission if a significant proportion oppose proposed changes to general licence conditions and that individual providers should have the right to appeal proposed changes to special licence conditions.

- Do you agree that Monitor should fund its regulatory activities through fees? What if any constraints should be imposed on Monitor’s ability to charge fees?

4.4 We believe that Monitor’s regulatory activities should remain funded by grant-in-aid from central government as we are unconvinced that Monitor would be able raise fees in a fair, proportionate and non-bureaucratic manner. If fees were to be implemented, they should be applicable to all providers of NHS services and related to volumes of cases treated. Fees need to be proportionate so as not to unfairly impact on small providers. Ideally, fees would be set in a case-by-case manner but we acknowledge that Monitor would be unlikely to be able to do this effectively. As such, to avoid damaging services provided by smaller providers, the simplest, cheapest and most non-bureaucratic method would be for Monitor to be centrally funded.

5. Price regulation and setting

- How should Monitor have regard to overall affordability constraints in regulating prices for NHS services?

5.1 When setting prices for NHS-funded services, deciding which services should be subject to national tariffs, determining appropriate currencies and performing similar functions, Monitor must consult commissioners, providers and the public. Monitor would need to be mindful of the annual budgets of commissioning consortia and annual cost pressures, together with a consideration of the financial pressures within the provider community. Prices would need to be fair for commissioners, providers and taxpayers.

---

• Under what circumstances and on what grounds should the NHS Commissioning Board or providers be able to appeal regarding Monitor’s pricing methodology?

5.2 Providers should have the right to appeal against Monitor’s pricing methodology in most if not all cases subject to a ‘prima facie’ case/leave to appeal. However, we would like to see details on which body the providers would appeal to and which body would make the final adjudication.

• How should Monitor and the Commissioning Board work together in developing the tariff? How can constructive behaviours be promoted?

5.3 The BMA believes that it should be the responsibility of the leadership of the two bodies to consult each other appropriately and show collective leadership.

6. Promoting competition

• Under what circumstances should Monitor be able to impose special licence conditions on individual providers to protect choice and competition?

6.1 The BMA does not support Monitor’s role as promoter of competition in healthcare and believes its focus should be on ensuring quality. Competition between providers should only be enforced where it can be demonstrated that there will be proven benefits for NHS patients and that they have been consulted. Equally, commissioners should not be required to enter contracts with providers simply for the purpose of encouraging competition in an area, which could undermine the quality of existing services to the detriment of patients. The BMA supports an NHS that cares for patients through cooperation, not competition, and is opposed to any new opportunities for the private and independent sectors to deliver healthcare.

6.2 We would urge caution over the use of powers to prevent anti-competitive behaviour. If Monitor is given a role in relation to promoting competition, then before making decisions about anti-competitive behaviour, it should seek the views of professionals and patients, to find out which services they want in the area, and if there are established pathways of care and existing collaboration, rather than force competition when it is inappropriate. Competition between hospitals can be wasteful and inefficient and so these powers should only be used when it can be shown that introducing competition will benefit patient care.

• What more should be done to support a level playing field for providers?

6.3 The BMA opposes the introduction of competition simply to create a market. Where it can be shown that introducing competition would be beneficial to patient care, it will be essential that there are equitable and transparent funding and contractual arrangements for all providers of NHS services. Monitor should ensure that private providers have no unfair advantage over NHS providers in respect of their funding or other recompense.

• How should we implement these proposals to prevent anti-competitive behaviour by commissioners? Do you agree that additional legislation is needed as a basis for addressing anti-competitive conduct by commissioners and what would such legislation need to cover? What problems could arise? What alternative solutions would you prefer and why?

6.4 Commissioners should be responsive to the needs of patients rather than the requirements of legislation. We would be concerned if legislation to address anti-competitive conduct prevented GP-led consortia from being able to commission high quality services that patients wished to access. We believe that it would be more appropriate for a code of practice to be developed by the regulator for commissioners and managers to guide them in their decisions. GPs, regulated by the General Medical Council, will not be able to take decisions that owe their primacy to a commercial or competition basis, as they will have to pay attention to patient need first.
7. Supporting continuity of services

- Would you agree that Monitor needs powers to impose additional regulation to help commissioners maintain access to essential public services? If so, in what circumstances, and under what criteria, should it be able to exercise such powers?

7.1 We agree that Monitor should have powers to impose additional regulation to help commissioners maintain access to essential public services. Monitor should be able to act to preserve access when requested to do so by commissioners and/or public representatives. However, care will be needed to determine the correct course of action where public representatives, such as local authorities, may wish to retain services for political reasons.

- What may be the optimal approach for funding continued provision of services in the event of special administration?

7.2 Historic funding of services that have needed special administration should be considered when determining the minimum funding for the continued provision of those services. However, if it is apparent that the underfunding of the services was the reason they were unsustainable, Monitor will need to use its discretion and ensure that additional funding is provided.

8. Further comments

- Do you have any further comments or proposals on freeing foundation trusts and introducing a system of economic regulation?

- What action needs to be taken to ensure that no-one is disadvantaged by the proposals, and how do you think they can promote equality of opportunity and outcome for all patients, the public, and where appropriate, staff?

8.1 Where a market is created there will always be those who are disadvantaged, as it brings with it the potential for significant inequalities in the level of care patients can access. To reduce disadvantage, it is important to listen to patients and respond meaningfully to their needs.

8.2 The BMA supports a comprehensive and universal NHS with national contracts and conditions. It is essential that national terms and conditions are protected to ensure an equitable spread of doctors across the UK irrespective of local differences in geography or economic wealth, to ensure equity of pay and to safeguard against poor working conditions. It is also vital to provide equality of access to the NHS pension scheme.