

- News: Monitor failed to interview a single GP over accusation that GPs weren't promoting choice, CCG chief says (*BMJ* 2014;349:g5916)
- News: MPs reject government's preferred candidate to chair Monitor (*BMJ* 2013;347:f6486)
- News: Monitor investigates reasons behind closure of "popular" Darzi walk-in centres (*BMJ* 2013;346:f3570)

A WOLF IN SHEEP'S CLOTHING

Is Monitor reducing hospital and community services in England under the guise of continuity?

Peter Roderick and **Allyson M Pollock** argue that the licence conditions imposed by Monitor on NHS foundation trusts will lead to a reduction in hospital services, and they question the legality of Monitor's approach

Market forces and budget cuts are challenging the financial viability of hospitals in England, with NHS beds and other services continuing to close as thousands of staff are laid off.¹ However, a further challenge to a comprehensive health service has received less publicity—an expected reduction by April 2016 in the services that NHS foundation trusts are legally obliged to provide. The reduction is a consequence of provisions in the Health and Social Care Act 2012 that have led to a change in the conditions imposed on foundation trusts.

Monitor's new powers

NHS foundation trusts were introduced in 2003 under conditions set out in "authorisations" from the regulating body, Monitor. The authorisations designated certain services as mandatory—that is, foundation trusts were obliged to provide them. The 2012 act replaced authorisations with licences issued by Monitor, and since April 2014 these licences have applied to commercial and voluntary sector providers as well as to foundation trusts.² Monitor's register shows

Box 1 | Monitor's definition of services that must be provided if a trust is in financial difficulty³

Commissioners may classify a service as one that must continue to be provided only if there is no alternative provider and ceasing to provide that service at or close to the failing provider is likely to:

- Have a significant adverse effect on the health of people who need the service or
- Significantly increase health inequalities or
- Cause a failure to prevent or ameliorate either a significant adverse effect on the health of such people or a significant increase in health inequalities

about 147 foundation trusts³ and 96 private providers licensed by the end of May 2014.⁴

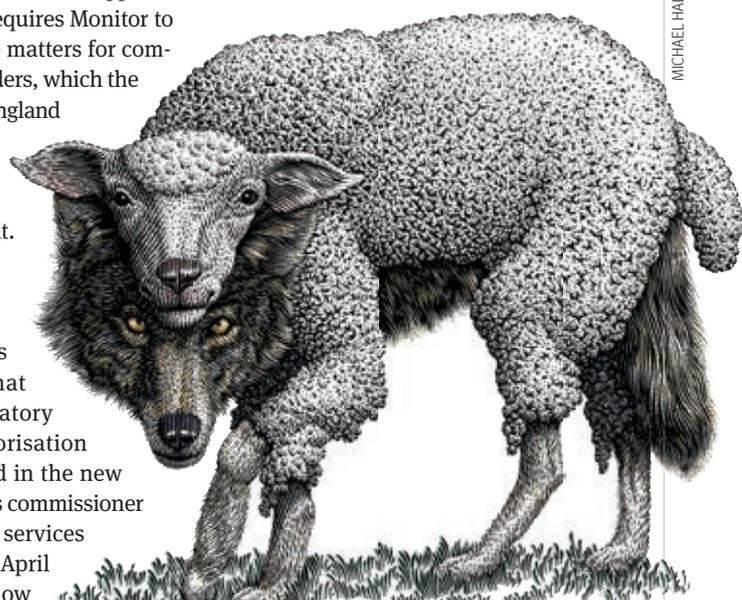
The 2012 act extends Monitor's powers by allowing it to impose licence conditions to ensure "the continued provision of health care services." It can require trusts to provide specific services and give notice if they intend to stop providing a service. Licences extend to the use and disposal of land, buildings, and equipment, and the making of investments. If Monitor imposes these conditions, it "must carry out an ongoing assessment of the risks to the continued provision of services." Monitor can also require licence holders to provide information to service commissioners, allow Monitor to enter trust premises, and require cooperation with people Monitor appoints to help in the management of a trust's "affairs, business and property." The last provision is not expressly limited to when a foundation trust has financial problems, though Monitor would need a rational basis for appointing such people. The act requires Monitor to publish guidance on these matters for commissioners and licence holders, which the secretary of state and NHS England must approve and to which commissioners must have regard, although they are not legally obliged to follow it.

How Monitor has exercised these new powers

When the 2012 act was implemented, services that had been listed as mandatory under the previous authorisation system were re-designated in the new foundation trust licences as commissioner requested services. These services have to be provided up to April 2016. However, between now

Many decisions about what are essential services will in effect be made by management consultants

and then, commissioners have been told by Monitor—in its guidance on continuity of service provision published in March 2013,⁵—to identify services that would need maintaining if a foundation trust were unable to pay its debts. These are termed location specific services and are defined as those services for which there is no alternative provider and for which removal would significantly increase inequalities (box 1). Monitor asserts the power to arbitrate if there is a dispute between commissioners and foundation trusts. It has also said that it expects the process to reduce the number of services that are designated as commissioner requested services.⁵



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Box 2 | Framework agreement to support the assessment of clinical service delivery and financial viability of healthcare providers

The agreement states:

- Under phase 1 (pre-administration) firms will initiate a contingency planning process for trusts assessed as at high risk of failure
 - They will “assess the local health economy” and identify which services “should be formally designated as location specific services in the event that the provider enters special administration”
 - For services that commissioners believe should not be designated as location specific services firms will “develop strategic recommendations as to how they should continue to be provided in the local health economy”—at the existing site, by other healthcare providers, or through other means, including “possible closure”
 - Under phase 2 (actual administration) the firms will provide the special administrator and prepare the draft and final reports
 - If the reports are approved by the secretary of state, the firms will implement them
- Contracts have been awarded with Bolt-HMP, Deloitte, Ernst & Young, FTI Consulting, KPMG, McKinsey, Oliver Wyman, PricewaterhouseCoopers, Roland Berger Strategy Consultants and TGKG to help Monitor, the NHS Trust Development Authority, and the Department of Health “prepare for, develop plans for, support and perform the potential special administration of Foundation Trusts, NHS Trusts or other healthcare providers” over four years

Monitor expects that initially the location specific services will be a subset of the commissioner requested services, but that over time the two categories will converge as the commissioner requested services reduce. This means that services that are currently mandatory will fall away (figure).⁵ The effect will be to reduce NHS-funded care to a basic package of services equivalent to those that must be provided in the event of foundation trust failure.

Furthermore, many decisions about what are essential services will in effect be made by management consultants. Alongside the continuity of service guidance, in September 2013 Monitor entered into a four year contract with 10 management and accounting firms⁶ to develop plans for providers in “financial distress” (box 2). With a value of £210m (€260m; \$340m), the contract extends to NHS trusts, as well as to foundation trusts and private providers, and envisages the firms identifying essential services using the same criteria as for location specific services. Consultancy fees paid by Monitor to six of the ten consulting firms have already risen more than six-fold since the 2012 act was passed: from £4.7m in the two years to March 2012 to £28.3m over the two years to March 2014 (table). The estimated

external cost of the special administration of Mid Staffordshire Foundation Trust was about £6m.⁷

Problems with Monitor's approach Smaller core set of services, regardless of financial position

Commissioners have a legal duty to arrange services to meet reasonable requirements, but under Monitor's continuity of service guidance they are being asked to consider the minimum services required under the assumption that a trust will become bankrupt. If consistently applied, the logic of Monitor's approach for determining commissioner requested services is that foundation trusts will provide a smaller core set of services by April 2016, even though they are not failing or at risk of failing. We question the lawfulness of applying this approach across all 147 foundation trusts, regardless of their individually assessed risk of failure.

Using continuity powers to discontinue services

When the Health and Social Care Bill was originally introduced in January 2011, the government proposed that commissioners would have to apply to Monitor for the prior designation of

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essential services that would be “subject to the special administration regime in the case of provider failure and to additional regulation to ensure their continued provision.” This was intended to be similar to the processes run by regulators in other sectors (such as the energy sector).⁸ Commissioners could apply for a service to be designated as essential only if they were satisfied that the specified criteria were met and had to back up their view with evidence. Monitor was to have the power to decide applications, subject to appeals, and to include conditions in provider licences for ensuring the continued provision of prior designated services.

However, in September 2011, in “response to concerns about the practicalities of designating which services should be subject to additional regulation,”⁹ the government dropped the need for these applications. New provisions were introduced that give Monitor the power to impose conditions for ensuring continued provision of services without the need for prior designation by commissioners as essential. In using these powers of “additional regulation” to bring about a reduction in mandatory services—rather than to maintain essential services if a foundation trust were to fail—Monitor is using its continuity of service provision powers to discontinue currently mandatory services by April 2016.

Unclear effect on NHS trusts

The knock-on effect for the 99 NHS trusts is unclear. According to Monitor's recently updated non-legally binding partnership agreement with the NHS Trust Development Authority, applying continuity of service conditions to NHS Trusts is “inappropriate”; but it also refers to unspecified agreements to ensure “that NHS trusts comply with equivalent obligations” to Monitor licensees.

Implications for the NHS, commissioners, and others

Monitor has stated clearly that it expects a reduction in services that are defined as mandatory.⁵ If its approach proceeds unchecked, this will lead to further “reconfiguration” of services, with some services commissioned from private companies or not at all. Closure and mergers are highlighted as options when the framework agreement (box 2) is invoked. All clinical staff will increasingly be required to provide care to private patients, with foundation trusts now able to raise 49% of their income from them, and denial of care to NHS patients will start to become routine.

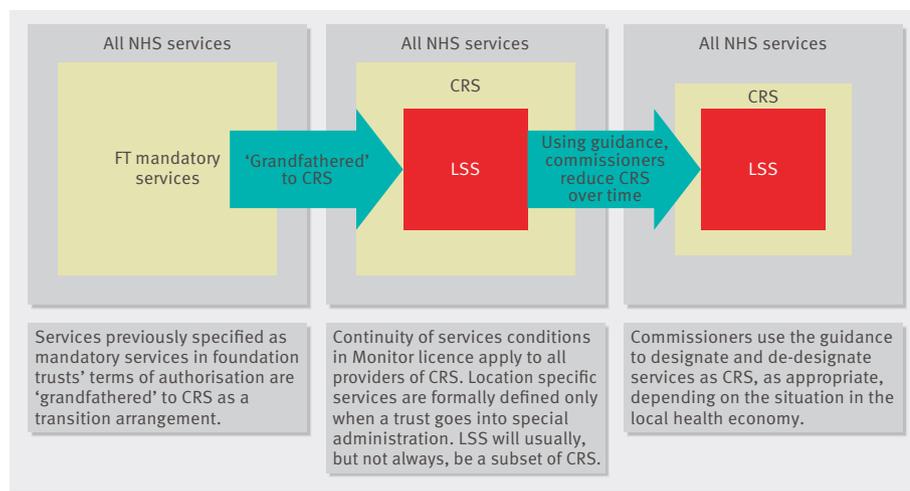
Consultancy fees paid by Monitor to six of the 10 firms* contracted to support trusts in financial difficulty in two years before and after the passing of the Health and Social Care Act 2012†

Consultancy firm	April 2010-March 2012 (£)	April 2012-March 2014 (£)	Total paid (£)
Deloitte	176 015.00	1 765 583.22	1 941 598.22
Ernst & Young	0	11 300 851.98	11 300 851.98
FTI Consulting	0	1 509 322.44	1 509 322.44
KPMG	270 465.91	2 066 391.50	2 336 857.41
McKinsey	1 925 375.00	4 459 200.00	6 384 575.00
PricewaterhouseCoopers	2 284 565.36	7 235 683.00	9 520 248.36
Total	4 656 421.27	28 337 032.14	32 993 453.41‡

* The data spreadsheets do not record any payments to Bolt-HMP, Oliver Wyman, Roland Berger, or TGKG.

† Figures from Monitor's monthly expenditure data (www.gov.uk/government/collections/monitor-financial-information).

‡ A further £1.74m was paid to these six firms during April 2014.



Changes to designation of mandatory services for foundation trusts under the Health and Social Care Act.⁵ Services designated mandatory before the act (left) became commissioner requested services (CRS), with a subset of location specific services (LSS) decided when a trust enters special administration, and CRS reduced by 2016

Commissioners can challenge a foundation trust if they consider it is thwarting fulfilment of their legal duty to arrange provision necessary to meet reasonable requirements. Monitor's continuity of service guidance does not mention this duty, which places commissioners in an invidious position: they have a legal duty to have regard to the guidance but are not legally required to comply with it. Those commissioning services from foundation trusts that are not in deficit, for example, may wish to draw up alternative proposals on what provision is needed in the light of current and future patient needs. However, if they are not designated commissioner requested services, the trust does not have to provide them and may have to look elsewhere. Commissioners should not be tempted to stop commissioning these services in light of their legal duty to meet reasonable requirements.

Local authorities have the power to review and scrutinise any matter relating to the planning, provision, and operation of the health service in their area. The effect of Monitor's guidance on local commissioners and providers or of Monitor's sending management consultants into a trust, for example, would clearly fall under that power. Under such circumstances a local authority can require foundation trusts, NHS trusts, and clinical commissioning groups to provide information and meet with the authority to answer questions. Given that so much public money has been, and will be, handed over to management consultants, it seems critical that authorities exercise this power of scrutiny.

Both local authorities and commissioning groups need to ensure that the causes and com-

ponents of so called deficits are transparent. Although the NHS has been in surplus for the past six years, foundation trusts have reported worse financial results, lower surpluses, higher values of fixed assets, and more indebtedness since 2008, when the Treasury required their accounts to be prepared in accordance with the International Financial Reporting Standards (designed for private sector firms) rather than with the UK's Generally Accepted Accounting Practice (used by the public sector).¹⁰ This raises questions about the reality of their financial problems. Moreover, the government's rejection of MPs' calls for reviewing inflexible accounting rules,¹¹ the contribution

made by capital charges, private finance initiative charges, and increased administrative costs, as well as radical changes to resource allocations, are concealing the extent to which these policies and rules are being used to portray deficits in order to facilitate discontinuity of NHS services and reduce levels of commissioning.

Health and wellbeing boards will also wish to keep a close eye on how Monitor's approach is being implemented in their area. The Department of Health's statutory guidance states that "the evidence base for decisions about local services" is supposed to be provided by boards' joint strategic needs assessments and by the joint health and wellbeing strategies. But unfortunately the 2012 act does not entitle the boards to do much more than moan.

Conclusion

Monitor has been described as an octopus.¹² Now its tentacles are extending with government approval to over-ruling commissioners,

to planning for failure, to reducing NHS-funded care to a basic package of services, and to discontinuing services under the guise of continuity. Time will tell how far its tentacles can lawfully extend.

In the absence of planning structures, and until the government's legal duty to provide the NHS in England is reinstated and the commissioner-provider split is abolished, the onus from now until 2016 is on commissioners not to be thrown off their legal duty, on local authorities to consider using their scrutiny powers, on health and wellbeing boards to investigate how, if at all, their assessments and strategies are being used, and on Monitor to reconsider the lawfulness of its approach.

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