Analysis of Coalition Programme

and

a) recognition that it allows several of the reforms in the Health and Social Care Bill

b) identification of the amendments needed to the Health and Social Care Bill implicit by the amended Lib Dem Conference Motion rejecting breaches of the Coalition Programme

The Liberal Democrat Conference passed amendments calling for the Health and Social Care bill to be amended and pointing out that some of the content of the bill was outside the coalition agreement.

> ***Conference regrets that some of the proposed reforms have never been Liberal Democrat policy, did not feature in our manifesto or in the Coalition agreement, which instead called for an end to large-scale top-down reorganisations.***

The analysis below identifies (red text) those aspects of the Coalition Programme which have been breached by the Government's Health policy and by provisions in the bill and offers a brief commentary (indented) on how the proposed amendments will identify the way forward.

The analysis below also identifies, **in bold text**, those key aspects of the coalition agreement which are included in the Government's policy and in the bill, which the Liberal Democrats are therefore not seeking to challenge.

There will follow an analysis of the Liberal Democrat conference motion as passed also identifying the amendments that are needed.

22. NHS

The Government believes that the NHS is an important expression of our national values. We are committed to an NHS that is free at the point of use and available to everyone based on need, not the ability to pay.

Duty on Secretary of State

This implies that there will be no derogation from the requirement on the Government to provide or secure an NHS both comprehensive and free at the point of use; and not the delegation of that to an unelected board or to unelected commissioners. The proposals in the bill (section 1) to downgrade this to a duty merely to promote such a service and delegate responsibility for providing or securing it to the NCB and GCCs is a breach of this commitment.

This is why we wish to see an amendment to the bill that restores the duty on the Secretary of State to provide or secure a comprehensive health service

Comprehensive Health services

It is said the bill in section 9 abolishes the duty on the health secretary to "provide [certain health services] throughout England, to such extent as he considers ***necessary*** *to meet all reasonable requirements." Commissioning consortiums will now "arrange for" the services necessary "to meet all reasonable requirements" and determine which services are "****appropriate*** *as parts of the health service" (section 9, 2a). A consortium does not have a duty to provide a comprehensive range of services but only "such services or facilities as it considers* ***appropriate****" (section 10, 1).*

Consortiums are not required to cover all persons or provide comprehensive healthcare. While the NHS Commissioning Board must "ensure that . . . commissioning consortia together cover the whole of England, it will not have a power of general direction over the health services for which consortiums contract or patients' entitlements. The secretary of state's influence is only indirect, exercised through an annual "mandate" that will set out the objectives of the independent NHS Commissioning Board. The economic regulator, Monitor, also has no duty to ensure provision for all residents. Its main duty will be to "protect and promote the interests of people who use health services . . . by promoting competition."

The commissioning consortiums' duty to arrange for health service provision applies to their enrolled population. In contrast to primary care trusts, the populations of consortiums will be drawn from the patient lists of member general practices rather than all residents living within a defined geographical area (section 9, 3, 1A).

The bill needs to provide for comprehensive cover for defined geographical populations which in turn requires co-terminosity of commissioning groups with local authority boundaries.

Availability based on need (and funded as such)

In addition the funds allocated to primary care trusts are determined by using formulas adjusted for area based population and needs. However, the budgets of consortiums will be allocated on the basis of aggregated general practice lists rather than geographical population.

There are no robust data existing to fairly allocate resources on the basis of GP practice lists. The data that exists relates to local authority areas. To mitigate the risks of adverse selection (risks that some consortiums will attract sicker and more expensive patients) the bill proposes a whole new risk equalisation mechanism in which consortiums can establish a pooled fund to off-set costs in consortiums that have different proportions of high and low risk patients. However, the absence of individual risk data and robust resource allocation methods is problematic, as are the high transaction costs associated with risk equalisation funds. This model is rather like social insurance schemes memberships and there is concern that this is where the reform is heading.

This requires an amendment allocating funds to commissioners on a the robust weighted capitation approach that occurs at the moment and is a further reason to provide for co-terminosity.

Free of Charge

The secretary of state's duty to provide free services that are "part of the health service in England," except where charges are expressly allowed (section 1, 4), is undermined because the (general?) power under the Health and Medicines Act 1988 (section 7 (h)) to impose charges is transferred from (or shared by?) the secretary of state to (with?) consortiums (section 22, new 14S). Given that under section 9 consortiums will determine which services are part of the health service this implies they can determine which are chargeable (section 9).

The bill needs amending to make clear that commissioning groups that only the Secretary of State, subject to parliament, can impose new or higher charges on NHS services and define what NHS services are chargeable

We want to free NHS staff from political micromanagement, increase democratic participation in the NHS and make the NHS more accountable to the patients that it serves. That way we will drive up standards, support professional responsibility, deliver better value for money and create a healthier nation.

It is not clear how there is any greater democratic participation in the NH, nor is it any more accountable under the proposals in the bill. Amendments are needed to provide for elected members on commissioning bodies.

• We will stop the top-down reorganisations of the NHS that have got in the way of patient care. We are committed to reducing duplication and the resources spent on administration, and diverting these resources back to front-line care.

The present re-organisation is a breach of this commitment and this is why we wish to see the reorganisation trialled and evaluated to ensure that it does not "get in the way of patient care before being rolled out.

• We will significantly cut the number of health quangos.

If there are more commissioning consortia than PCTs then this is breached which is another reason why we have called for the co-terminosity of commissioning groups with local authority areas.

• We will stop the centrally dictated closure of A&E and maternity wards, so that people have better access to local services.

Isn't the ability of the NHS Commissioning Board to define (protected) designated services centralised and unaccountable.

• We will strengthen the power of GPs as patients' expert guides through the health system by enabling them to commission care on their behalf.

This is provides for a greater role for GPs in commissioning.

• We will ensure that there is a stronger voice for patients locally through directly elected individuals on the boards of their local primary care trust (PCT).

Given that the role envisaged for PCTs here is commissioning, this is breached by the replacement of PCts by commissioning bodies with no directly elected individuals.

The remainder of the PCT's board will be appointed by the relevant local authority or authorities, and the Chief Executive and principal officers will be appointed by the Secretary of State on the advice of the new independent NHS board. This will ensure the right balance between locally accountable individuals and technical expertise.

• The local PCT will act as a champion for patients and commission those residual services that are best undertaken at a wider level, rather than directly by GPs. It will also take responsibility for improving public health for people in their area, working closely with the local authority and other local organisations.

The abolition of PCTs is a breach of the coalition agreement but Liberal Democrats may concede, in the light of the transfer of commissioning and public health roles, that this should proceed, subject to all the amendments proposed.

• If a local authority has concerns about a significant proposed closure of local services, for example an A&E department, it will have the right to challenge health organisations, and refer the case to the Independent Reconfiguration Panel. The Panel would then provide advice to the Secretary of State for Health**.**

> ***The bill breaches this as there is no challenge to commissioning decisions of CCs nor any right to refer upwards. It is tackled by democratising CCs and/or allowing local authority challenge to commissioning decisions.***

• We will develop Monitor into an economic regulator that will oversee aspects of access, competition and price-setting in the NHS.

• We will establish an independent NHS board to allocate resources and provide commissioning guidelines.

> ***The presence of these two lines in the coalition agreement are why the Liberal Democrats are not seeking to reject the existence of monitor and the NCB but we propose to see their role amended.***

• We are committed to the continuous improvement of the quality of services to patients, and to achieving this through much greater involvement of independent and voluntary providers.

• We will give every patient the power to choose any healthcare provider that meets NHS standards, within NHS prices. This includes independent, voluntary and community sector providers.

> ***The presence of this in the coalition agreement enables the Government to continue a system whereby non-NHS providers can apply to be commissioned to provide services, but the Lib Dem conference identified safeguards required.***

28. SOCIAL CARE AND DISABILITY

• We will break down barriers between health and social care funding to incentivise preventative action

> ***Without co-terminosity and elected councillors on commissioning bodies the bill will create barriers between health and social care commissioning***