The King's Fund

Ideas that change health care

Briefing

THE HEALTH AND SOCIAL CARE BILL REPORT AND THIRD READING 6-7 SEPTEMBER 2011

Summary

Throughout the debate on the Health and Social Care Bill, The King's Fund has argued that the real choice is not between stability and change but between reforms that are well designed and deliver benefits to patients and those that are poorly planned and undermine NHS performance. The amendments made following the NHS Future Forum's report address many of our concerns and have significantly improved the Bill. We particularly welcome the new emphasis on integration, the more nuanced approach to competition and the changes made to the arrangements for commissioning.

Nevertheless, we remain concerned that the scale of the structural changes set out in the Bill and the challenges associated with implementing them present risks that could damage NHS performance and harm patient care. The uncertainty of the past few months has caused significant instability within the NHS. It is essential to move on from this so that the NHS can focus on its key priority – the need to find £20 billion in productivity improvements to maintain quality and avoid significant cuts to services.

There are a number of areas of the Bill where further clarity is required and the government needs to set out its thinking more clearly. Our views are summarised below.

- We strongly welcome the amendments made to promote integration. However, while the Bill now provides a useful starting point, wider changes to policy are needed to ensure integration is hard-wired throughout the NHS. Ministers should use the remaining debates on the Bill to outline what further steps they will take to promote integrated care.

- The sheer number of changes being made to the health system risk creating confusion and additional bureaucracy. The government must do more to clarify the roles of the various different bodies and how they will work together, especially the roles of clinical senates and networks, which are currently unclear. There is a risk of too much power being centralised in the NHS Commissioning Board and a need to balance national strategic leadership with local autonomy.

- While we welcome the changes made to promote a more nuanced approach to competition and the amendments to Monitor's duties, concerns remain about the extent of the role of competition in the future NHS. The government must use the remaining debates on the Bill to make its intentions about the role of competition absolutely clear.

- Major reconfigurations of hospital services are urgently needed for clinical and financial reasons. We remain concerned about the lack of clear responsibility for driving forward hospital reconfigurations under the Bill and that the changes it proposes will add to an already complex and bureaucratic decision-making process. We will shortly publish proposals to improve this process.

- High-quality leadership and management are essential to implementing the reforms and meeting the financial and operational challenges facing the NHS. Nevertheless, senior members of the government continue to denigrate NHS managers as 'bureaucrats'. This should stop, and the arbitrary target to cut the number of managers by 45 per cent should be re-visited.

- While we welcome the commitment to establish a clearer failure regime for providers, the government's proposals to achieve this have arrived late on in the parliamentary process. The failure regime must strike a balance between maintaining access to essential services and avoiding subsidising inefficient or poor-quality providers – it is not yet clear whether the proposals achieve this, and further clarity is needed on a number of issues.

- The recent public health command paper failed to provide much needed clarity on a number of issues. This adds to the uncertainty created by the wider structural changes in the NHS and risks disconnecting public health from the NHS reforms. We welcome the announcement that the NHS Future Forum will undertake work on public health – the government must move quickly to clarify funding and other arrangements so that local authorities and health bodies can plan their work.

The remainder of this briefing outlines the main provisions in the Bill and our views on them in more detail.

Market-based reforms

We welcome moves to extend patient choice, increase diversity of supply, and increase competition where this brings benefits to patients. However, the previous version of the Bill went too far in promoting competition as an end in itself, so we welcome amendments made to ensure a more nuanced approach to competition.

The economic regulator

The establishment of a sector-specific regulator with expertise in health care will provide the most effective safeguard against inappropriate application of competition law, so we agree that Monitor should assume responsibility for overseeing competition in the NHS and for setting prices (in association with the NHS Commissioning Board). We have consistently argued that competition should not be an end in itself so welcome the amendments made to remove the duty on Monitor to promote competition and focus its primary duty on protecting and promoting patients' interests.

- Monitor must strike the right balance between tackling anti-competitive behaviour and promoting integration.
- The absorption of the Co-operation and Competition Panel within Monitor should be used as an opportunity to review the principles guiding its work – at present these are heavily skewed towards promoting competition.
- In light of the problems experienced by Southern Cross, there is a case for extending Monitor's role to include prudential oversight of the financial viability of health and social care providers with a significant market share of publicly funded services.

Choice

The government's response to the Future Forum report pledged to phase in the move to extending choice of 'any qualified provider' beyond elective surgery to other types of care. Ministers recently announced that the policy will be initially implemented in eight types of mental health and community services from April 2012. A 'choice mandate' will now be included in the Secretary of State's mandate to the NHS Commissioning Board, and the duties on commissioners have been amended to better reflect the principle of 'no decision about me without me'. Publication of the government's information strategy has been further delayed.

- Under the current arrangements for choice at the point of referral, PCTs often limit the range of providers and GPs do not routinely offer choice to their patients, so it will be important to monitor how any qualified provider is implemented.
- As our recent report on shared decision-making argued, 'no decision about me without me' must mean going beyond offering choice of provider to actively involving patients in decisions about their treatment – this needs to be systematically embedded in clinical practice (Coulter and Collins 2011).
- To support choice, information must be relevant, accessible and presented in a way that patients can understand – the government's information strategy should set out how this will be achieved, alongside meeting the data requirements of providers, commissioners and regulators.

Competition

Competition can bring benefits to patients – research suggests it can work well in areas of care such as elective surgery where services are easily defined and outcomes can be clearly measured. However, in more complex areas of care, evidence suggests that the emphasis should be on collaboration and integration. A more nuanced approach will now be taken to competition than proposed in the original Bill, and competition on price has been ruled out. The Secretary of State recently assured the Health Select Committee that 'it is absolutely clear that integration around the needs of the patient will trump other issues, including the application of competition', although a recent report by the Co-operation and Competition Panel, commissioned by the government and Monitor, appeared to jar with ministerial assurances about the limits of competition in the NHS (Co-operation and Competition Panel 2011).

- While we welcome the changes made to promote a more nuanced approach to competition, concerns remain about the extent of the role of competition in the future NHS. The government must use the remaining debates on the Bill to make its intentions about the role of competition absolutely clear.
- We welcome the move to rule out competition on price – evidence suggests that price competition reduces quality and increases transaction costs.
- Although the new arrangements could provide opportunities for social enterprises and the voluntary sector, our work suggests they may struggle to compete in the new environment – this risks reducing diversity of supply.

Commissioning

The King's Fund supports clinical commissioning as an opportunity to improve patient care by linking clinical and financial decisions. The arrangements for commissioning are now much more prescriptive than the permissive approach set out in the original version of the Bill. We welcome the amendments made to widen clinical involvement in commissioning, strengthen governance arrangements and adopt a more flexible approach to implementation.

Clinical commissioning

Clinical commissioning groups (previously GP consortia) will now be required to obtain a wide range of clinical advice and consult a number of bodies in developing their commissioning plans. Existing clinical networks (groups of experts working in specialist areas such as cancer) will be strengthened and new clinical senates established to bring together a wide range of health and social care professionals, although little detail has been published about their role. Clinical commissioning groups will also be required to include a nurse and a hospital specialist on their governing body. The Bill now makes it clear that they will be responsible for commissioning services for unregistered people in their area, not just for registered patients, although there is no duty to promote population-wide health.

- Although we welcome the emphasis on wider clinical involvement in commissioning, the number of bodies that local commissioners will need to consult and take advice from risks creating confusion and additional bureaucracy.

- The role of clinical senates is unclear – the government should move quickly to clarify this.
- We welcome clarification that commissioners will be responsible for unregistered patients but remain concerned that the absence of a clear duty to promote population-wide health could result in GPs giving insufficient priority to public health.

Governance and authorisation

Clinical commissioning groups will now be required to have governing bodies, which must include two lay members (one to champion patient and public involvement and one to lead on governance). Governing bodies must adhere to Nolan principles, meet in public and publish the minutes of meetings. The April 2013 deadline for establishing GP consortia has been relaxed – clinical commissioning groups will be established either in full or in shadow form by this date, but take on their new responsibilities only when they are ready and willing to do so. The government's response to the Future Forum made clear that their boundaries must not now cross those of local authorities unless this can be justified in terms of benefits to patients and integration of health and social care services.

- We welcome the more flexible approach to authorising clinical commissioning groups, but it will be important to continue to encourage those that are ready and willing to move quickly in taking on their responsibilities, and for the NHS Commissioning Board to play a strong role in supporting this.
- The response to the government's pathfinder scheme has been very encouraging – it will be important to sustain the momentum this has generated and evaluate the lessons learned to inform the roll-out of clinical commissioning groups.
- Aligning boundaries will help to promote health and social care integration, although local authority boundaries do not always reflect patterns of need, so some flexibility should be retained.

Primary care services

Our independent inquiry into the quality of care in general practice (The King's Fund 2011) highlighted widespread variations in performance and the need to improve quality in general practice – this should be addressed as a priority. Experience suggests that innovation in service delivery often comes from GPs delivering services. This creates a potential conflict of interest for GPs as providers and commissioners of services. The quality premium paid to high-performing clinical commissioning groups will now focus on quality and outcomes, rather than financial performance, and may take account of progress in reducing health inequalities.

- The NHS Commissioning Board and clinical commissioning groups should work together to improve quality in general practice as a priority – this will be best achieved by supporting locally led initiatives rather than adopting a top-down management approach.
- Clarity is needed about the arrangements for managing potential conflicts of interest for GPs – while these arrangements must provide transparency, they should not act as a barrier to GPs delivering services that benefit patients.
- We welcome clarification that the quality premium will not be based on financial performance and the requirement for clinical commissioning groups to account for how the additional money awarded to them has been spent.

Provider reforms

The provider reforms aim to encourage innovation by granting them more autonomy. This will be achieved by building on the process started by the last government and converting remaining NHS trusts into foundation trusts. These aspects of the reforms have received relatively little attention so far during the debate on the Bill but are nonetheless very important and will be challenging to deliver in a difficult financial context.

Foundation trusts

The government has relaxed its original April 2014 deadline for remaining NHS trusts to become foundation trusts, although it has stressed that the majority will still be expected to meet it. It was always clear that a number of NHS trusts are not financially sustainable and would not be able to meet the deadline, so this will allow more time for the NHS Trust Development Agency to help trusts struggling to achieve foundation trust status. The provisions in the Bill to streamline the process for mergers and acquisitions of struggling trusts should help to kick start the process, which has stalled recently.

- The NHS Trust Development Agency will need to work closely with trusts with financial and clinical challenges to deliver planned reductions in services and, in some cases, closures.

The failure regime for providers and continuity of services

The government has tabled a series of amendments to replace the failure regime for providers of NHS care currently set out in the Bill. The proposals to 'designate' essential services and apply insolvency law to unsustainable foundation trusts are being withdrawn. Instead, Monitor will be responsible for intervening to support providers before they reach crisis point and commissioners will identify services that should be protected only when it becomes clear that a provider is unsustainable. The current failure regime for foundation trusts will be strengthened, and new arrangements will be applied to independent providers. While we welcome the commitment to establish a clearer failure regime that avoids subsidising inefficient or poor-quality providers, these proposals have arrived late on in the parliamentary process and raise a number of questions. In particular, more clarity is needed about how the regime will be applied to independent providers, what happens when intervention is needed on grounds of quality rather than financial sustainability, and the role of the Secretary of State in the process.

- The failure regime must strike a balance between maintaining access to essential services and avoiding subsidising inefficient or poor-quality providers – it is not yet clear whether the government's proposals achieve this, and further clarity is needed on a number of issues.

Governance

In recognition that many foundation trust governing bodies have struggled to hold their boards to account, Monitor's oversight of foundation trusts has been extended to 2016 to enable governors to develop their capabilities. Foundation trusts will also now be required to hold their board meetings in public.

- We welcome the extension of Monitor's oversight of foundation trusts – governors should be provided with support to develop their capabilities in the period up to 2016.

Local authorities and the NHS

The Bill extends the role of local authorities in the health system by creating health and wellbeing boards and giving them responsibility for public health. A number of changes are being made to the Bill to reflect the recommendations made by the Future Forum on these issues.

Health and wellbeing boards

Health and wellbeing boards provide an opportunity to strengthen democratic legitimacy and join up commissioning across the NHS, social care and public health. Their role has been strengthened in a number of ways. They will now be given a stronger role in the development of local commissioning plans, more responsibility for promoting joint commissioning and health and social care integration, and a lead role in local public involvement. They will also be able to refer commissioning plans back to clinical commissioning groups or the NHS Commissioning

Board if they are not satisfied it takes proper account of the local health and wellbeing strategy. A flexible approach will be adopted towards the membership of boards, which will be left to local authority discretion.

- The previous version of the Bill failed to give health and wellbeing boards sufficient powers to fulfil their remit in joining up local commissioning, so we welcome the enhanced role for them now set out in the Bill.
- Stronger duties to promote health and social care integration are welcome but are only a starting point – the key to achieving this will be strong leadership and cultural change to develop joint working at a local level.
- Legal powers for joint commissioning and pooled budgets have existed for some time but few local authorities have used them – the approach set out in the Bill may therefore not be strong enough.

Public health

We have previously welcomed the transfer of responsibility for public health to local authorities as an opportunity to improve the co-ordination of public health with other local services. However, the government's public health command paper, published in July, failed to provide much-needed clarity on a number of issues, including funding levels, and has deferred key decisions to the autumn. Some changes have been made as a result of the Future Forum's report. Public Health England (PHE), the new national public health service, will now be established as an executive agency of the Department of Health, as a response to concerns that locating it in the Department could have undermined the independence of its advice. Duties on the NHS Commissioning Board and clinical commissioning groups to secure advice from public health professionals have been strengthened and they will also have a role in the new clinical senates.

- The deferral of key decisions about public health adds to the uncertainty created by the wider structural changes in the NHS – the government must move quickly to clarify funding and other arrangements for public health so that local authorities and health bodies can plan their work.
- While the amendments to strengthen the involvement of public health professionals in commissioning are welcome, there is a risk that there will not be sufficient public health capacity to fulfil its various responsibilities.
- We are concerned that making PHE an executive agency may weaken the voice of public health within government – ministers must set out clear arrangements for ensuring that public health is given priority across government.

Health inequalities

Our review of NHS performance from 1997 to 2010, published in April last year, identified the lack of progress in reducing health inequalities as the most significant health policy failure of the last decade. We have therefore welcomed the duties on the Secretary of State, NHS Commissioning Board and clinical commissioning groups to have regard to the need to reduce health inequalities, although we noted that these are narrowly drawn and do not extend to local authorities. New duties on the NHS Commissioning Board, Monitor and clinical commissioning groups to promote integrated care also place a welcome emphasis on reducing inequalities. However, while the NHS Future Forum's report called for these duties to be 'translated into practical action', the government has not yet set out how this will be achieved. Meanwhile, the weighting given to health inequalities in the formula for allocating NHS funding has been reduced from 15 per cent to 10 per cent.

- While the new duties to reduce health inequalities are welcome, they should be widened to reflect the broader role the NHS plays as a major employer and contributor to the economy, and equivalent duties should be placed on local authorities.
- The government should set out how it intends to use non-legislative levers and incentives to translate the duties in the Bill into practical action and how the NHS will be accountable for progress in reducing health inequalities.

- While the reduction in the weighting for health inequalities in the allocation of NHS funding will be implemented gradually, reducing the impact on local budgets, we are concerned about the signal this sends about NHS priorities.

System reform

The Bill sets in train a radical reorganisation of the NHS at the same time as it needs to find £20 billion in productivity improvements to maintain quality and avoid significant cuts to services. Following the recommendations made by the NHS Future Forum, further structural reforms are now proposed and changes have been to the timetable for implementing them. It will take some time before the full implications of these changes and their impact on the various bodies in the health system become clear.

Integration

Throughout the debate on the reforms, we have argued that integrated care, based on stronger collaboration among professionals and better co-ordination between services, offers the most promising approach to improving patient care and meeting the key future challenge facing the NHS – demographic change and supporting the increasing number of people with long-term conditions. We therefore strongly welcome the Prime Minister's pledge to put integration at the heart of the reforms and the new duties placed on the NHS Commissioning Board, Monitor and clinical commissioning groups to promote it, although it is not clear why the duties are qualified and differ between the different bodies. There are also stronger duties on clinical commissioning groups and health and wellbeing boards to promote integration between health, social care and 'health-related' services such as public health.

- While the Bill now provides a useful starting point, changes are needed to wider health policy to ensure that integration is hard-wired throughout the NHS – ministers should outline what further steps they will take to promote integrated care.
- Although changes to widen clinical involvement in commissioning will help, a culture change is needed among health professionals who must work much more closely together – leading this process must be a top priority for the NHS Commissioning Board.
- We have previously argued for a single outcomes framework for the NHS, public health and social care – given the new emphasis on promoting integration, the current outcomes frameworks should be reviewed and more closely aligned.

Structural changes

A number of changes have been made to the timetable for the structural reforms. The abolition of strategic health authorities (SHAs) will now be delayed until April 2013, and the NHS Commissioning Board will now be established in shadow form in October 2011, before taking on its full responsibilities from April 2013. In the meantime, SHAs will retain responsibility for NHS finances and will be slimmed down to four 'clusters'. The PCT clusters currently being formed from the consolidation of PCTs will become local arms of the NHS Commissioning Board and will oversee clinical commissioning groups after April 2013. This leaves a very crowded health environment, with clinical commissioning groups, health and wellbeing boards, SHA clusters (until April 2013), PCT clusters and clinical senates and networks operating at a regional, sub-regional and local level.

- The sheer number of changes being made to the structure of the health system risks creating confusion and additional bureaucracy – the government must set out very clearly how these bodies will operate and work together.
- The NHS Commissioning Board will be very powerful and seems unlikely to be the 'lean and expert' body described in the NHS White Paper – it will need to ensure that it avoids over-centralisation and encourages locally led innovation.
- The dismantling of PCTs and move to PCT clusters risks breaking up established arrangements for integrating health and social care in some local areas – more flexibility is needed in the arrangements for managing the transition to avoid this.

The Nicholson challenge

Although its budget has been protected, the NHS faces the tightest financial settlement in its history. This will be implemented alongside significant cuts in local government funding, with the risk that the strain on social care services will add to the pressure on the NHS. The key priority therefore remains the need to find up to £20 billion in productivity improvements by 2015 – the so-called 'Nicholson challenge'. Implementing the reforms while maintaining the focus needed to achieve this will be very challenging, and there remains a real risk that NHS performance could be undermined during this crucial period. Against this background, the Prime Minister's pledge to keep waiting times low will be difficult to meet. Although the government's response to the Future Forum recognised the need for high-quality leadership and management to manage these risks, the commitment to reduce management costs by 45 per cent remains in place.

- Delivering on the 'Nicholson challenge' must be the NHS's top priority – it is essential to move on from the uncertainty of the last few months so that it can focus on the financial and operational challenges this presents.
- Major reconfigurations of hospital services are essential to meeting the 'Nicholson challenge' – we remain concerned about the lack of clear responsibility for driving forward hospital reconfigurations, while there is a pressing need to improve the decision-making process for reconfigurations, which is complex and bureaucratic.
- While we welcome the recognition of the importance of leadership and management, we believe ministers should stop denigrating NHS managers as 'bureaucrats' and the target to cut the number of managers by 45 per cent should be re-visited.

Conclusion

While the changes made following the NHS Future Forum's report have significantly improved the Bill, a number of areas need further clarification and explanation. The Bill's remaining stages in the House of Commons provide an opportunity to address the important issues that we and others have raised.

Despite the headlines generated by the reforms, the key priority facing the NHS remains the need to find £20 billion in productivity improvements to maintain quality and avoid significant cuts to services. The uncertainty of the last few months has caused instability within the NHS at a time when it faces significant financial and operational difficulties. The government must now provide the direction and stability the NHS desperately needs to navigate the challenging times ahead.

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